School of Public Health

Ageing Transgender People's Experiences of Health and Health Provision

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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

This theme contains no material which has been accepted for the award of any other degree or diploma in any university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number #HRE_2017_0202.

Abstract

This study responds to calls from the United Nations Development Program (2013) and prominent transgender authors for more quality research (Whittle et al., 2007; Winter et al., 2016a, 2016c; Reisner et al, 2016a). There has been a deficit of specific information regarding transgender people who have experienced Australian healthcare provision and systems and are ageing (over 50 years). Transgender (trans) people are defined as individuals "who experience a degree of gender incongruence; that is, a discordance between their personal sense of their own gender (gender identity) and the sex assigned to them at birth" (Winter et al., 2016a, p.390).

An exploration was made of what positively or negatively impacted ageing transgender people's health, healthcare provision, and access to services. Purposive samples (followed by snowball sampling to increase participant numbers) were sourced from known transgender community groups and social spaces, and by advertising through known transgender support organisations around Australia (hard print and online). A qualitative phenomenological approach facilitated data collection from 19 semi-structured interviews with participants aged between 51-66 years. Aims of the study were not to fit information into any pre-existing theoretical frameworks, but to undertake contextual exploration of the key factors impacting ageing transgender and gender diverse participants. Collated data was analysed inductively by way of thematic analysis and following six-step guidelines set out in Braun and Clarke (2006).

Findings showed that, although participants' amalgamated health determinants for both general health and gender affirmation issues were unique to each person, there were several similarities within the key individual factors. Health determinants were mostly associated with the following: (1) psychosocial issues, such as those relating to social authenticity and past trauma (marginalization, prejudice, and concealment); (2) economic issues, such as employment, education, and, housing discrimination; (3) systematic issues, such as identity-specific medical transition needs, access to appropriate care and institutional care; and, (4) geographic factors, such as distance from specialist health practitioners.

Recommendations for filling health determinant research gaps involve multi-sectoral collaborations that include transgender community members in the planning and gathering of data. Collaborative data collection, which includes a range of determinants for good health and wellbeing, as well as healthcare issues, will likely improve data accuracy and ensure appropriate modifications to health policies impacting ageing transgender and gender diverse people.

Table of Contents

Figures

Tables

Acknowledgements

List of Abbreviations

ABS	Australian Bureau of Statistics
AFAB	Assigned Female at Birth
AHRC	Australian Human Rights Commission
AIDS	Acquired Immunodeficiency Syndrome
AIHW	Australian Institute of Health & Welfare
AMAB	Assigned Male at Birth
APA	American Psychiatric Association
ARCSHS	Australian Research Center in Sex, Health, and Society
ATPEH	Ageing Transgender People's Experiences of Health
AusPATH	The Australian Professional Association for Trans Health
CDC	Consumer Directed Care
CHD	Coronary Heart Disease
CHSP	Commonwealth Home Support Programme
COTA	Council of Ageing (Victoria)
DOH	Department of Health
DSD	Disorder of Sex Development
DSM	Diagnostic and Statistical Manual of Mental Disorders
FtM	Female-to-Male
GAHT	Gender Affirming Hormonal Therapy
GAS	Gender Affirming Surgeries
GD	Gender Dysphoria
GDC	Gender Dysphoria Clinic
GP	General Practitioner
HEI	Healthcare Equality Index
HIV	Human Immunodeficiency Virus
HP	Health Provision, Provider, Professional, or Practitioner
ICD	International Classification of Diseases
ICHOM	International Consortium For Health Outcomes Measurement
IOM	Institute of Medicine
LGB	Lesbian, Gay, and Bisexual

LGBT	LGB and Transgender
LGBTI	LGBT and Intersex
LGBTIQ	LGBTI and Queer
LHN	Local Hospital Networks
LTC	Long-Term Care
MtF	Male-to-Female
Monash GDC	Monash Gender Dysphoria Clinic (former name of Monash Health Gender Clinic)
NARI	Australian National Ageing Research Institute
NHPA	National Health Priority Areas
NSQHS	The National Safety and Quality Health Service Standards
OECD	Organisation for Economic Co-Operation and Development
PATHA	The Professional Association for Transgender Health Aotearoa
PBS	Pharmaceutical Benefits Scheme
PCC	Patient-Centred Care
PE	Patient Experience
PFACs	Patient and Family Advisory Councils
PHN	Primary Health Networks
PPI	Patient and Public Involvement
QOL	Quality of Life
SEIFAs	Socio-Economic Indexes for Areas
SMI	Severe (or Serious) Mental Health Illness
SOGII	Sexual Orientation, Gender Identity and Intersex
SRS	Sex Re-Assignment Surgery* *Typically used within the literature review and participants. the term mostly describes genital surgeries.
STD	Sexually Transmitted Disease(S)
TGNC	Transgender and Gender Non-Conforming
TGV	Transgender Victoria
US	United States (of America)
WHO	World Health Organisation
WPATH	World Professional Association for Transgender Health

Chapter 1.   Introduction

1.1   Being Transgender and Definition of Key Terms

Transgender people, also known as trans people, are defined as a broad spectrum of individuals who "experience a degree of gender incongruence; that is, a discordance between their personal sense of their own gender (their gender identity) and the sex assigned to them at birth" (Winter et al., 2016, p. 390). Conflict between people's societal expectations of gender identities being binary gender (male/man or female/woman) has created difficulties for many people to express their gender as they truly feel it. When this occurs, the often-high levels of distress people may experience is known as gender dysphoria (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010; cited in, Coleman et al., 2012). Gender dysphoria is a condition reflected in an overarching diagnosis for transgender adults in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (American Psychiatric Association [APA], 2013a). The term gender dysphoria has been adopted across much of the world by health providers, professionals, and practitioners (HPs), as is evident by the large volume of healthcare literature using the phenomenon to describe and explain transgender health issues.

The APA diagnosis for gender dysphoria, as "affective/cognitive discontent with the assigned gender" (American Psychiatric Association, 2013a, p. 82), has caused much controversy because there is no sole cogent definition for the term (Winters, 2019). For example, prominent authors have argued that gender dysphoria should not be placed in a manual of mental disorders because "gender non-conformity is not, in and of itself, pathological" (Wylie et al., 2016, p. 404). In another example, Houssayni and Nilsen (2018) used a definition that pointed to the cause of gender dysphoria as "the outcome of distress and negative experiences associated with incongruence between her/his experienced and expressed gender" (p.15).

Definitions are significant to improving the overall health of transgender people. Those that are associated with the negative impacts, such as distress, of gender dysphoria also relate to the issues of how transgender people's needs are met. This point is particularly pertinent to the new non-psychiatric definition, as published in a revised (11th) edition of the *International Classification of Diseases (ICD-11)* (WHO, 2019). This definition is as follows: "Gender incongruence is characterized by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group" (WHO, 2019, para 1). This indicates when a diagnosis should be considered, and how individuals should be provided with treatment for their health issues, including medical and surgical transitions, by health systems, medical communities, and health providers. Leaders in the field argue that there should be a consideration for whether treatment be given for psychopathological reasons, or, whether people with gender dysphoria should be treated with standardized care that aligns with general population practices for other biological and physical conditions (Winters, 2019).

The consequences of avoiding healthcare are widespread amongst transgender people. For example, they are sometimes deterred (by negative social attitudes) from addressing their gender dysphoria; not all transgender people will live openly in society in a way that is congruent with their gender identity, particularly if they feel their safety or wellbeing is compromised (Burnes & Chen, 2012).

Gender identity also varies with social context and culture, and changes across time and generations, and/or geographical location (Reisner, Radix, & Deutsch, 2016b). A recent definition by prominent authors describing non-binary (NB) transgender identities has been "individuals who identify outside of the gender binary 'man' and 'woman,' identifying as neither, as both or as another gender identity on the continuum between the two. Some individuals, particularly in cultures which accept the idea of gender beyond 'man' and 'woman', identify as members of 'third genders', and/or employ indigenous gender labels" (Reisner et al., 2016b, p. 1).

In this study the term transgender and trans (gender), have been used as umbrella terms to discuss people whose identity differs to the sex they were assigned at birth. Changes of identity may have included modifications to a person's gendered expression and/or appearance. Examples are modifications in the following: clothing; clinical processes (gender affirming surgeries or hormonal therapy); non-clinical body treatments (hair removal, make-up); mannerisms, or behaviour. The acronym used for all gender affirming surgeries in this study is GAS, and for all gender affirming hormonal therapies it is GAHT. The terms transgender and trans also includes "those who engage in a physical transition [who] are often popularly described as transsexual people" (Winter et al., 2016b, p. 391). Other terms and contextual definitions adopted by organisations, such as the World Professional Association for Transgender Health (WPATH), the Professional Association for Transgender Health Aotearoa (PATHA), and the Australian Professional Association for Trans Health (AusPATH), which relate to transgender people, have been listed in the Glossary.

Some authors use a TGNC acronym to describe transgender and gender non-conforming people as "those whose gender identity is not aligned with their sex assigned at birth (e.g., female, male), or societal expectations for binary gender identities (e.g., woman, man) or expression (e.g., feminine, masculine)" (American Psychiatric Association, 2015; cited in Porter et al., 2016, p. 366). Porter et al. (2016) have acknowledged that, whilst the use of the acronym was to include as many people as possible with one term, not every transgender person would choose to identify with it. In this study TGNC has only been used for citation reasons.

Additionally, people who transition often make other social changes, for example by correcting their identity documentation. This has helped some people to live in society in their authentic gender after transition, with or without cross-gender surgeries or hormone treatment, and not as transgender identifying. Alternatively, when some NB identifying transgender people make an

outward gender transition in society, they may request that others refer to them with specific and related pronouns (they, their, ze, zie, hir).

Terms describing transgender contrast to those describing cisgender. Cisgender people are those "whose gender identity matches their sex assigned at birth, and who therefore, unlike transgender people, experience[s] no gender incongruence" (Winter et al., 2016b, p. 391).

1.2   Background

Western European knowledge about transgender health and wellbeing has benefitted from the United States (US) acting as the forerunner in transgender health determinants and medical advancements. However, resulting knowledge base has lacked cultural diversity. We know relatively little about other non-Western transgender histories, such as those from South East Asia.

What we do know is that transgender populations, in countries with long and rich histories of gender diversity, have been understood in ways related to their social, religious, legal, and cultural contexts (Burnes & Chen, 2012). Malaysia's transgender populations are lawfully regulated according to their religion. For example, Malaysian Muslim, "Mak Nyah" transgender people are penalised for dressing or changing their gender with imprisonment or heavy fines, whereas Buddhist, Hindu, and Christian populations incur much lighter fines (Burnes & Chen, 2012). Thailand has diverse populations whose identities are intertwined with social and sexual practices. Thai society makes social distinctions between those who are assigned male at birth and identify in the following ways: "gay" males who have masculine identities; "Kathoey" persons who identify as female (Burnes & Chen, 2012); and, "Sao braphet SONG," who "reject the gender of masculinity for femininity … [and identify as] a second type of woman" (Costa and Matzner, 2013, pg.1).

Australian Indigenous populations have a rich history in relation to transgender identities however this is often overlooked in Australian society (Brown, 2004). Brown (2004) suggests an oversight has occurred because Aboriginal people's concept of identity expressions differs from the Western viewpoint. For example, an individual who is regarded as transgender, and a Sistergirl, by white Australia may, by their own community, be regarded as a "woman, a daughter, a sister, an aunty, and a mother - a valuable part of the family, a carer and a supporter" (Brown, 2004, p. 25). The emphasis in this regard is their authentic expression and role within the community.

Sadly, much of the history relating to Australian Aboriginal people's transgender histories includes discrimination, trauma (related to drugs, alcohol, rape, unemployment, violence, loss of identity), isolation, stigmatization, and misunderstanding. Much of this is caused by the intersection of being black and transgender in environments and social situations, such as Christian churches, which lack knowledge or awareness of Australian Aboriginal identities (Brown, 2004). This issue is also prevalent in Australian healthcare systems and environments. Brown (2004) emphasized a continuing

and significant issue that Sistergirls mostly do not communicate any concerns for gaining gender dysphoria diagnosis, or having a mental illness, in relation their transgender identities.

What is not known is precisely what causes all people, trans and cisgender, to experience specific gender identities. A study by Saraswat, Weinand, and Safer (2015) reviewed a number of related recent studies and found that "there is a biologic basis for gender identity [that] primarily involves (1) data on gender identity in (intersex) patients with differences in sex development" (pg. 199) (it should be noted here that the authors of this study used the term disorders of sex development [DSDs]. However, there have more recently been strong objections to the label "disorder" referring to congenital conditions as atypical. Therefore, the intersex conditions are included in diversity matters that Diamond (2009) defines as "neuroanatomical differences associated with gender identity" (cited in, Coleman et al., 2012, p.199).

Brain structures in transgender men and women were examined. Results showed similarities with the general population in comparison with study participants, even when results were controlled for hormones (Saraswat et al., 2015). Whilst the study has supported the biological rationale for being transgender, the authors reported most of the research available only focuses on biological context and has been limited due to small sample sizes (Saraswat et al., 2015).

Other studies that have helped us understand transgender people have discussed their medical and social issues. Many have shown how historical negative events (e.g., stigma, marginalisation, discrimination) in mainstream society and associated healthcare situations have framed their unwillingness to be visible in society (Bauer et al., 2009; Bauer, Scheim, Deutsch, & Massarella, 2014; Winter et al., 2016a).

