Reproductive Health

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Opportunities for improving abortion care: a key stakeholder analysis of best practices for addressing the needs of transgender, nonbinary, and gender expansive people seeking abortions

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Abstract

Objectives Transgender, nonbinary, and gender expansive (TGE) persons experience pregnancies and have abortions, yet abortion care remains rooted in a gender binary, often centering the needs, experiences, and challenges of cisgender women. Despite guidance supporting gender-affirming sexual and reproductive healthcare (SRH), barriers for TGE people seeking abortions persist. We conducted an exploratory case study with key informants to understand their perception of TGE abortion seekers' needs with specific considerations for those in restrictive abortion settings.

Methods Qualitative interviews focused on gender-affirming care and abortion provision were conducted with U.S.-based key informant clinicians (n = 4) who could provide powerful insights into gaps and experiences faced by TGE individuals. Participants were eligible if they currently or previously provided abortions and had experience practicing gender-affirming care. Interviews focused on informants' perceptions of TGE patients' needs when seeking abortions.

Results Findings highlight the unique barriers TGE patients face when seeking abortions, including lack of provider knowledge, in-clinic stigmatization, and gender marginalization. It is notable that key informants who practiced in abortion-protective political environments have greater access to resources to implement gender-affirming care than those in restrictive contexts. Results are summarized in a clinical recommendations document which provides an accessible starting point for clinicians to begin building gender-inclusive abortion spaces.

Conclusions It is necessary to further understand barriers facing TGE abortion seekers and integrate recommendations and emerging evidence into abortion practice. This study contributes to a growing knowledge base which emphasizes the need for inclusive abortion spaces and highlights key considerations for improving access and quality for TGE abortions seekers.

Keywords Abortion care, Gender-affirming care, Sexual and reproductive health, Transgender, nonbinary, and gender expansive health, Health care delivery, Case study

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Introduction

Transgender, nonbinary, and gender expansive (TGE) persons experience pregnancies and have abortions, yet abortion care remains rooted in a gender binary, often centering the needs, experiences, and challenges of cisgender women [1–5]. Worldwide reproductive justice and gender equity struggles are intertwined, as gender inclusion is often at the forefront of conversations surrounding abortion rights, inviting the opportunity to look at abortion rights within the lens of queer inclusion [6].

Gender-affirming care is a widely recognized medical intervention that can range from hormone treatments to affirming language which can increase social, emotional, and physical health outcomes among TGE individuals [4, 7]. The American College of Obstetrics and Gynecology recommends the use of gender-affirming care in abortion care [2, 4]. The World Professional Association for Transgender Health (WPATH) has emphasized the global importance of accessible abortion care and gender-affirming care for gender diverse individuals [5].

Despite clinical guidance supporting gender-affirming sexual and reproductive healthcare (SRH), barriers for TGE abortion seekers persist [2, 3, 5, 7–9]. According to the 2022 U.S. Transgender Survey, 24% of respondents reported not seeing a doctor when medically necessary and 48% reported a negative provider experience related to gender identity [10]. TGE patients similarly report high rates of mistreatment in SRH facilities, often heightened through intersections with other experiences of marginalization, particularly related to race, socio-economic, and insurance status [1, 2, 7, 9–11].

Some literature has reported the challenges of TGE abortion-seekers, yet little is documented on abortion providers' awareness of access barriers or specific needs of this population [1–3]. To contribute, we conducted an exploratory case study with key informants to understand their perception of the needs of TGE abortion seekers with specific considerations for those in restrictive abortion settings in the United States.

Methods

From November 2022 to March 2023, we conducted an exploratory qualitative study with U.S.-based clinicians in gender-affirming care and abortion provision (n = 4), recruited through informal networks, who could provide powerful insights into gaps and experiences faced by TGE individuals. Participants were eligible if they currently or previously provided abortions and had experience practicing gender-affirming care. Key informants worked in SRH settings in different U.S. states: two in abortion-protective landscapes, and two in Southern and restrictive contexts. Three of the four key informants self-identified as queer, and one key informant self-identified as trans and nonbinary. Interviews (lasting 40–80 min) were conducted via Zoom™; informants provided verbal consent at the start of the interview and did not receive compensation.

Interviews were informed by literature and focused on informants' perceptions of TGE patients' needs when seeking abortion and further understanding the influence of abortion restrictions on abortion provision. The first author transcribed interviews, then used MAXQDA 2022 to conduct coding and analysis. A codebook of deductive and inductive codes was developed, which informed a thematic content analysis specifically focused on TGE barriers and clinical best practices.