Western (predominantly US) transgender histories have shown emerging populations in urban locations since the mid-19th century, when demographic and geographical changes in population migration (rural to urban) increased opportunities for transgender people to live anonymous and safer existences in densely populated environments (Beemyn, 2013; Stryker, 2017). In the same era and into the 20th century medical conceptions of gender incongruence pathologized transgender people as having abnormal tendencies and sexual fetishes (Beemyn, 2013). They were thought to be mentally disturbed. However, in the 1900s Magnus Hirschfield, a prominent non-medical sexologist, ascertained that transgender people should not be pathologized with a mental disorder. He believed that the overall wellbeing of "transvestites" would be improved by presenting as a gender opposite to their biological (assigned at birth) sex (Beemyn, 2013). His viewpoint did not win over his medical counterparts and gender non-conformity was treated as pathology, despite rising visibility of transgender people throughout the 20th century (Beemyn, 2013).

Health providers began to publish diagnoses relating to gender identity in the latter half of the 20th century. Initial views from the World Health Organization's (WHO) experts were that

transgender people were sexual deviants, so they were assigned a classification code for transvestism (Transvestic Disorder) in the *International Classification of Diseases 8 and 9th Editions (ICD-8/9)* (1965; cited in Drescher, Cohen-Kettenis, & Winter, 2012, p. 570). This classification continued until the late 20th century. Since that time, there has been significant progress made towards understanding transgender issues.

Gender identity disorder (GID) was included in the *Sexual Disorders* chapter of the *DSM-IV* and *IV-TR* (APA, 2000a/b) until the diagnostic manual was revised by the American Psychiatric Association (*DSM-V*) in 2013. Furthermore, the *ICD-10* diagnoses of sexual pathologies persisted until the revised 11th Edition was published by WHO (2019). Drescher, Cohen-Ketteris, and Winter (2012) have criticized the use of previous diagnoses because "the diagnostic classification of disorders related to (trans)gender identity is an area long characterized by lack of knowledge, misconceptions and controversy" (2012, p. 568). Sadly, the cross-referencing of codes (between the *ICD-10* and *DSM-5*; which still includes Blanchard's 'Transvestic Disorder') has continued in the US and Canada, despite the diagnosis correction in the most recent *ICD-11*. These uses have damaging consequences, as can be understood from historical cases where HPs believed that gender reparative therapies were a solution to "cure" transgender people (Hollenbach, Eckstrand, & Dreger, 2014).

For much of the 20th century transgender people experienced mutual intersectional and compounded social oppression (e.g., stigma and homophobia) with cisgender lesbian, gay, and bisexual (LGB) populations. However, in the 1960s a social movement (specifically the Stonewall Riots) fought for equality and legal rights against anti-gay and anti-trans laws, and the intensifying oppression caused by them. This caused division between transgender people and others in the combined LGB and transgender (LGBT) movement. During these events transgender people felt that their LGB counterparts had used them to bolster their own agendas (Stryker, 2017). For example, violent demonstrations resulted in increased gay activism and fighting for gay and lesbian rights but lacked loyalty to transgender people by not defending rights specific to them. Stryker (2017) supported this interpretation by pointing to Compton's 1966 protest where police primarily targeted transgender people.

After the Stonewall Riots, transgender people continued to report macro-environmental, sociocultural, political, and economic harassment (e.g., within police, medical, and legal systems), as well as some hostility from their LGB counterparts (Stryker, 2017). Stryker (2017) related this antipathy as being significant to transgender people because being socially understood within the LGBT context has rendered transgender people as prey to ongoing homophobic discriminations.

First-hand US accounts, published in the 1960s, detail the lives of Virginia Prince and Christine Jorgensen. Prince's memoirs include lived experiences of gender affirmation, as did Jorgensen's; however, Jorgensen's also included associated surgical procedures. Michael Dillon, a

transgender man, affirmed his gender at a similar time with hormones and surgery (Beemyn, 2013). In the same era, transgender advocate Harry Benjamin, American endocrinologist and sexologist, argued in favour of hormonally and surgically aligning transgender peoples' bodies with the way they felt inside.

Benjamin's beliefs contrasted with several prominent physicians who maintained transgender people were mentally unstable and sometimes needed corrective therapies (Beemyn, 2013). Theorists, such as the highly regarded Judith Butler, helped foster a rising interest in transgender issues in the 1980s and 90s with ideas of gender as being performative. Whilst these researchers have helped raise awareness of transgender people's issues, some theories are criticized for not truly conveying an understanding of transgender people's lived experiences (Australian Human Rights Commission [AHRC], 2013).

Australia's first Gender Dysphoria Clinic (GDC) was founded in 1975 by psychiatrists, Dr Trudy Kennedy and Dr Herbert Bower, at Melbourne's Queen Victoria Hospital. Not long after (1979), the first trans-led activist organisations were formed. The Victorian Transsexual Coalition, the Victorian Transsexual Association, and the Australian Transsexual Association were actively assisting Australian transgender people through the late 20th Century (Monash Health, n.d.). In 1989, the GDC moved to a sexual health clinic at the Monash Medical Centre in Melbourne. The GDC offered surgical procedures until 2009 (Monash Health, n.d.). At this time of writing, patients of the – now named – Monash Health Gender Clinic are mostly referred to private surgeons (in Australia) for genital and chest surgeries. Other services at the Monash Health Gender Clinic available then and through to today include: mental health assessments; endocrinology and gender affirming hormonal therapy; hysterectomy (removal of womb) and oophorectomy (removal of ovaries); speech therapy, and an information point for other transgender services or networks (Monash Health Gender Clinic, n.d.). Until recent times the Monash Health Gender Clinic has been the sole Australian government-funded specialist clinic to provide services for people experiencing gender dysphoria, both from within and outside Victoria (Monash Health, 2014).

Whilst surgeries and hormonal therapies have been possible for some time, Australian legislation has created barriers to transitioning in society and/or accessing service provision (AHRC, 2015a). In 1987, Estelle Asmodelle was one of the first post-operative transgender women to register her change of sex and have her passport updated in New South Wales (NSW). Asmodelle persistently pleaded with the Attorney General's Department of the Australian Government to grant passport changes that would reflect her gender change (Rhodes, 2017). Her actions helped Australian transgender people gain recognition, and spurred others to seek surgical procedures and change their gender markers on passports (Wachsmuth, 2015). In 2011, amendments were made by the Department of Foreign Affairs to make it possible for people to change their gender on their passports without undertaking sex re-assignment surgeries (Fredriksen-Goldsen et al., 2014).

Passport legislation has also impacted transgender NB identified people. Norrie May-Welby was, in 2011, the first gender diverse person to gain an X marked passport (May-Welby, n.d.). As Asmodelle had done, May-Welby campaigned for several years before successfully gaining legal recognition of gender diverse people who "experience variations in physical presentation and social behaviour that is other than stereotypically male or female" (May-Welby, 2015).

Other issues with passports have related to state governance and legislation. Prior to 2012, in some (but not all) Australian states, transgender people must have undergone a sex affirmation procedure (alteration of reproductive organs) in order to receive altered sex classifications on their birth certificates (AHRC, 2015b; Registry of Births Deaths & Marriages, nd). Whilst homophobia and transphobia has remained prevalent in Australian society, discriminating legislation has been combated by the resilience of LGBT Australians. Much has been done to rectify historical, societal, and cultural misconceptions (AHRC, 2015a). Cisgender LGB people gained the right to same-sex marriage in 2017. Prior to changes in legislation, people were prohibited from having same-sex marriages if a spouse or partner had changed their gender.

This has resulted in transgender people being left behind in Australian society, creating human rights disparities. Identified key issues have been: (1) regional inequalities; (2) difficulties affirming gender in key life stages; (3) social and welfare systems for ageing and aged transgender people; (4) participation in the workplace (legislative protection); (5) gaining respect for transgender individuals and communities, and (6) reversing the historical, social, and cultural contextual understandings of homophobia and transphobia (AHRC, 2015a).

1.3 Statement of Problem

1.3.1 Gender affirmation

Across the world people who seek access to gender affirming healthcare may need to first submit for diagnosis. The APA diagnosis is "Gender Dysphoria in Adolescents and Adults" (APA, 2013, 302.86). This diagnosis is essential for lower (genital) surgeries. However, WPATHs, *Standards of Care* (*SOC7)* (Coleman et al., 2012)*,* which guides most health providers across the world, has no inclusion of social role requirements as being necessary for adults to access and commence hormonal therapy. In relation to these *SOC7* guidelines, there is also no requirement for a gender dysphoria diagnosis from the APA's *DSM-5* (2013). Regardless, some health providers do require this diagnosis before commencing any hormonal program.

In the Australian context, although there is no minimum timeframe or number of assessments to obtain a diagnosis, being diagnosed with gender dysphoria can involve multiple assessments (typically) over a period of at least six months. Health providers sometimes impose additional barriers

to hormonal care when they are guided by APA's advice that this duration is needed for an individual to demonstrate that their condition is gender dysphoria (2013b). The rigour of an assessment process that spans several months has often increased transgender people's vulnerability. This is particularly distressing for transgender individuals if their health providers are associating the same *SOC7* gender dysphoria diagnosis name (which describes distress caused by gender incongruence and associated issues) with a *DSM-5* mental illness label, which stereotypes them as being mentally unstable. Living full-time in a congruent identity during these months can be fraught with difficulties, such as stigmatisation and marginalisation, because transgender people have often been without safeguards (e.g., the protection of legal documentation or visible gender affirming processes) (Green, 2017; Wylie et al., 2016).

Legislation has not always protected transgender people from systematic marginalisation, stigmatization, discrimination, and prejudice. This often occurs in healthcare situations at a higher rate than the corresponding general populations (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Grant et al., 2011). Many transgender people have been exposed to intentional or unintentional hostile behaviour; for example, "microaggressions (everyday experiences of discrimination: [e.g., derogatory remarks or misgendering]) or macroaggressions (institutional discrimination and acts of violence)" (American Psychiatric Association, 2015, p. 1). As a result, transgender people have often been impacted with loss of social functioning or capacity to cope with daily life (American Psychiatric Association, 2015).

Once transgender people have undergone a transition, they often require continued access to a range of specific transgender healthcare provisions. To protect transgender people's access rights to healthcare provision the "DSM-5 diagnosis adds a post-transition specifier for people who are living full-time as the desired gender (with or without legal sanction of the gender change)" (American Psychiatric Association, 2013b, p. 1). Whilst the specifier aims to assist trans people to have their needs met, leaders in the field (trans policy, experts, and advocates) argue that it may be damaging, because it does not protect their rights. In other words, the mental illness label has not been removed, and it does not indicate what standards of care should be given, meaning that trans people cannot escape a gender dysphoria diagnosis that is known to cause harm (Winters, 2019).

Hormonal treatment effects have helped transgender people with their mental wellbeing by modifying their physical appearance (e.g., face, chest, muscle mass, body hair) and enabling them to more closely bring their sex characteristics into alignment with their gender expression. Typical surgeries for gender affirmation have included: (1) genital reconstruction; (2) masculinization or feminization (face, chest, voice), and (3) non-genital surgeries (i.e., changes to hair, eyebrows, cheekbones) (Houssayni & Nilsen, 2018).

In Australia, hormonal therapies have been administered safely by health providers (specialists, endocrinologists, GPs, Primary Health Care [PHC] workers) who, for example, may be trained to give hormonal treatments to general population patients and/or are educated in trans healthcare. This is particularly so when they adhere to evidence-based guidelines such as those recommended by both the Australian and the American endocrine societies (Endocrine Society of Australia, 2017; Hembree et al., 2017); and WPATH's *SOC7* (Coleman et al., 2012). For over 30 years, WPATH has established the most carefully developed and effective practices for transgender people (Coleman et al., 2012).

The most recent version of *SOC7* (at the time of writing) has adopted a multi-disciplinary approach to developing a clinical consensus about gender affirming therapies. This approach was determined as necessary for aligning transgender people's physical attributes with their gender identity (Coleman et al., 2012). Hormonal and surgical treatment methods have aimed to be flexible to enable practitioners to take people's psychosocial and biological issues into consideration (Rotondi et al., 2013). Despite the progress and versatility of HPs' capacities to meet specific gender affirming needs, many transgender people have lacked resources to access such treatments. Some have resorted to self-administering non-prescription hormones, or even attempting to do their own surgeries (Rotondi et al., 2013).

1.3.2   Defining ageing

Evidence has shown there is no typical ageing or aged person (World Health Organisation [WHO], 2018a). However, some researchers and organisations have chosen to define ageing by considering human life stages. An example of this has been assessing life stages and their associations with prevalence of major health stressors. In high income countries a major health stressor has been reported as age-related deterioration resulting in "frailty," otherwise explained as negative pathways impacting a person's functional abilities (WHO, 2018; Beard et al., 2016). Disability and dependency (outcomes of frailty) have been widely understood as being caused by physical and mental deterioration. This deterioration generally begins in the transition years between the ages of 50 to 64, and often worsens as a person becomes aged (Beard et al., 2016).

In this Australian study, the onset of vulnerability to frailty due to age-degeneration is considered in some healthcare interventions and provision (such as cancer screening), with ageing and aged adults being defined as 50 years and above. Further evidence to support people as "ageing" when they reach 50 years can be found in the Australian Institute of Health and Welfare's [AIHW] (2007), *Older Australia at a glance* (4th Ed) report, which included ageing people from 50 to 64 years, as well as people of post-retirement age. Additionally, the Australian Government has a variety of preventive health and wellbeing schemes for people of 50 years and above.

1.3.3   Ageing transgender people: General and gender affirming needs

According to Gooren and T'Sjoen (2018), ageing transgender people usually understand any associated risks and/or limitations to both gender affirming hormonal therapies and surgical procedures. The risks and health issues vary for each individual and often relate to secondary health conditions. As such, ageing transgender people have typically needed to access a broad range of general population clinical and non-clinical services in addition to specialist gender affirming healthcare services. International studies, such as from Gooren and T'Sjoen (2018) and Cannon, Shukla, and Vanderbilt (2017), have shown that ageing transgender people who experience contra-indications to treatment often require modifications to hormone administration programs and regular check-ups in mainstream healthcare. These include screening for:
(1) medication dosage; (2) bone density; (3) weight gain and diabetes; (4) thrombo-embolism (transgender women), and (5) cancers and cardiovascular diseases (post-chest reconstructive surgery: transgender men and women).

Evidence has further shown that early general preventive measures (e.g., exercise, better nutrition, Vitamin D exposure) help to reduce the likelihood of incurring the compounded negative effects of age and transgender health-related issues (Gooren & T'Sjoen, 2018). However, this information also suggested that what matters most to ageing transgender people in relation to healthcare may differ from their younger counterparts. For this reason, it could be argued that ageing transgender peoples' experiences of general healthcare provision and services for their broader health may benefit more from being matched against ageing general populations.

1.4   Background of Problem

(1) Target population prevalence

 Wylie et al. (2016), Winter et al. (2016b), and Reisner et al. (2016) have argued that investigations have been complicated by poor population estimations and research sample recruitment. World-wide, researchers have not been able to rely on general population health data because transgender people have often avoided self-report surveys. Avoidance is often linked to reports by transgender people who feared that status disclosure might expose them to transphobic discrimination, stigmatization, or violence (Amnesty International, 2014; Motmans, de Biolley, & Debunne, 2010).

Faced with these problems, researchers have tended to estimate the size of the transgender populations by counting clinical referrals. Olyslager and Conway (2007) argue this information is misleading because collating data from trans people who do attend clinics (for example, for re-assignment surgery) causes estimations to represent only the "lower-bounds" of population

prevalence. In other words, in some prevalence estimates only a fraction of transgender people are represented in the published statistics (Olyslager & Conway, 2007). This means that non-attendance in data collection is an issue that can negatively impact trans people. It occurs because many transgender people avoid, or do not require, clinical care (Bauer et al., 2014; Fredriksen-Goldsen et al., 2014; Hyde et al., 2014). Notwithstanding difficulties in ascertaining the size of the transgender population, current prevalence estimations for all age groups is 0.5% of the global population (Winter et al., 2016b, p. 390). This estimation, however, is further complicated when considering the global distribution of transgender populations.

In Australia there have been few attempts to estimate transgender populations, particularly those specific to transgender sub-groups. Ageing population size estimations that do exist for people of diversity have been made by the AIHW (2018). These are limited because they have only included aggregated information about groups belonging to the LGBTI (LGBT and intersex) population who are over the age of 65. The AIHW has highlighted problems estimating population sizes, such as non-reporting through the national census. However, on a positive note, the AIHW (2018) also clarified that population sizes are increasing as societal stigma reduces and people become more willing to reveal their identity. This information warrants the need for more data to assist anticipations of how best to provide for increasing population sizes.

(2) The Yogyakarta Principles

The Yogyakarta Principles have been accepted by most international human rights authorities as a set of universally applicable principles, which should guide countries and their governments in compliance with their human rights obligations towards the SOGII community (Cabral Grinspan et al., 2017; Yogyakarta Principles, 2007). In Australia, the most relevant principles to transgender people are: (1) Principle 1: The right to the universal enjoyment of human rights; (2) Principle 2: The rights to equality and non-discrimination; (3) Principle 3: The right to recognition before the law; (4) Principle 5: The right to security of the person; (6) Principle 6: The right to privacy; (7) Principle 9: The right to treatment with humanity while in detention; (8) Principle 12: The right to work; (9) Principle 17: The right to the highest attainable standard of health; (10) Principle 19: The right to freedom of opinion and expression; (11) Principle 24: The right to found a family; and, (12) Principle 28: The right to effective remedies and redress.

Recently, progress has been made by updating a binding legal standard to specifically address all sexual and gender identity injustices (Cabral Grinspan et al., 2017). Additions to the Yogyakarta Principles have been useful for exposing direct or indirect violations of human rights law towards people based on their gender or sexual identity and for ensuring that "rights claims, and legal justice do not undermine social justice issues" (Mulé, 2018, p. 92).

There are nine additional Yogyakarta Principles. Those relevant to the ageing transgender people in this study are: (1) Principle 30: The right to state protection; (2) Principle 31: The right to legal recognition; (3) Principle 32: The right to bodily and mental integrity; and, (4) Principle 38: The right to practise, protect, preserve and revive cultural diversity (Cabral Grinspan et al., 2017). These are particularly relevant to the good health and wellbeing of transgender people in Australia because they emphasise the importance of interpreting human right standards through the lens of sexually and gender diverse people (Cabral Grinspan et al., 2017). Most significantly for Australian transgender people, these additions relate to violence, justice, privacy, discrimination, freedom of expression and assembly, and access to employment, healthcare, and education (Cabral Grinspan et al., 2017; Yogyakarta Principles, 2007).

(3) Health system data collection

Many health system investigations have been for health issues in general (cisgender) older populations. However, most overlooked people who were undertaking life-altering transitions in their mid-ages (50-64), in data gathering strategies. Beard et al. (2016) demonstrated a possible cause for not gathering data by quoting the example of a large European general population report. That report had gathered data from people over 75 years of age who were eligible for a high level of assistance in their health needs (such as housing or nursing care). Beard et al. (2016) argued that data collection for people in their transition years has possibly been ignored because there has been no universal agreement of how best to gain and define accurate data to outline mid-aged people's needs and concerns.

Several major studies have attempted to overcome data collection issues by determining what public health measures (particularly within primary healthcare [PHC] situations) can be taken to prevent negative impacts. The WHO (2019) asserts that its focus for countries in the Western Pacific is to ensure that PHC be made available universally to all people. Moreover, PHC should be made available to all people by being closely accessible to areas in which people live and work, and by involving individuals, families, and communities in healthcare education and delivery of programs.

To gain such knowledge, researchers have suggested that future planning could benefit from equal input from biological data and information about the impact on health determinants such as: (1) psychosocial issues; (2) health behaviours (intrinsic ability to achieve good health); (3) environments; (4) barriers to accessing appropriate healthcare; (5) space to age safely, and, (6) frailty (age-related physical and mental deterioration) (Beard et al., 2016; WHO, 2018a).

As well as a shifting focus on people's health determinants, many highly developed countries have focused on improving the quality of patient care by gaining transferrable data for use across health sectors. This has been achieved by using strategies that gain information from standardized

patient experience (PE) data collections (Corscadden et al., 2017). This may be successful for general populations; however, there remains significant reporting issues for minority sub-groups. A possible reason for this omission has been uncovered by Urquhart and Saunders (2016) who assert that most public health research is limited to the domains of infectious diseases and health technologies. Whilst these areas of health have advanced scientific knowledge for common treatment regimes, they have done little to further knowledge on ageing people, who have health issues outside the general population and cisgender population research spectrum. Particularly challenging for ageing Australian transgender people is that, as a community, they have had relatively little physical presence in general population data collection (AIHW, 2018).

Australia-wide, big data surveys, such as the *National Health Survey* (Australian Bureau of Statistics [ABS], 2017), were able to scope out a substantial range of population health issues by using a household survey instrument. Most questions related to chronic conditions, socioeconomic status, and age-related issues. Information supplied by respondents was extracted verbatim (from each survey) but did not include descriptive information relating to quality of care or engagement with HPs (ABS, 2017). Of note was that significant proportions of the Australian population reported experiences of mental health issues and/or addictions. However, there was no provision in the survey to allow respondents to give information on likely causes, or to report what healthcare services may have been sought. Significant to this study, and to the reliability of the ABS (2017) survey, is sampling balance: that is, that sampling did not allow individuals to convey their viewpoint, therefore bias may have occurred (e.g., non-sampling & non-response). If they had done so collectively, any missing respondent data may have created some important and unique information.

Despite an increasing awareness amongst HPs and policy makers, of how including all sub-population groups in determining the effectiveness of healthcare and patient experience can improve related revised program delivery, some large-scale research projects have yet to embrace this need. Evidence shows how these large-scale investigations may appear to have been inclusive; however, they may have avoided diminished sample sizes (e.g., omitting specific sociodemographic grouping) by using research designs that favour large group reporting of common issues (Narayanan & Greco, 2016). For example, after assessing for impacts of sample errors or instability, researchers have often overcome reporting issues by adding values for missing data from sample sub-groups (AIHW, 2014). As discussed by Narayanan (2016), overlooking small quantities of sub-sample data may cause response and reporting errors, and prevent opportunities to gather in-depth information about people's varied experiences of healthcare situations.

Some researchers support the need for gathering data at system level to establish national indicators that assist in promoting service integration. Anticipated outcomes could influence health systems, which in turn would enable the design and implementation of education programs, by using

multi-disciplinary models of care for workforce development (Gardner et al., 2016). An example of a national indicator would be an individual State survey.

In the following example, the *Adult Population Health Survey* conducted by NSW Health (2017) aimed to obtain more descriptive information by including telephone interviewing to gain respondents' health and healthcare experiences. Ageing and aged people were largely targeted due to the sample strategy of only interviewing people dwelling in their own residential homes. The enquiry covered a range of HP and socioeconomic issues, such as what prevented people from accessing healthcare, or having insurance (e.g., costs). Limitations arose because questions were only suited to cisgender and general population issues, and there was no accommodation for specific diversity issues. Whilst these aspects were missing, the survey did require respondents to report their sexual orientation or gender identity. However, this only accommodated cisgender LGB people and provided no options to report specific trans identities. This means bias was likely if a significant proportion of people refused to respond.

Targeted approaches have been found to be helpful for gaining more specific information, particularly within PHC contexts, as in the following example.

Gardner et al. (2016) maintained that surveys with a defined purpose are crucial for progress and accountability. However, in "Australian primary health care, little is known about which patient experience surveys are used and which aspects of experience they measure" (p.93). The authors note that, of 95 surveys in their review, only six system performance measures had the capacity to collect patient experience data (p.94). These measures were: (1) patient-reported impacts; (2) health literacy; (3) tailored care; (4) capacity for self-management; (5) tracked improvements over time, and (6) access to care. The authors' recommendations are that indicators such as these reveal issues encountered by under-served groups of people and include much needed issues of respect and cultural competence.

1.5   Rationale of the Current Study

The literature review (Chapter 2) shows that neither international nor Australian research has included any substantial detail concerning the relationship between ageing transgender people's broad range of health determinants and gender affirming and other physical healthcare services required. A paucity of information has prompted this research project to include a spectrum of related health and healthcare issues, as well as those directly related to physical health. It is anticipated that a broader focus will gain a richer understanding of the target population's lived experiences and ongoing health-related needs.

The importance of in-depth information about ageing transgender people's health determinants, as well as their physical and gender affirming health, has been summed up in a recent

study by Narayanan and Greco (2016). In discussion they argue that misleading information may have impacted the way in which policy makers and decision makers have shaped reports for under-served populations, particularly those attending health services in rural and remote areas.

1.6   Research Aims

Expert opinion from the Institute of Medicine (IOM) has asserted that effective care must have six key features, as cited in Scott (2014). These are that care is: "safe, effective, patient-centred, efficient, timely, and equitable" (p.3).

The purpose of this study has been to consider these issues by investigating the following: (1) What healthcare experiences do ageing transgender people encounter? (2) What are the differences between specific ageing transgender issues and those most reported for people identified under the LGBT umbrella, as well as general populations? (3) What specific gender affirming and health needs (including aged care) do ageing transgender people have? (4) What health determinants impact health and access to healthcare systems when barriers (for example, geographical, psychosocial, and economic) such as discrimination occurs? (5) What positive and negative issues impact the broad health and wellbeing of ageing transgender people (including the intersection of aged-related issues and being transgender)? (6) What and how health and healthcare issues differ when experiences are related to gender identification (non-binary, trans men /male identifying, and trans women/female identifying)?

1.7   Significance of the Study to Public Health

Identifying the unique health and healthcare challenges of older transgender people is essential in providing comprehensive information to healthcare and policy makers. It may also contribute to the global knowledge base needed for stimulating health reform. Data to be collected aims to reveal what barriers to care exist and how they can be lowered, what healthcare and health system improvements can be made to improve the quality of care, and what factors positively or negatively impact ageing transgender people's access to care, quality of life, and ability to reduce risks of experiencing poor health or loss of life. Additionally, studies such as this are necessary to motivate further research in uncovering the complex ways ageing transgender people in Australia experience health and associated inequalities. The information gained from this study may further empower and support ageing transgender people by providing them with a voice to articulate evidence-based inequalities.

1.8   Research Questions

A qualitative phenomenological approach has been used to explore, identify, and describe the context, challenges, and ranges of people's lived experiences of health and healthcare (including related residential care).

The aims of the investigation and of the research approach informed the research questions, which are:

(a) What experiences do ageing transgender people have in relation to health and wellbeing and healthcare services?

(b) What hinders or enables good health and access to healthcare services?

(c) What factors assist or hinder them to be resilient?

Chapter 2.   Literature Review

This chapter begins with an overview and analysis of issues relating to human rights, and healthcare systems and provision, as relevant to ageing transgender people residing in Australia. Thereafter, there is some explanatory information (to assist understanding) and an analysis of health and healthcare situations concerning ageing general populations, ageing LGBT populations, and ageing transgender populations. Throughout this chapter there are discussions that concern both international and Australian issues and some related contextual information to assist with understanding the broad health issues of ageing transgender people. There is also some related explanatory information regarding protective human rights principles and theories. These are linked to transgender people's psychosocial health and health determinant issues and relate to accessing healthcare provision.

2.1   Global Health and International Law

Since the recognition of global rights to health, as set out in the (1948) *Universal Declaration of Human Rights,* many countries (including Australia) have been bound to a comprehensive statement to provide all human beings with equal rights, regardless of where or who they are (United Nations [UN], 1998); that is, individuals should be free of discrimination and able to enjoy basic human rights to health. To ensure that worldwide health equality could be achievable, the (1978) *Treaty of Alma Ata* included a new focus for urgent action by all countries and governments; that is, the provision of PHC does enable collaboration between a wide range of HPs (Office of the United Nations High Commissioner for Human Rights [OHCHR], n.d.).