Results

All four key informants discussed barriers specific to TGE patients seeking abortions and provided recommendations on ways providers can create more gender inclusive abortion spaces. Three themes emerged from the data, exemplified by key informant quotes (Table 1) and summarized in a clinical recommendations document (Fig. 1).

1. All reproductive healthcare providers see gender expansive patients (whether they know it or not).

Informants noted that providers may mistakenly believe they do not serve TGE patients. They emphasized that TGE patients are present in abortion spaces and need access to the full scope of SRH care provided to cisgender patients yet are sometimes not asked about gender identity. This inattention can result in lack of feelings of safety for patients to disclose gender identity, setting the stage for providers' incomplete understanding of patients' lived experiences and health profiles resulting in less than comprehensive care.

2. For TGE patients, abortion settings can be rigidly gendered and thus exclusionary spaces.

All informants acknowledged that general-access barriers for people seeking an abortion (e.g., transportation, cost, stigma) are present for TGE patients, who also face compounding barriers such as gendered clinic spaces, which create exclusionary environments. Clinics are setup to serve and prioritize cisgender women, evidenced by the utilization of the word "women" in many SRH facility names. Additionally, clinics may not have resources tailored to TGE abortion seekers such as materials in waiting rooms and post-abortion care documents. Internal systems may also lack diverse gender

Table 1 Summary of key validation parameters of the three immunoassays and LC-HRMS method

Theme 1:	**All reproductive healthcare providers see TGE patients (whether they know it or not).**
	"*I've had other providers say to me… 'I haven't seen TGE patients in my practice.' And I'm like, you have. You just didn't know, and you didn't ask.*" – OB/GYN in abortion-restrictive state
	"*I think un-gendering the spaces and understanding that TGE patients also need abortion care, and probably are at even more risk of not being able to access that care because of not feeling safe in this space. And I think we need to really look at ourselves and understand that well, maybe the majority of our patients we take care of are cis female patients, [but] even ACOG has made the statement about 'pregnant people,' right? All of us recognize that like you don't have to be a woman to be pregnant. And we need to create safer space for them.*" – Advanced OB/GYN in abortion-restrictive state
Theme 2:	**All reproductive healthcare providers see TGE patients (whether they know it or not).**
	"A lot of the problem is the name of the clinics… 'A Woman's Choice,' 'A Pregnant Woman…' when in reality, we know that we're not just caring for women. So even before they walk through the door, a lot of the time, TGE patients are already feeling affronted." – Advanced OB/GYN in abortion-restrictive state
	"*Patients encounter front-of-house staff before they ever see a provider when they're seeking out an abortion or other reproductive health care. And if those are bad experiences, like, obviously, what happens with the provider still matters, but it's not going to be a good experience if their experiences before they see the provider were not good experiences.*" – Family Nurse Practitioner in abortion-protective state
	"*I mean, my high-risk clinic that I work at, I think if a transgender patient came in, people would literally not know what to do. Our forms are very gendered. We talk about moms and dads and babies and pregnant women, and it kills me a little bit. Our clinic manager does not understand the concept of pronouns. We're also in the Deep South, not that that's an excuse, but it is what it is, right? Like there's only so much change you're going to be able to make.*" – Advanced OB/GYN in abortion-restrictive state
Theme 3:	**Context, resources, and lack of knowledge or training on gender-affirming care present additional barriers for patients.**
	"*There are great many people out there who, I think, just really lack the basic vocabulary, [and] don't know where to look for resources. There's just a huge dearth of provider information… patients present to care, the front desk staff misgendered somebody [or] dead names them in the waiting room, and they're in a clinic that says 'Women's Health Center, and [are] the only non-woman in the waiting room—by the time they even see a provider the whole experience has just been super dysphoric. And so, the entire healthcare system is just set up to fail for these patients.*" – Family Medicine Provider in abortion-protective state
	"*Those of us who were there to do the abortion work-- you have to be really familiar with the laws and policies. I'm wondering if that's the same thing in spaces where it's really regulated, if [gender-affirming] care is so siloed, because trying to get someone up to snuff on how they don't break the law by providing abortion care is so much, that I don't know that you could even dedicate any time to then helping them learn how to do gender-affirming care.*" – Advanced OB/GYN in abortion-restrictive state
	"*None of this [TGE specific care], is taught in medical schools. Folks who are more than three or four years out of medical training, have received literally no education on any of this at all, and you know in many ways that's not their fault, like we don't choose what is taught to us in medical school, right? We're sort of at the whims of our education committee.*" – Family Medicine Provider in abortion-protective state

reporting options in their clinic forms, electronic medical systems, and protocols.