The United Nations made a worldwide appeal to all governments, including Australia, to demonstrate their commitment towards universal health equity by undertaking systematic gathering of regional and national data. Such an undertaking could assist the Australian Government and its agencies to formulate health initiatives and plans of action. Policy reforms and legislation would provide "health impact assessments before major health-related policies are finalized" (OHCHR, n.d., p. 29). In addition, such data would provide information regarding the training needed to appropriately educate health workers and professionals.

Some UN agencies have assisted with this movement. The World Health Organization (WHO) has been important to transgender people, particularly by defining what constitutes their "health" (2016). The current definition for health, adopted by WHO, is: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Official Records of WHO, 19 June - 22 July 1946, p. 100 no. 2). In addition to these factors, WHO's *Health Impact Assessment* stipulates that people's determinants of health must also be considered if people are to achieve good broad health (physical, mental, wellbeing and quality of life): "To a large extent,

factors such as where we [people] live, the state of our environment, genetics, our income, and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact" (WHO, 2017, para 1).

Evidence from general population surveys has demonstrated how the WHO health determinant definitions have benefitted health systems. Health determinant concepts have been adopted by many researchers to uncover which health issues and needs are prevalent in any given community or society (WHO, 2016, 2017).

Given that ageing transgender people must cope with additional health determinant impacts, a generalised population health report may not provide adequate information about the range of services transgender people need. Researchers have found that valuable information is gained by gathering data about transgender people's health and/or health determinants (e.g., environmental, socioeconomic, geographic) alongside their additional broad health needs (e.g., mental, physical, gender affirming) (Hyde & Brown, 2011; Witten, 2009). However, in Australia, reporting has not been sufficiently substantial to enable policy writers and health systems to gain an accurate understanding about the complexities of ageing transgender broad health issues. This is particularly so for later life care needs, both assisted and residential. An example of these issues is revealed in the work of Cannon et al. (2017). Their findings indicate that when ageing transgender people's health determinants have been impacted negatively, their strategies for coping may result in: (1) HP avoidance; (2) substance abuse (drugs, alcohol, smoking); (3) social isolation; and (4) suicide ideation.

The UN has encouraged governments to fill these gaps by acknowledging that some population sub-groups (cultural, race, ethnicity, gender, and sexual orientation) encounter disproportionate biological or socioeconomic issues, leading to stigmatization and consequential marginalisation or discrimination when accessing healthcare (OHCHR & WHO, n.d.). Under the guidelines of the UN, state legislation and health laws should address the issues of people under their protection by paying particular attention to those individuals, groups, and specific populations who are most vulnerable in society (OHCHR & WHO, n.d., p. 29).

In Australia, changes in legislation (marriage laws, passport regulations) have marked some progression. However, the consensus is that ageing transgender sub-populations are not, yet, free from discrimination, marginalisation, stigmatization, and prejudice in healthcare settings. This has been evidenced by current research (Australian Research Centre in Sex, Health and Society [ARCSHS], 2017; 2017).

2.2   **Healthcare Provision**

This section reports on health system and healthcare access issues relevant to this research and what factors impact Australian society, including ageing transgender people. Increasing ages of populations of people born within two decades after world war II (baby boomers), have been a motivating factor for driving healthcare provision reforms (Lindmeier, 2017; WHO, 2018c). Recent reports estimate that one in five members of Australian society will have reached 60 years of age by 2050 (Lindmeier, 2017; WHO, 2018a). This has led to organisations such as WHO encouraging countries to increase the efficiency of health systems. This can be done by integrating health services where possible. The aim is to increase economic growth by including ageing people's capacities to contribute to society. As part of the process, health systems should foster prolonged good health and wellbeing over an entire lifespan through the implementation of preventive health strategies (Lindmeier, 2017; WHO, 2018a).

Performance commentary about Australia's highly ranked healthcare systems and services (and their provision), has included comparisons with other countries to establish causes of health inequalities. The Australian healthcare system has similarities with the UK's National Health System (NHS) services (a publicly funded welfare system) and the US model (privatised healthcare service model). The NHS's broadly publicly funded healthcare provision has arguably caused problems of over-reliance, quality of care, and payment capitation issues (Smith, 2012). Conversely, US activists have argued that increased healthcare inequalities have been exacerbated by the 'marketplace' of service provision, manufacturing of pharmaceuticals, and clinical technologies. For instance, in the US there is heavy reliance on high profit margins that influence and elevate drug pricing. This issue was demonstrated in one study which found that: "Prices for the 30 most-commonly prescribed drugs are one-third higher than in Canada and Germany, and more than double the prices in Australia, France, Netherlands, New Zealand, and the U.K" (Squires, 2012; cited in Smith, 2013, p. 28).

Researchers such as Tervalon and Murray-García (1998) and Davidson et al. (2018) have carried out comparative investigations relating to population health and access to services. Davidson et al. (2018), in their study, *"Social ecological model influencing ethical practice,"* have designed a framework (see Appendix I), designed to assist investigation of "the culture of healthcare systems and organisations to identify the root causes and address the barriers and enablers of ethical practice" (pg. e1233). The original framework comprises eight concentric circles. Each circle details positive or negative factors that positively impact people's personal abilities to cope with daily life challenges. Mostly these interactions only occur outwardly or inwardly across one circle. Davidson et al. (2018) emphasised the importance of utilizing this type of model to reveal the complexities of ageing and the intersections with health-related matters. The framework assists in explaining the dynamic interplay between discussion and circumstances. It reveals the outcomes of interactions in health and health

determinant contexts ("social, cultural, political, and economic drivers" [p.e1233]) in relation to societal healthcare matters.

2.3   Ageing People's Health Systems and Provision

Researchers have argued that policy makers should pay attention to ageing people's health issues because these populations have been (and will be over the coming decades) major healthcare consumers (Elliott et al., 2016). The result will be that health spending for later life stages becomes an increasingly important topic for data gatherers. Economic information is particularly significant to transgender populations because spending on healthcare is associated with the way that advantaged and disadvantaged sub-groups seek and access care (Andritsos & Tang, 2014). However, at the time of writing, very little health economic research has been found that reports on health spending issues for diverse populations. Moreover, there is relatively little in-depth detail concerning the healthcare related economic issues of ageing transgender sub-populations.

Economic research detailing people's institutional arrangements typically relates to ageing general populations and has prioritised people over 65 years of age as opposed to people over 50 years of age (Katz, 2013). To bridge this gap, Zeeb, Rothgang, and Darmann-Finck (2018) recently reviewed available literature investigating how socioeconomic status might impact middle-aged people's wellbeing and quality of life. Findings show there has been a lack of representation, even for general populations, of data collection that reports the range and associated challenges.

Significantly, researchers have been uncertain of the point at which ageing carries the most burden, and how social gradients across age ranges influence ageing and aged people differently (Zeeb et al., 2018). In their discussion, Zeeb et al. (2018) raise the question of middle-aged people needing care as well as being caregivers. Do these needs differ from ageing people's later and end-of-life needs?

An approach for improving the health and wellbeing of all people, regardless of socioeconomic background, has been for health systems to be guided by international authorities and their publications, such as *The World Report on Ageing and Health* – a policy framework for healthy ageing and quality of life, discussed by Beard et al. (2016). This report has been a major influence on multi-sectoral collaborations because it emphasised the importance of inclusive healthcare environments and culturally competent healthcare providers to improve healthcare experiences for all people, particularly ageing and vulnerable populations (WHO, 2018a).

Standard preventative measures for people approaching retirement age have addressed achievable healthy ageing measures, such as health literacy, social networking, and physical activity programs. Evidence has shown that people who demonstrate physical and mental resilience in life challenges also gain opportunities to acquire what is valued for good health. Resilience is sometimes

demonstrated in ageing people when they can assist with care of others because they are in good health (WHO, 2016). Moreover, good health and resilience is evident in examples of people who have obtained physical and mental health beyond their 80s. This contrasts with people who may have had vulnerable poor health and experienced a premature decline and shorter life span due to chronic disease or serious mental illness (SMI) (WHO, 2018a).

Evidence has shown that vulnerable populations, such as ageing transgender people, have been most susceptible to health inequities, particularly where health determinants have negatively impacted healthcare, and/or associated services, seeking behaviour (Reisner et al., Bauer et al., 2009; Couch et al., 2007; 2016). WHO has attempted to combat health inequities by encouraging supportive and comprehensive public health approaches that acknowledge ageing people as diverse and with a substantial variation in healthcare needs (WHO, 2018a). Advice for action has included a need for evidence-based research that prioritises ageing health issues, with the emphasis on reducing reduce negative social impacts of ageism (WHO, 2018a). Ageism has been defined as "the stereotyping and discrimination against individuals or groups on the basis of their age; ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical beliefs" (WHO, 2018b, para 1).

Researchers argue that information discrepancies arise from single condition studies (Elliott et al., 2016). An example of a single condition study would be an investigation that involves only biological issues associated with a chronic disease rather than additional factors that may cause people to contract or suffer from it. Suggestions for improvements include systematically reviewing the contexts and baseline of ageing peoples' daily living (Elliott et al., 2016); for example, collecting contextual data to help HPs understand "what matters to you (patient)" as a healthcare consumer, rather than "what is the matter with you" as a way of analysing perceptions, attitude, and behaviour (Akpan et al., 2018, p. 4).

In response to calls for improved contextual data gathering, and positive partnerships, researchers and organisations have developed frameworks to standardise data collection. Elliott et al.'s (2016) Spectrum of Engagement and Akpan et al.'s (2018) The International Consortium for Health Outcomes Measurement are examples of interactive approaches. The models (shown in Figure 8, Appendices

Appendix I) include categories for sociodemographic factors, health determinants, and resilience. These additional factors invite investigations into querying the roles played by family and friends, social support networks, or caregivers, in helping to overcome complex situations. Typically, these roles may include reducing patient confusion (information assistance), support throughout continuum of care, and navigating networked or broader health systems (Elliott et al., 2016).

Positive outcomes of in-depth investigations have been recognised in ageing specific initiatives. One example has been the Australian Commonwealth Home Support Programme (CHSP), a service using preventive approaches to help care for ageing populations throughout their lives. The CHSP was anticipated to reduce public spending and improve the efficiency of hospitals by making access to care more equitable (Department of Health [DOH], 2016). Equitable care in this context is recognised as consumer-directed (CDC) and patient-centred care (PCC). This assists improvements to health outcomes by placing consumers at the centre of care choices. Fortuna et al. (2017) assert that shared decision-making and approaches should avoid the use of costly physicians, by instead making use of specifically trained nurses and social workers. This may also alleviate time poor constraints in clinical settings. It is anticipated that CDC and PCC will be able to deliver health services in environments deemed socially or culturally appropriate and non-discriminatory (DOH, 2016).

The DOH's (2016) report includes the establishment of working groups for LGBTI strategies, alongside other vulnerable populations, with the intention of improving current issues. Whilst these have been key areas of healthcare for highlighting the importance of CDC- and PCC-based data collection, there has been a general paucity of information reporting on specific minority groups, such as ageing and aged transgender people as a stand-alone community (away from LGB) in Australia.

Other issues that are motivating more equitable policies for ageing people have related to the advancing demographic shift. Populations currently in mid-life stages will also be a large proportion of the Australian population when they are elderly and frail (Edgar et al., 2017). The full national demographic impact of this population having increased healthcare needs is anticipated to occur by 2030, because middle-age population sizes are reported by Australian National Ageing Research Institute (NARI) as: "7.1 million Australians (a third of our population) are [named] 'new middle-age'(50-75) or the PEAK years" (Edgar et al., 2017, p. 3). Edgar et al. (2017) asserted that a focus on healthy ageing would be particularly helpful; that "healthy ageing means more than medical interventions and care; it means promoting health measures" (p. 11). A better understanding about how to innovate effective and efficient preventive health programs may improve the ageing population health statistics and further reduce the healthcare needs of an ageing population.

Rich data has been gained by democratizing research with patient collaboration or user-led patient and public involvement (PPI) (Schilling & Gerhardus, 2017). When information gathering has been problematic for older patients (e.g., participation, continuity constraints, or confidentiality issues) PPI in decision-making processes has overcome structural or temporal problems by addressing environmental issues (accessibility, location, appropriate communication, rapport building needs). Schilling and Gerhardus (2017) demonstrate that this reciprocal approach has been particularly helpful in terms of "how to" in gathering relevant data from individuals who may have missed an opportunity to report their perspectives and experiences.

Relative to people's psychosocial impacts on good health and healthcare access, there has been scant research investigating severe mental illness (SMI) in ageing and aged people, in comparison with the bulk of material reporting the most typical ageing problems. Yet health disparities in ageing populations who experience depressive symptoms have stood out in large scale investigations (Martino et al., 2016).

Evidence has shown that SMI negatively impacts all aspects of ageing peoples' lives. Care needs increase with chronic illness and difficulty in maintaining good health whilst managing mental health problems. This increases the risk of premature care dependence and early entry into care homes (Fortuna et al., 2017). Such risks rise with compounded impacts such as low levels of: (1) preventive healthcare; (2) health literacy; (3) navigation of healthcare provision; and (4) inappropriate or misinformed healthcare provision (Fortuna et al., 2017; Martino et al., 2016). These issues justify a need for future research to include possible pathways to help less-advantaged people navigate managed programs (Martino et al., 2016); and further, to have appropriate access to services.

LGBT researchers in Australia have also been calling for new frameworks that include middle-aged people in health policy reforms. General population researchers, such as the Australian National Ageing Research Institute (NARI) (2016), have called for government participation, justifying this plea with the need for broadening policy making and governmental agents' opinions about the political weight of ageing generations. NARI has also made significant progress in Australia by supporting such measures in diverse populations, and in changing stereotypical views of ageing and aged people as being redundant in society from mid-life onwards. Instead, NARI has raised awareness of ageing people's ranges in functionality, resilience (even in adverse situations), and social or economic contributions to society (shared skill sets, financial security, social networks) (2016).

2.4   Ageing People's Healthcare Experiences

Australian reports have shown that patients have the capacity to overcome certain barriers yet have struggled to access appropriate providers. Patients' perceptions of pursuing supply and availability have been described as contextual. A conceptual framework has been created to illustrate how barriers to accessing healthcare occur (see Appendix I). Corscadden et al. (2017) adapted the original model devised by Levesque, Harris, and Russell (2013), which set out to define access to healthcare, to enable international data comparisons. Corscadden et al. (2017) listed the following significant factors: (1) self-identification of health needs; (2) seeking appropriate care; (3) health literacy and knowing what type of service provider to access; and, (4) geographical location in relation to service provision.

General practice and hospital healthcare investigations concerning ageing people have revealed that not all people matched their satisfaction of clinical and medical services against their expectations of healthcare provision. For example, Bowling, Rowe, and McKee (2013) found that as patients aged their expectations of healthcare, such as what healthcare was received, were influenced by the life changes they were experiencing. Hargreaves et al. (2015) carried out a systematic review of literature comparing varied elements of ageing patient experiences (patient satisfaction, economic barriers, consultation factors, time, & information issues). The authors found an important correlation between unfavourable attitudes toward healthcare, diminished attendance, and impacts of negative healthcare experiences throughout life stages, even during younger life vulnerabilities (Hargreaves et al., 2015).

In a related study, Bowling et al. (2013) sourced a large sample (*Number [N]=833)* of patients attending London-based hospitals to develop an understanding about where sub-optimal areas of care occurred. Areas of care were associated with having individuals' expectations met as opposed to measuring clinical outcomes. The study outcomes linked patients' personal lives to the issues that were most important to them at various stages of their lives; for example, they examined how satisfaction was perceived for differing age increments, and how patients at each age stage may have negatively or positively experienced health changes. The authors conclude that service providers who stereotype older patients and exhibit traditional mindsets cause health workers to have misperceptions about patients' needs (Bowling et al., 2013).

Communication has been a recent cause for investigation. Teunissen, Rotink, and Lagro-Janssen (2016) found that whilst research quality has been markedly improved by including discussions of patients' views and perspectives, and patient experiences of communication, in relation to gender differences have rarely been reported. The authors argued that filling gaps for gender differences is important because their research revealed significant (binary) gender differences between perceptions of medicinal care quality (Teunissen et al., 2016).

Health Talk Australia (2018) adopted qualitative research methods to uncover the lived healthcare experiences of ageing and aged people. A group of academics from multiple Australian universities collaborated with Health Direct, a government health information organisation, to improve healthcare provision. Strategies for gathering information included inviting service-users to share their views. An advisory panel ensured a diverse (age and culture) range of participants was recruited to allow the voices of people from different backgrounds to be heard. Many people in the report were over 60 years, meaning middle-aged people were under-represented (Health Talk Australia, 2018). Nevertheless, important issues were identified, such as: (1) shortages of health and age care workers; (2) positive and negative reports of provider attitude and communication; (3) service and health insurance costs; (4) the importance of care continuum and entering the hospital system; and, (5) issues related to living in rural or remote Australia (Health Talk Australia, 2018). It

was noted that the respondents need to be treated as people first, and related this issue to Australian health system errors, such as problems concerning appointments, waiting times, and travel problems (Health Talk Australia, 2018).

Barriers for people over 50 years entering healthcare have been reported by the Australian Bureau of Statistics (ABS), especially for people who have multiple health conditions (cited in, Temple & Williams, 2018). Higher risks of encountering barriers to seeking care have been associated with people who have disabilities as opposed to people without. Whilst bias may have occurred due to non-reporting for certain groups, the ABS report revealed that discrimination issues appear to be most prevalent in healthcare settings. Examples given were: (1) lack of fairness; (2) marginalisation due to cost; (3) difficulties with accessing suitable general practitioners (GPs); and, (4) un-partnered people having increased difficulties accessing care (Temple & Williams, 2018). The authors have called for longitudinal studies to improve data quality by reporting people's experiences over time.

There has been very little qualitative research to show what common healthcare access-related factors ageing transgender populations share with ageing cisgender people. But (as is shown in general population ageing investigations) qualitative information is necessary to uncover common factors across ageing populations. This is particularly so when: (1) patient satisfaction did not necessarily rely on the outcome of healthcare provision; (2) patient expectations had changed with changes in life stages (Bowling et al., 2013), and (3) historical events had shaped patients' perceptions of healthcare (Hargreaves et al., 2015).

2.5   Ageing LGBT People's Healthcare Experiences

This section discusses issues that commonly concern all ageing individuals identifying under the LGBT umbrella in the global context. This is done because there is significantly more combined reporting on ageing LGBT populations than ageing transgender populations. As this is the case, this section highlights some health and healthcare concerns that are known to impact ageing LGBT communities differently than ageing general or cisgender populations. The issues discussed are particularly relevant to ageing transgender people in the context of accessing non-specific transgender care. It also shows how people may be impacted when entering a healthcare environment or situation that may misunderstand any differences in needs between cisgender ageing LGB people and ageing trans people.

Many high-income countries have strived to provide healthcare that is inclusive of more diverse populations. However, many have lacked specific knowledge to fully understand what, and who, could provide the best support for the LGBT population (Kimmel, 2014). The result has been that interventions have not fulfilled goals, leaving LGBT seniors continuing to fear healthcare situations. LGBT individuals have been particularly reluctant to enter hospital accident and

emergency departments (A&E) or residential care (Taylor, 2016). This provides a clear indication that HPs and researchers still have much to understand in continuing to improve care by accommodating the specific needs of LGBT seniors (Kimmel, 2014).

US Federal level evaluations (in the *National Survey of Older Americans Act,* mandated by the Administration for Community Living of the US Department of Health and Human Services) have investigated how older Americans – including LGBT people as a specific population – perceived performance of funded programs (Loewy, 2017). Whilst studies focusing on one healthcare issue may have been useful, they clearly have not gained enough information about LGBT peoples' multi-dimensional healthcare issues. Ageing LGBT people often access multiple healthcare services. Additionally, broader investigations may gain deeper understandings of LGBT people's perceptions of service provision. Such multi-directional studies are particularly necessary because, as evidenced in the US and other high-income countries, by 2030 populations of LGBT people over the age of 65 years will have more than doubled since the turn of the century (Cannon et al., 2017; Smith, Altman, Meeks, & Hinrichs, 2018). Smith et al. (2018) indicate that, within the LGBT sub-population, (possibly) "70% of people over age 65 will require some long-term care (LTC)" (p.2).

The growing visibility of ageing LGBT populations has been a major cause for investigations concerning ongoing discrimination in healthcare situations. Researchers have provided evidence that health disparities have been significantly higher than general ageing populations due to discriminative practices and attitudes in healthcare environments (Loewy, 2017). It has also been reported that there are "higher rates of disability, mental health challenges, and chronic health problems, including asthma, diabetes, HIV/AIDS, obesity, and illnesses such as cancer. These conditions are exacerbated by the tendency of LGBT older adults to withhold information about their identities from providers and to delay screening for fear of discrimination" (Fredriksen-Goldsen, Kim, Bryan, Shiu, & Emlet, 2017; cited in, Loewy, 2017, p. 1217).

Other surveys have shown that in some long-term care environments (e.g., residential: aged and mental), there have been additional barriers related to specific mental and physical health issues, because findings had not established whether LGBT seniors were having their needs met (Smith et al., 2018). Loewy (2017), in a related study, proposed that non-specific reporting was an indication that public resources may not have allocated for their healthcare provision. This could further signify that the diversity and vulnerability of LGBT adults has been overlooked.

Most recent ageing LGBT studies have focused on people of post-retirement years (over the age of 65 years), but there have also been some investigations including middle-aged people in sub-sample groups. A Spanish study of 243 LGBT adults over 55 years of age encompassed people's strategies for coping with their life issues and found that their strategies diversified with age and gender (Moye, 2016).

Similarly, another large-scale study sought information from adults over 40 years of age. This study examined how compounded events might impact an ageing person's capacity for good health in relation to "identity development, work and kin relationships, and their associations with health and quality of life" (Fredriksen-Goldsen, et al., 2017b, p. S15). The authors found that ageing LGBT people have benefitted from "early detections and prevention of health risks for [these] individuals before they reach older age" (2017b, p. S26). Risk factors were uncovered by clustering life events and observing causal links between historical and environmental context, psychosocial, and economic health risk factors (such as employment discrimination). Of the four emerging clusters (as described in their study) adults coming out in their 40s were most likely to be negatively impacted by employment discrimination and diminished social resources. However, the cluster showing the best outcome (and most individual resilience) was explained as "visibly resourced," or in other words had high visibility and economic status (Fredriksen-Goldsen et al., 2017b, p. S15).

The significant risk factor connections for the Fredriksen-Goldsen et al. (2017b) study were shown to occur: (1) between coming out between the age of 40 to 50 and having a past marriage to a member of the opposite sex; (2) between previous marriages and the likelihood of having partners and/or children; (3) between past events and risk taking decisions in later life; and (4) between life stage transitions and significant psychosocial influences (behaviours, responsibilities, expectations).

Administration processes have been other major issues that impact on health. People may have often been marginalised from program opportunities and health workers may have been inadequately prepared for interactions (relationship building) with patients and residents in their care (Kimmel, 2014). Kimmel reported that many ageing LGBT people have felt unwelcome, or anticipated stigma and discrimination, even in otherwise optimal care situations (2014).

Evidence suggests that LGBT people avoid taking preventative health measures because of negative healthcare experiences over long periods, including where caregivers have lacked cultural competence and engaged in harmful practices (Hollenbach et al., 2014). These challenges can occur in a range of healthcare settings and can contribute to devastating health conditions as well as ongoing cycles of internalised stigma and minority stress (DiNapoli, Garcia-Dia, Garcia-Ona, O'Flaherty, & Siller, 2014).

Evidence has also shown that many healthcare and social care providers lack cultural competence by assuming people in their care to be heterosexual and heteronormative, particularly in aged or long-term care settings (Cannon et al., 2017). Researchers have stressed the importance of encouraging health workers to take a holistic assessment approach to people entering care. Cannon et al. recommend that information-gathering strategies be improved by gathering demographic information (2017). Taylor (2016) also maintains that health workers should allow patients to feel

welcome to share details about their bodies in physical health assessments, as "an inextricable part of human wholeness and personhood throughout the life span that must be considerately valued" (p.170).

Regardless of increasing research indicating the need to stimulate more positive change, ongoing issues remain with unwilling health workers, cultural stigmas around diversity, and atypicality (Cannon et al., 2017; Hollenbach et al., 2014). Reluctance to change has motivated researchers to respond to such findings with increased research to fill gaps in specific healthcare knowledge (Cannon et al., 2017; Hollenbach et al., 2014).

A common focus has been to improve caregiver institutions' education and training about culturally competent care, and any health disparities, that LGBT people encounter (Cannon et al., 2017). A national assessment tool has been developed in the US (Healthcare Equality Index [HEI]), by the Human Rights Campaign Foundation. The HEI has been used in many countries to report specific LGBT issues and provide protective environments by forcing "hospitals and health systems [to] self-report their patient and employee non-discrimination policies, patient visitation policies, and training programs in LGBT patient-care" (Hollenbach et al., 2014, p. 112).

HPs themselves have been investigated for the purpose of uncovering the range of perceptions they have, when working with LGBT individuals. Smith et al.'s (2018) study of 57 mental healthcare providers reported responses to questions were related to their practice characteristics (for example, preparedness, willingness, education, and other barriers). Results showed an overall positive attitude, with few reports of discomfort towards LGBT people. Additionally, HPs indicated a willingness to be educated in LGBT appropriateness. However, quality of care was impeded by insufficient training, as well as a paucity of evidence for providing effective treatments. The authors stressed the significance of their findings, showing that most providers report limited experience of working with ageing and aged LGBT. Smith et al. (2018) argue that such limited experience may indicate an underestimation of LGBT residents due to non-disclosure of identity and fear of stigmatisation.

A further example of the way in which insufficient training has impacted healthcare delivery was uncovered in a qualitative Irish study of LGBT people aged over 55 years. Health and aged care workers were shown to have overlooked important issues. Within the scope of this study, healthcare workers had minimal awareness about the relationship between heteronormative and ageist assumptions, and misconceptions about the personal significance of this sub-group's identity (Sharek, McCann, Sheerin, Glacken, & Higgins, 2015). In-depth interviews conducted by Sharek et al. (2015) reported that participants voiced a desire to avoid residential care homes in later life, in fear of the "heteronormative culture of long-term residential care facilities" (p.230).

Whilst ageing LGBT people encounter similar physical health problems to non-LGBT people, evidence has shown that those who are LGBT also have many other health determinants (physical and psychosocial) that may impact care needs. Specifically, these are issues which occur due their

identity. For example, they may have been less likely to have significant others (partners, children, close social networks) for support than their heteronormative counterparts (Fredriksen-Goldsen et al., 2017a; Fredriksen-Goldsen et al., 2017b). This has been shown to occur when close social connections (e.g., chosen families or significant others) have also aged and become vulnerable themselves. In addition, ageing LGBT people may suffer further stress if they have been deterred from revealing their identity to avoid encountering stigma or discrimination when caring for significant others (Kimmel, 2014).