3. Context, resources, and lack of knowledge or training on gender-affirming care present additional barriers for patients.

Key informants stated that clinic staff may not have the training, skills, nor resources to compassionately provide care to TGE patients. Key informants noted that gender-affirming care is not standard in medical education, and therefore regular, consistent training was critically necessary for providers. Furthermore, key informants from Southern U.S. contexts discussed how restrictive abortion policies impacted their ability to prioritize care for TGE abortion seekers, juxtaposing the responses from providers in non-restrictive states who explained how more resources and energy can be dedicated to inclusive, patient-centered care for TGE individuals in their practices.

Discussion

Findings from this exploratory case study highlight the unique barriers TGE patients face when seeking abortions, including lack of provider knowledge and resources, in-clinic stigmatization, and gender marginalization. These findings illuminate the necessity to further understand barriers facing TGE patients seeking abortions and to integrate recommendations and emerging evidence for TGE patients into abortion practice. It is crucial that voices of the most marginalized, particularly from abortion restrictive settings, be centered in broadening the current knowledge base.

It is notable that key informants who practiced in abortion-protective political environments have greater access to resources and support than those in restrictive

Fig. 1 Clinical recommendations document synthesizing major themes from key-informant interviews, to provide steps for clinicians to begin creating more gender inclusive abortion care spaces [16–18]

contexts [7, 12]. The two Southern U.S. key informants reported navigating complex laws that increase stigma and limit their ability to provide lifesaving SRH care. Abortion restrictions are compounded by the proliferation of anti-trans legislation sweeping the U.S. South, further constraining implementation of gender-affirming SRH care, thus, highlighting the need to prioritize context-specific solutions for TGE abortion care [13]. Themes that have emerged from providers in restrictive abortion contexts in the U.S. are relevant in global settings where abortion and SRH is limited, especially in settings where legacies of or current anti-trans and LGBTQ+ legislation impact TGE health [6, 14, 15]. The importance of addressing barriers to safe abortion care for TGE people is of global importance and must be addressed to increase health equity for those who are the most marginalized with the least access to care.

We assert that TGE inclusion in abortion care is essential. This study contributes to a growing knowledge base which emphasizes the need for inclusive abortion spaces and provides an accessible starting point for clinicians (Fig. 1) [1, 2, 6, 7]. It is essential to integrate current literature on this subject into practice and implement context-specific training for TGE care into abortion education for all SRH providers. This study was designed to be solely exploratory, focused on a small group of key informants and thus was not intended to be generalizable. While one of the four key informants self-identified as TGE, including additional perspectives of TGE stakeholders themselves is necessary to build on the results from this study. Furthermore, there is a need to understand perspectives outside the U.S. in both restrictive and non-restrictive abortion settings, especially given the difficulty of integrating these best practices in settings where TGE and LGBTQ+ identities are criminalized. Still, these results have highlighted key considerations for improving access and quality for TGE abortion seekers and should be expanded upon for future studies and in informing clinical, context specific recommendations.

Abbreviations

TGE Transgender, nonbinary, and gender expansive
SRH Sexual and reproductive healthcare

Acknowledgements

Not Applicable

Author contributions

AJB and ANL contributed to the conceptualization of and design of the study. AJB performed data collection. AJB and ANL conducted thematic analysis. AJB wrote the draft manuscript and ANL, SN, and SH provided substantial revisions of draft manuscripts. All authors reviewed the manuscript and approved the final version for publication.

Funding

This study is supported by the Center for Reproductive Health Research in the Southeast (RISE) through support from an anonymous foundation and the Collaborative for Gender + Reproductive Equity, a sponsored project of Rockefeller Philanthropy Advisors. Dr. Narasimhan is supported by the Building Interdisciplinary Research Careers in Women's Health of the National Institutes of Health (NIH) Award Number K12HD085850, the Georgia Clinical and Translational Science Alliance (GCTSA) Award Number KL2TR002381, and National Center for Advancing Translational Sciences of the National Institutes of Health under Award Number U1TR002378; Dr. Newton-Levinson was supported by a grant from K12 GM000680/GM/NIGMS NIH HHS/United States. The content is authors' responsibility and does not necessarily represent the official views of the anonymous foundation, CGRE, the NIH or the GCTSA.

Availability of data and materials

The interview data that support the findings of this study are not public due to participant confidentiality but are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate

The study was approved by the Emory Institutional Review Board. Verbal informed consent was obtained from all the study participants prior to interviews. All the research methods were performed in accordance with relevant guidelines and regulations (Declaration of Helsinki).

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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Received: 29 June 2024 Accepted: 9 August 2024
Published online: 27 September 2024

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