Attention has been given to LGBT people's vulnerability to isolation and loneliness. Researchers argue that this increases when uninformed nurses and professionals are the key agents for hearing patients' concerns during sensitive conversations and disclosures (Sharek et al., 2015). Without social or health networks to enable discussions about related problems, researchers have found that LGBT people may resort to coping strategies that exacerbate poor physical and mental health (e.g., substance abuse or reliance, smoking) (Moye, 2016).

Research deficits in the reporting of LGBT health determinants were discussed by Van Wagenen, Driskell, and Bradford (2013) in a scoping review. Van Wagenen et al. (2013) argue that missing data has obscured pathways to better health promotion and the development of appropriate policies. In order to overcome research gaps Van Wagenen et al. (2013) recommend the adoption of qualitative research approaches to investigate modifiable health determinants. Such information will be a valuable tool to inform best practice (Gahagan & Colpitts, 2016; Van Wagenen et al., 2013). Qualitative research methods enable individuals to describe their lived experiences about the processes, or continuum, of ageing as well as record direct impacts to health (Barrett, Crameri, Lambourne, Latham, & Whyte, 2015; 2016);

Hughes et al. (2016), however, indicate that information gathering of this nature has proven problematic for ageing LGBT people. Those without social connections or those avoiding healthcare situations may not have known how to pass on information or may have withheld information for fear of bias (Hughes et al., 2016). A way of overcoming non-reporting has been to collaborate with community elders. LGBT elders have been able to raise some awareness about the complexities of gaining specific information from groups of people whose characteristics and identities are highly diverse. Many may also have histories of damaging relationships with governmental agencies and health systems (Kimmel, 2014).

Research gaps relating to the range of diversity under the LGBT umbrella have motivated a recent call for more specific and contextual information on people's lived experiences of healthcare (Kimmel, 2014; Van Wagenen et al., 2013). These research gaps include a lack of reporting on: (1) enablers or barriers to healthcare access; (2) service needs to facilitate positive continuums of care; and, (3) what clinical implications exist in the absence of appropriate treatment (Kimmel, 2014).

2.6   Ageing LGBT People's Healthcare Experiences: Australia

In comparison with the US and Europe, Australia has relatively less published research detailing the healthcare experiences of LGBT people under the retirement age of 65. However, some larger scale Australian reports (found in the grey literature) have included the middle-aged and give some general national insights into LGBT peoples' challenges. High-quality information has often translated into essential resources to understand how health disparities occur, and has also been valuable in guiding legislation (ARCSHS, 2017)

The AIDS Council of NSW's (ACON) (2017) *Health Outcome Strategy 2017-2018* reminds its readers of the importance of acknowledging "the diversity of each person who identifies under the LGBTI acronym, whose experiences vary as does the extent to which their identities are central to their definition" (p.40). As previously mentioned, current Australian generations of ageing and elderly LGBT people's sense of self may have been shaped by multiple historical prejudices. Their diverse identities correlate with a range of broad health conditions that often include psychosocial issues, such as fear, depression or anxiety, and consistent use of medications (Barrett, Whyte, Leonard, & Comfort, 2014). Unsurprisingly, the common term "no one size fits all" has been used by many authors to portray people's health situations and needs.

Australian ageing LGBTI research often attempts to report any differences occurring between LGBTI and general population research outcomes for physical health and ageing. These reports provide evidence that LGBTI people have been more likely to encounter chronic health conditions prior to Australia's statutory retirement age (ACON, 2017). Evidence shows that premature health problems may have occurred because ageing LGBTI people in Australia have "higher rates of tobacco, alcohol and other drug use, high rates of cardiovascular disease and bone problems, and higher rates of cervical and anal cancer" (ACON, 2017, p. 4).

LGBT people's range of health conditions often requires interactions with a variety of HPs in differing healthcare contexts. Recognition of elevated healthcare demands has raised concerns about how best to achieve equitable services, particularly for LGBT and intersex (LGBTI) people who may need heightened levels of specialised care (McPhail & Fulop, 2016). Many people suffering the compounded effects of lifelong discrimination require culturally competent services. As such, they may favour LGBTI inclusive care providers with specific knowledge about the relationship between physical health and severe mental illness (SMI), caused by isolation and loneliness (ACON, 2017).

Whilst there have been some successful strategies for providing safe healthcare spaces for LGBTIQ (LGBTI and queer) people to engage with knowledgeable well-trained HPs, and build trustworthy long-standing relationships, these programs have been limited to central urban districts where LGBTIQ sub-populations have been most visible (ACON, 2017; Government of Victoria, 2011). A Melbourne based study with a sample of LGBTI adults aged 16 to 89 years showed that

most participants lived in cities. This was followed by approximately one-fifth residing in regional areas, and only a marginal proportion living in rural areas of Australia (Leonard et al., 2012). Gathering data about people's experiences outside inner metropolitan areas has been demonstrably more difficult because LGBTIQ people have been more likely than their urban counterparts to avoid disclosing identity or using mainstream services in these locations (Government of Victoria, 2011).

Australian LGBTI services have generally been increasing in both urban and rural settings in recent times. However, existing gaps for resource, education, and location specific reporting has hindered nationwide implementation (ACON, 2017). Additionally, recent age-related reforms have only aimed to improve aged care systems (assisted living, residential care, and other day care help). Reforms have not included people under 65 years of age who have premature disability, or age-related health conditions (ACON, 2017). As a result, AIDS Council of New South Wales (2017) asserts that Government funded initiatives have not covered some important and specific ageing issues for certain sub-populations.

Other existing health disparities have been investigated by ACON (2017), revealing that "the mental health of Australian LGBTI people is worse than the national average, with higher rates of depression, anxiety, self-harm and suicide" (p.9). Risk factors for compounded effects of stigma and marginalisation further impact people's mental health. Compounded mental health impacts have correlated with elevated LGBTIQ people's risks of suicide and suicidal behaviours. However, to date, there has been limited research to inform mental health needs and help understand how to implement protective and preventive health strategies (Joosten et al., 2015; Skerrett, Kõlves, & De Leo, 2015).

Ageing LGBTI people commonly rely on general practitioners for first point of contact to provide medication prescriptions and initial referral to specialists (utilizing GPs as mediators) for ongoing treatment pathways (e.g., mental health). Joosten et al.'s (2015) research revealed that some mental health patients view HPs and medications as necessary components for good health, whereas others combined good healthcare with self-managed physical wellbeing strategies. Other LGBTQI people encountered difficulties in having their needs met because they could not find a willing or knowledgeable HP.

Ageing LGBTI people's mental health issues have often been further complicated by broken or damaged family ties, physical or psychological abuse, pain, or, sexual or gender rights issues (Barrett et al., 2015). Community elders have voiced their concerns about how these broader contexts and health determinants impact people's capacities to maintain good health. Health determinants are often affected by other areas of life, particularly when impacted by historical stressors such as discrimination, housing, financial insecurity, employment, and social connections (ACON, 2017).

Rosenstreich, Comfort, and Martin (2011) predict that better LGBTI health outcomes could be achieved by adding previously overlooked social determinants as a health priority in health

frameworks. In their rationale a key recommendation is for the inclusion of social determinants (including mental health) in health policies to reduce inequalities. These inclusions are predicted to assist LGBTI sub-populations in Australia to overcome service access barriers and challenges in healthcare settings and, further, increase health worker knowledge (Leonard et al., 2012; Rosenstreich et al., 2011). In this respect, however, some authors claim that combined LGBTI research obscures the unique challenges facing transgender people, who have a greater need for medical and clinical provision (DiNapoli et al., 2014; Government of Victoria, 2014; Leonard et al., 2012; Womens Health West, 2014; Zelle & Arms, 2015).

For Australian ageing and aged LGBTI populations, investigations into health needs and social determinants have also required inclusion of retirement services (residential or home care). Comfort (2010) indicates that these are often environments where LGBT people encounter serious disadvantage and discrimination. Barrett et al. (2015) have provided evidence showing that ageing LGBTI people who have experienced discrimination or marginalisation in care situations have needed more assistance from significant others but may fear negative attitudes from service providers. Barrett et al. (2015) and Barrett and Stephens (2012) provided examples showing that some service providers continue to believe they should provide identical services to everyone regardless of orientation or identity. As a result of a study conducted by Hughes et al. (2016) the need for improvement of organisational support is necessary. The authors found that participants were particularly concerned that aged care services overlooked their relationships. Hughes (2016) reported that workers were often unaware of their own prejudicial behaviour and were without resources or networks to better equip themselves for inclusivity.

Significant consequences of not having specific ageing LGBTI needs met has been shown in individuals with neurocognitive disorders. Without adequate support LGBTI individuals have difficulties determining whether aged-care services are suitably offering safety and protection (ACON, 2017; Barrett et al., 2015). Where safety and protection are lacking LGBTI people may hide their identity. Barrett et al. (2015) show that concealment results in providers assuming people have discarded their LGBTI identity and reverted to heteronormativity.

These concerns are acknowledged by the DOH, and Butler (2012) highlights additional, more subtle, and widespread issues of societal prejudice and stereotyping. Barrett and Stephens (2012) give the example of one aged-care report, which revealed that culturally competent health workers encountered barriers to providing appropriate care because of: (1) unsupportive colleagues; (2) staff unwillingness to share inclusivity knowledge; (3) non-supportive staff team members causing others to feel "overburdened by being labelled the 'GLBTI worker'" (pg.4); and, (4) reduced capacities for "meeting high organisational expectations to work with GLBTI communities without adequate support" (p.4-5).

Mixed-method studies, conducted by the Australian Research Council, have improved the quality of data available on LGBTI people's healthcare challenges and outlined the difficulties organisations themselves may encounter (ACRSHS, 2017). Recent research has shown that negative service provision may have either originated at leadership level (e.g., management misinterpretations of discriminatory behaviour), or that health and aged care staff have lacked necessary training and could not provide appropriate support to uphold overarching values of inclusivity (McPhail & Fulop, 2016). Rosenstreich et al. (2011) cautioned that if Australian health reforms omit specific healthcare needs, LGBTI people could be further marginalised by the reinforcement of exclusive practices in primary healthcare settings.

A recent investigation of older LGBTI people, by the Council on the Ageing (COTA) and Transgender Victoria (2017), gathered valuable information about LGBTI people to estimate their needs for medical services and residential or home care, in relation to financing and end-of-life issues. Whilst in previous times there have been complications collecting data, due to disproportionate reporting between LGB and transgender people, the methods used in this COTA survey were verbatim transcriptions or direct viewing of people's experiences and opinions. Case studies from Barrett et al. (2015) reveal first-hand accounts of psychosocial issues and family rejection or concealment in care. Barret et al. (2015) also investigated carer perspectives and organisational matters. Key concerns arising from this relate to safeguards in accessing personal information, and appropriate cultural competency from service providers (COTA, 2017).

In summary, research on ageing sub-groups of LGBTI people has been lacking, particularly for the middle-aged. McPhail and Fulop (2016) carried out a healthcare worker survey involving LGBTI elders. This study shows that (the) "least understood areas were LGBTI sexual health, LGBTI mental health, social pressures that affect LGBTI elders, and providing inclusive services to LGBTI elders" (p.636).

In the study *Private Lives 2* the authors stated that, in the sample analysed, transgender participants were under-represented. Even so, it was clearly demonstrated that they experienced worse health levels than the rest of the study sample (Leonard et al., 2012). Transgender people have had to endure ongoing pathologisation. They may cope with life's adversities by embarking on a difficult pathway to transition through undertaking bodily changes with medications and painful surgeries (Joosten et al., 2015). Barrett, Crameri, Lambourne, Latham, and Whyte (2015), in another related study of dementia patients, found that none of the 30 LGBT people (aged 47-79 yrs) identified as transgender, meaning the LGB experiences of dementia may be different (both physically and contextually) from those of transgender people.

These findings indicate that when describing the experiences of LGBT as one population group, some key determinant issues of the transgender sub-group may not have been addressed.

Whilst transgender people suffer similar homophobic hostilities to LGB people, they have the added societal hostilities of transphobia and expectation of having to conform in line with their birth-assigned sex. In addition, risk factors for poor health are exacerbated and undermined in the absence of specific data to inform appropriate services and policies for preventive health programs (e.g., marginalisation for screening services after gender crossing) (Leonard, 2012; Mayer et al., 2008; WHO, 2013). An absence of data suggests that more qualitative research will be helpful for unconvering institutional gaps in such services.

A previous Australian Human Rights Commissioner, Tim Wilson, has acknowledged the disparity between LGB and transgender people. In the Sexual Orientation, Gender Identity and Intersex (SOGII) portfolio for 2015, Commissioner Wilson stated his intention to motivate legal reforms by collecting nationwide data from all Australian cultures, races, and ethnicities, about what legal and non-legal challenges people face (AHRC, 2015a).

There is clearly a need for specific qualitative research for ageing transgender populations. Understanding their unique gender affirming and preventative health needs, in relation to how they are impacted by psychosocial and economic stressors, is particularly important for prompting appropriate service provision (Houssayni & Nilsen, 2018). What is known already is that increased care, in terms of preventative health measures, for ageing transgender people is necessary. This especially so in later life where cross-sex hormones or surgeries may have compounded physical health risks, particularly if they add to, or conflict with, age-related health issues (Gooren & T'Sjoen, 2018).

2.7   Ageing Transgender People's Healthcare Experiences: International

Reisner et al.(2016b), Winter et al.(2016a), and Wylie et al. (2016), in a recent series in the *The Lancet* medical journal, indicate the global LGBT health burden is increasing due to the prominence given to transgender issues in health research worldwide. Despite rising transgender health research, scoping searches across five databases reveal most studies have taken place in the US and Northern Europe. Reports on HP discrimination and aggression in healthcare settings for other regions remain largely under-studied (Shires & Jaffee, 2015). A Proquest database search conducted by this writer, covering the last five years, included very little discussion on the equity of transgender health issues in comparison with ageing general or LGBT populations.

Based on their investigation in the US, Houssayni and Nilsen (2018) maintain that "the transgender health movement is young yet showing positive changes in healthcare learners when proper exposure and education takes place" (p.19). A given example of education includes health worker competency training to address transgender health needs and disparities. Mindful and empathetic approaches have been acknowledged as crucial for people who face challenges

maintaining their gender expression as health-related risks increase with age (Houssayni & Nilsen, 2018). However, evidence shows that some hospital (nursing and medical school) and allied education curriculums have not yet engaged with transgender health education (Houssayni & Nilsen, 2018; Markwick, 2016).

Hughes (2017) highlights healthcare situations where medical bias impacting on transgender healthcare may not be intentional. Bias may occur when providing inappropriate or inadequate care, or through refusal to treat a transgender person due to misunderstandings (e.g., due to an absence of knowledge). Absence of transgender inclusive policies has also been associated with delayed shifts in health worker attitudes towards more positive and knowledgeable medical care environments (Houssayni & Nilsen, 2018).

To counter these issues, the World Professional Association of Transgender Health (WPATH) has been instrumental in creating the Global Education Initiative (GEI) for healthcare providers (2019). The GEI provides an easily accessible pathway for health workers and specialists to increase their knowledge and gain certifications that will provide evidence of their competence in working with transgender people. Additionally, this education complies with WPATH's standards of care and could provide all health workers and specialists with knowledge needed to broaden their service availability, if educational institutions standardise the need for transgender health inclusion (2019). Specific to Australia is the Australian Professional Association for Trans Health (AusPATH), whose efforts in this regard are discussed in the oncoming section (2.9).

Wylie et al. (2016b), Winter et al. (2016a), and Reisner et al. (2016) (when reporting in the recent *Lancet Series*), have also asserted that filling research gaps with specific sociodemographic data will enable institutions, professionals, and society in general to gain improved understandings. This point is most relevant to those less visible sub-groups, such as ageing transgender people, who have been particularly overlooked in research (Auldridge, Tamar-Mattis, Kennedy, Ames, & Tobin, 2012; Siverskog, 2015; Winter et al., 2016a).

To exemplify disparities in ageing transgender people's health research, only five out of 187 reference list titles given by Reisner et al. (2016a) in the *Lancet Series* article, *Global health burden and needs of transgender populations: A review*, specifically targeted ageing transgender adults and/or their life course health issues. Combined age studies rarely have proportionate numbers of older adults in relation to their younger counterparts. Many prominent studies have the largest numbers of participants in the mid-to-late 30s age group, showing significant age group drop-offs in participants over 50 years old (Asscheman, 2012; Bockting et al., 2013; Devor, 1993; Gottschalk, 2006 ; Grant et al., 2011; Hyde et al., 2014; Kattari & Hasche, 2016; Motmans et al., 2010; Riggs, Coleman, & Due, 2014; Sanchez, Sanchez, & Danoff, 2009; Sasaki, 2007; Whittle, Turner, Al-Alami, Rundall, & Thom, 2007; Xavier et al., 2013).

A prominent study in Australia, *The First Australian National Trans Mental Health Study,* conducted by Hyde et al. (2014), included a reasonably high (*23%*) sub-group of trans people over the age of 50 years within their sample. Although the focus was primarily on the mental health of trans people in Australia, the researchers did include some important questions regarding social and economic factors that negatively impact trans people's mental wellbeing. However, as the study aimed to recruit large numbers of trans people across Australia, the data was collected by way of survey and the researchers reported that some questions could not be tailored and/or made specific to participants being interviewed (Hyde et al., 2014). This meant that issues such as how and why transgender people over the age of 50 years made their choices about gender affirmation and related healthcare seeking behaviours may not have been included in the report.

Contemporary healthcare, including that accessed by transgender people, has tended to focus on diagnosis of pathology (Reisner et al., 2016b). This only assists transgender patients with biological issues identified by blood and urine testing. However, these clinical assessments often ignore the cumulative effect of adverse health impacts unless they include psychosocial health determinants (Ettner & Wylie, 2013). Fredriksen-Goldsen et al. (2014) reported that ageing transgender populations generally experience higher levels of victimization and internalized stigma than non-transgender people. Porter et al.'s (2016) literature review of discriminative practices within the US found that almost half of the transgender and gender non-conforming participants encountered financial difficulties relating to discrimination in workplaces, and more than half concealed their identity. Health problems were exacerbated by psychosocial barriers, such as "employment, and financial resources, as well as experiences of hate crimes, interpersonal violence, sexual assault, and anti-TGNC prejudice when accessing caregiving supports" (p.367).

Many discriminating incidents in healthcare settings go unreported because ageing transgender people fear further abuses from the agencies that might otherwise be expected to protect their rights (Porter et al., 2016; Xavier & Simmons, 2000). What little evidence exists for transgender people of colour shows that they suffer even more violence and discrimination than other transgender populations (Auldridge et al., 2012).

Negative knock-on effects of discrimination issues in healthcare situations may have included self-administration of non-prescription hormones, high mental health and suicidality rates, and substance abuse (Porter et al., 2016). These adverse outcomes have, in some situations, been addressed by equipping ageing transgender people with resilience to overcome these challenges. Affirming gender has been supported as highly likely to improve mental health. Researchers such as Porter et al. (2016) recommend HPs acknowledge transition as a pathway to becoming more resilient against discriminative social systems.

Jaffee, Shires, and Stroumsa (2016) argue that ageing trans men are less visible and encounter more challenges in healthcare settings because they have been less understood than trans women. This argument is supported by Riggs, Coleman, and Due (2014). In a broad age survey (US) including a relatively small sub-group of ageing trans men, Jaffee et al. (2016) examined determinants that could indicate the likelihood of discrimination in healthcare settings. Factors considered included participants' socioeconomic and demographic situations, and HPs' competency (knowledge and comfort levels). Results in this trans male study showed that, overall, "participants over 45 years of age and those with an annual income of over $60,000 were less likely to experience discrimination" (Shires & Jaffee, 2015, p. 134) than all sub-groups controlled for race, education, full-time trans male status, use of gender affirming therapies or surgery, and matched legal documentation. Moreover, participants were more likely to report discrimination experiences when the aforementioned factors were controlled.

This signifies that major protective factors for ageing transgender people correlate with their financial status, and with sufficient visibility to report negative healthcare experiences. Shires and Jaffee (2015) related intersectionality theories to their findings by exemplifying that "those with higher levels of education were more likely, not less likely, to experience discrimination" (p.139), if income was lower than the benchmarked $60,000, or their age was less than 45 years. Shires and Jaffee (2015) hypothesise that people with a higher education may have been more assertive during their interactions with HPs, which may challenge health workers and professionals unfamiliar with transgender health issues.

Related studies, such as Auldridge et al. (2012) and Markwick (2016), show that social support systems and staff have lacked adequate training to help transgender people experiencing financial difficulties (e.g., with employment, housing). These examples of stressors, compounded with multi-sectoral discriminations, have caused increased risk-taking behaviours in ageing transgender people to be observed. Auldridge et al. (2012) (in a New York based study) found older transgender people were more likely to engage in unprotected sex work and have high rates of sexually transmitted diseases (STD) than non-transgender people. Moreover, when avoiding or refusing care such as screening (e.g., cervical, prostate, breast), ageing transgender people have put themselves at risk of undiagnosed cancers. Evidence has shown this has also occurred when post-transition transgender people have been excluded from health insurance coverage (Auldridge et al., 2012), or have been less likely to have health insurance for economic reasons (Markwick, 2016).

A review of the 2010 *National Transgender Discrimination Survey* (which included all age groups of trans people) by Kattari and Hasche (2016) identified issues specific to ageing people who, over their life course, had encountered a domino effect of discrimination. An absence of sociodemographic positive influences, such as health insurance and being able to "pass" (by being assisted with outward appearance with gender affirming processes), correlated with lower overall

physical and mental health in the older sub-groups (Fredriksen-Goldsen et al., 2014; Kattari & Hasche, 2016).

Researchers such as Fredriksen-Goldsen et al. (2014) and Kattari and Hasche (2016) also examined how a life course of negative experiences, such as HPs' (conscious or non-conscious) attitudes, behaviour, and beliefs, may have impacted individuals' trust for revealing their true identity in healthcare settings. Related findings have shown that reluctance to disclose identity has resulted in health disparities and associated reduction in broad health and quality of life (Fredriksen-Goldsen et al., 2014). Again, outcomes show age-related differences where the very elderly have been included and negative impacts have been most significant (Fredriksen-Goldsen et al., 2014; Kattari & Hasche, 2016).

Kattari and Hasche (2016) investigated participants presenting part-time in their true gender throughout their life course and found that the likelihood of individuals to report discrimination, and other social aggressions in accessing healthcare, decreased as they aged (Kattari & Hasche, 2016). Whilst some discrimination has been reported openly, other incidences may have been more subtle, unrecognised, or unaddressed, due to the difficulty of reporting. In their report, Kattari and Hasche (2016) included descriptions of discrimination or stigmatization in healthcare settings where people have: (1) been refused care; (2) encountered transphobia (e.g. using gloves when not necessary); (3) experienced health workers making assumptions about transgender people's anatomy; and, (4) encountered inappropriate language (including misgendering and incorrect use of pronouns). These experiences have been related to people's level of physical transition and outward expressions; that is, the likelihood of an individual encountering discrimination was determined by how much time they spent in their authentic gender.

Social and economic difficulties are regarded as primary barriers for people wanting to affirm and live in their authentic gender. More socioeconomic research is urgently needed to assist understanding about the key stressors deterring ageing transgender people from seeking care. What is known is that avoidance of attending to basic healthcare needs often results in overall poor health outcomes and transgender people overusing emergency services in urgent situations (Auldridge et al., 2012). Without confidence in healthcare providers, people who conceal their gender identity and/or live in relative social isolation may not acquire important health knowledge; and further, may delay seeking healthcare to avoid the possibility of having to reveal their sex assigned at birth, even in emergency situations (Bauer et al., 2009; Fredriksen-Goldsen et al., 2014; Taylor, 2016). This increases the difficulty of research determining the impacts in age-related issues, experiences of ageism, degenerating health, chronic disease, and screening needs (Fredriksen-Goldsen et al., Ettner & Wylie, 2013; 2014).

Literature reviewed would appear to indicate that more research examining the historical context of transgender people's experiences is needed. This research (if conducted) would improve interventions and health policies (including insurance) regarding transgender-specific service needs, and cultural competency training, particularly in relation to the intersectionality of multiple identities. Kattari and Hasche (2016) suggest that discrimination originated from HPs lacking education, when entering gender affirmation and age-related service provision. Shires and Jaffee (2015) conducted targeted studies aimed at gaining insights from first contact support professionals, such as social workers. This has proved to be highly beneficial in providing information to other close contact HPs and/or workers who might be unfamiliar with transgender health. Shires and Jaffee (2015) assert that social workers play a significant role in educating healthcare providers and providing safe pathways to healthcare for people who conceal their identity or live in relative social isolation.

Globally, there have been limited longitudinal or qualitative studies that specifically examine the broader health (psychosocial, sociodemographic) issues that ageing transgender people experience throughout their lifetimes. The WPATH's well established guidelines have not yet included the diversity or unique care needs of ageing transgender people (Porter et al., 2016). This means that there is limited knowledge available showing how to support, or positively modify, social determinants that would support good health (Ettner, 2013; Ettner & Wylie, 2013). Dissemination of specifically targeted, quality broad health knowledge about ageing transgender people has been recommended to give HPs (including primary healthcare providers) increased clinical competency (Persson, 2009; Zelle & Arms, 2015).

Porter et al. (2016) have reported prejudices within the gerontology and ageing related sectors of healthcare. Within this field, HPs have been most likely to encounter post-transition ageing and aged people who have been living full-time in their non-birth gender. According to Porter et al. (2016), intersectionality and multi-dimensional prejudices have interfered with healthcare access and care involving gerontologists, geriatricians, and aged care health workers. A lack of cultural competence correlates to HPs' inability to cope with both geriatric medical issues and transgender people's unique health issues (Porter et al., 2016).

End-of-life issues have also caught the attention of researchers. Porter et al. (2016) reported ageing transgender people's concerns about legal matters (wills, power of attorney, and rights in care), and lack of specific policies that might otherwise protect them. Fear of institutional maltreatment has caused many transgender people to either revert to their birth gender, as they approach end-of-life, or plan end-of-life euthanasia or suicide (Porter et al., 2016). This relates to Australian statistics provided by Couch et al. (2007) showing that 20% of trans respondents reported experiencing suicidal ideation and another study showed that as many as 50% of trans people have made an attempt to take their own lives (cited in Rosenstreich, 2013, p. 3). Whilst these figures are not specific to ageing

transgender people, they do provide evidence and the likelihood that many ageing transgender people will have such experiences throughout their lifetimes.

Ageing transgender people have been particularly impacted by Western civilisations' historical understanding of people being male or female. Social conditioning and associated gender role expectations occurring from early life are typical in many countries, including Australia. Riggs and Due (2013) define this process as "coercive gendering as deemed appropriate to our natal-assigned sex" (p.4). Once a gender crossing has occurred, cisgender and general population societal attitudes often render individuals vulnerable to negative judgements and increased discrimination (marginalisation, stigmatization, or prejudice), particularly if they are not able to benefit from the protection of transgender communities (Riggs & Due, 2013).

Prolonged periods of difficulties are also experienced by ageing transgender people. The compounded impact of factors affecting people's health determinants has been shown to cause secondary mental health conditions. This has been particularly likely when transgender people have been impacted by negative experiences over a lifetime, causing a slip down a "slope from stigma to sickness" (Winter et al., 2016a, p. 318), linked to minority stress.

Meyer (2003) explains that minority stress has occurred in the cisgender LGB population when "stigma, prejudice, and discrimination create a hostile and stressful social environment," which "includes the experience of prejudice events, expectations of rejection, hiding and concealing, internalized homophobia, and ameliorative coping processes" (p.674). Again, this warrants more in-depth investigation about how people develop resilience and prioritise their health needs in relation to determinants of health and access capacities.

2.8   Intersectionality

Many transgender people use a coping strategy of interacting with others with differing personalities, or identities, to overcome intersecting forms of discrimination or stigma in their daily lives; for example, in social and employment situations. Researchers such as Crenshaw (1989) devised a framework of "Intersectionality" (a sociological analytical framework used to investigate the interconnected nature of social categorizations) in an attempt to understand identity development in individuals (gender, class, age). Other researchers such as Burnes and Chen (2012), and Riggs and Due (2013), have also used intersectionality to understand people's identity behaviours "both within-group differences and within-group similarities of marginalized communities and how inequality plays a role" (Burnes & Chen, 2012, p. 8).

Burnes and Chen (2012) explain how intersectionality has also been used to analyse how systems of power are able to control or oppress vulnerable sub-populations; and further, how transgender people may develop multiple identities to be safe and avoid harmful situations.

Intersectionality frameworks in psychology demonstrate how the interplay between an individual and their social context causes changes in identity salience. Some situations allow full expression, while others cause a person to conceal their identity (Burnes & Chen, 2012).

Riggs and Due's (2013) example of cisgender positions of power explain how masculine cisgender people may overtly display rejection of people presenting outside gender norms by punishing them for those "transgressions". Their study participants included two categories: trans women and trans feminine non-binary people, and trans men and trans masculine non-binary people. Riggs and Due (2013) made an important assertion regarding differential types of punishment targeting transgender people, which was that trans men and trans masculine non-binary people would have experienced punishment differently to trans women and trans feminine non-binary people. Abusers of trans women and trans feminine non-binary people have often been dealt punishment, perceived by the abuser to be appropriate for masculine identities (e.g., physical violence); whereas, the trans women and trans feminine non-binary people may have been subjected to abuse deemed by an abuser to be appropriate to feminine identities (e.g., rape).

Social characteristics that can impact a person's identity have been found to be linked to social vulnerability, including race, gender, age, disability, class, and ethnicity. Each of these elements are widely correlated with increased vulnerability in society generally. According to Burnes and Chen (2012) transgender people who have experienced vulnerability in more than one category have been more likely to have multiple identities.

2.9   Ageing Transgender People's Healthcare Experiences: Australia

In Australia, investigations about health and gender affirming issues have been raised to inform policy makers and HPs about the health needs of transgender people. However, until recent times, larger scale Australian studies have been scarce. For this reason, this section's reporting of ageing transgender people's healthcare experiences has drawn on all-age studies that include ageing sub-groups within their samples.

Most existing studies have been conducted in the Eastern states and have drawn on information from people geographically located in, or near to, Australia's major cities. Other state or regional studies have been smaller scale and have mostly included ageing participants in mixed-age or topic-specific studies. Given the intersectional nature of ageing and being transgender, it is important to remember those healthcare issues shared by all ageing populations. Evidence shows a general awareness of the importance of Australian transgender people's need for adequate access to mainstream services, and social support systems, as well as gender-specific services (Couch et al., 2007; Leonard et al., 2012; Riggs et al., 2014). Andritsos and Tang (2014) highlight the impact of lengthy waiting times associated with elective care within healthcare systems. A procedure deemed

beneficial that has been chosen by a patient or their doctor, for example sex-reassignment surgery (SRS, referred to in this study as GAS), may not have been deemed essential at the time and not prioritised.

Whilst the following study is reasonably old, it is one of the few Australian studies that can be used to compare and highlight how some healthcare situations have been improving over time. Couch et al. (2007) conducted a mixed-age study (mean age 41.7 yrs [p.17]), including a small sub-set of transgender people over 50 years, and reported the difficulties encountered in accessing various screening services. Comparisons showed as little as one-third of transgender people eligible for screening attended screening clinics within the proposed timeframes, as opposed to nearly two-thirds of the mainstream populations (Couch et al., 2007). Hyde and Brown (2011) in a later study showed that prostate screening attendance fared better, with most participants reporting access to services as needed.

Couch et al. (2007), in their Australian study, reported that most transgender respondents had a regular GP and utilised a diverse range of services (Couch et al., 2007). Leonard et al. (2012), in *The Second National Survey on The Health and Wellbeing of GLBT,* sought to strengthen people's healthcare access by demonstrating the range of services utilized by Australian participants. These included "mainstream providers: psychologists, optometrists, chiropractors, [to] alternative and complementary therapists, including acupuncturists and massage therapists," and "over three-quarters of the total sample reported having a regular GP" (Leonard et al., 2012, p. VII). Whilst the study has given an important insight into the range of Australian services accessed, the total study only included a relatively small sub-group of transgender people. Moreover, it did not determine which services were most important to ageing transgender people's needs or how they might have experienced discrimination in alternative ways to their LGB counterparts (Leonard et al., 2012).

The mental health of Australian transgender people has been targeted by a variety of researchers. A prominent investigation conducted on behalf of the DOH revealed that all transgender age groups have been more likely than cisgender people to be impacted by conditions such as anxiety and depression disorders, and suicide ideation (Government of Victoria, 2014). However, whilst related literature has demonstrated disparities between physical and mental health experiences of Australian transgender populations, there has been little information detailing the relationship between ageing transgender populations and resultant poor mental health (Government of Victoria, 2014; Hyde et al., 2014).

Hyde et al. (2014) did report on 216 trans people over the age of 50 years out of a total sample of 936 participants. This important Australian study aimed to report the mental wellbeing of participants (quantitatively and qualitatively) by investigating and discussing the significance of the following: the impact of discrimination; benefits of gender affirming hormonal therapies and

surgeries; social relationships; and, economic factors such as employment, income, health insurance, as well as funding sources for healthcare. The study showed that in relation to these factors trans participants over the age of 50 years faired relatively well with their mental health in comparison with younger trans participants. For instance, only 19.4% of those 50 years and above experienced a major depressive syndrome in comparison to those in aged 40 to 29 years (46.4%) (Hyde et al., 2014, p. 18). Yet, as the study was not tailored specifically to ageing trans populations, the discussion did not consider any issues that may have accounted for the 50 years and over age group's outcomes. Given that many participants were residing in Victoria and NSW and within a reasonable distance from culturally competent healthcare provision, the reporting may not have demonstrated reporting balance, or included fundamental issues relating to ageing trans communities in other states. However, in their recommendations, Hyde et al. (2014) did assert that using research instruments that could capture information about broader concerns, and that allow trans people to voice any concerns relevant to their specific circumstances, would be highly beneficial.

Australian researchers such as Riggs and Due (2013) have attempted to understand which aspects of healthcare and support systems assist gender diverse people to avoid discrimination. Riggs and Due took participants' health determinants information (sociodemographic, environmental and economic) into consideration. Evidence shows that, for their respondents, a common factor is that discrimination is experienced differently according to whether their identity is masculine or feminine. Moreover, increased discrimination is encountered by trans women and those with a trans feminine non-binary identity (Riggs & Due,2013). Whilst these researchers noted differences for age cohorts between their study participant groups (trans women and trans feminine non-binary people, and trans men and trans masculine non-binary people), no information was given about their specific issues related to ageing.

Recent studies by Riggs et al. (2014) have managed to attract ageing trans and gender diverse people (N=188, mean age 44.87 yrs [p.3]) who, in the past, may have been less likely to openly disclose personal information. Perceived mental and physical wellbeing were measured with Likert scales, together with ratings for experiences with a wide range of HPs (GPs, psychiatrists, psychologists, surgeons) (Riggs et al., 2014). Findings revealed that non-binary trans men and trans masculine identifying people, in general, had reduced opportunities for surgeries. It is asserted that this occurs as an outcome of reduced prospects for surgeons to undertake transgender-specific training (for example phalloplasty).

Generally, Riggs et al.'s (2014) results confirmed that people who had gender affirming surgeries reported better broad health and better experiences with professionals than those who had not had surgery. The authors propose that reduced opportunities for gender affirming treatments may result in less preferential treatment (Riggs et al., 2014). Recommendations for increased service provision have related to surgeons being positioned as Australian gatekeepers. Increased service

provision is reliant on surgeons being obliged to undertake appropriate training, so they can recognise gender diverse people who may be vulnerable to poor mental health (Riggs et al., 2014).

Without inclusion in policy writing, ageing and aged transgender people are excluded from having their needs met by Australian healthcare provision. For example, gender identity markers, (relative to historical issues of Medicare's binary sex classification and identity-matching) have prevented transgender people from surgeries or hormonal therapies (Government of Victoria, 2014). Some amendments have been made to address these issues, such as billing codes and subsidies, but there has been scant funding for all gender affirming processes, such non-genital surgical procedures (breast augmentation or hair transplants [Government of Victoria, 2014]).

The WPATH's *SOC7* (Coleman et al., 2012) drew the attention of the Government of Victoria to the guide for HPs, which involved reported barriers because the majority of specialised clinicians practice from private clinics and not within the public sphere (Government of Victoria, 2014). Any possible access through the public system has relied on referrals. Increases in transgender populations have resulted in many people avoiding long waiting lists by paying large fees (Government of Victoria, 2014). Evidence for increased specialist involvement has been reflected in that government's development of precautionary policies and stimulating consistency amongst caregivers, including surgical services.

From a transgender health perspective, the WA Gender Project argues that "one major important factor regarding gender reassignment surgery, that a number of trans* community members and lobby groups agree on, is a lack of trained medical professionals in Australia … even if treatments were to be fully covered by Medicare, there are currently few, and in some cases no, surgeons or health facilities with the expertise to actually provide the treatments required" (Alexander, 2012, para 11).

Later life complexities, of service-related complications, increase with the intersection of ageing and gender affirming health needs, and socioeconomic health determinants (Michael et al., 2018). Difficult transition decisions have been reported as fraught with problems. Challenges of hormonal or surgical contra-indications (secondary health issues), screening or assessment for gender affirmation, or finding HPs with sufficient expertise and associated costs, has caused people to avoid gender affirming procedures (Michael et al., 2018). Mental health issues have also been shown to be exacerbated by diverse psychosocial impacts and barriers encountered through the Australian gender affirming process (Government of Victoria, 2014; Hyde et al., 2014). Previously mentioned evidence has shown that these stressors further compromise mental health by increasing the likelihood of substance abuse and smoking (Cannon et al., 2017).

Aged-related chronic health issues may have been heightened in the absence of knowledgeable care; however, Australians under the age of 65 years have not been eligible for aged-

care services. Without sufficient evidence of ageing transgender people's needs for equitable access (as outlined in the *National LGBTI Ageing and Aged Care Strategy, 2012*), ageing transgender people may not be able to overcome their struggle to address unique health issues unless organisational and legislative support is available. This is particularly so in the event that some people prefer to identify in their authentic identity (male identifying, female identifying, NB), and not as transgender (Michael et al., 2018).

Evaluating the resources available to older transgender people in aged-care settings has been gaining more attention in Australia, in combination with LGB investigations (ACON, 2017; Comfort, 2010; Rosenstreich et al., 2011). In recent times, researchers have acknowledged the need for specific resources to be provided to support transgender people in aged care. Over a life course people may have experienced many losses (for example, the loss of significant others or retrenchment from employment), as well as coping with gender-related stressors. Michael et al. (2018) report that mental health issues, such as anxiety and depression, and institutionalised abuse, is commonly reported as higher for transgender people than for cisgender LGB community members in aged-care facilities. However, they also report that regardless of anticipated difficulties of ageing, people have chosen to transition in the later stages of their life (Michael et al., 2018).

Bariola et al. (2015) made use of sub-sample material, gained from the *Private Lives 2* online survey (Leonard et al., 2012), to consider what "demographic and psychosocial factors, that are known determinants of general population mental health, have also been identified as risk factors for reduced mental health among this [LGBT] minority group" (Bariola et al., 2015, p. 2108). Based on the hypothesis that unique capacity building strategies may rely on different health determinants, there have been some important recommendations made. One recommendation includes drawing on associated health determinants (economic, psychosocial, environmental) and comparing them with those for general populations.

Bariola et al. (2015) based their rationale on findings that typical mechanisms for resilience involved the related concepts of "group-level coping," by socially connecting marginalized people with "similar" others; that is, engaging with peers who could help individuals develop resilience (Bariola et al., 2015). The outcomes informed further questions relating to resilience (support networks) and building programs for target populations across all regions of Australia (Bariola et al., 2015). Whilst this information was not ageing specific and did not include people with isolation issues or disabilities, it has highlighted research considerations for intersectionality and ageing specific sub-groups.

In conclusion, the research studied has shown that Australian transgender people need a wider range of easily accessible healthcare services in order to promote better health outcomes and increased resilience (AHRC, 2015b; Couch et al., 2007; Pitts, Mitchell, Smith, & Patel, 2006). Gaps

remain in Australian reporting for ageing generation sub-groups, informing just how resilience has been gained, and by whom. Data has been lacking in many studies where only small sub-sets of ageing transgender people with cisgender LGB populations have been included. Moreover, most studies have only undertaken broad age reporting (Couch et al., 2007; Leonard et al., 2012; Pitts et al., 2006). Other limitations have included an under-representation in the Australian data of broader transgender issues, such as the ageing transgender sub-population who could not, or did not want to, transition for psychosocial, economic, physical health reasons (e.g., pre-existing health conditions) (Couch et al., 2007).

Chapter 3.   Methodology

Chapter Two's literature review showed significant gaps in existing Australian reporting on contextual accounts of ageing transgender people's unique health determinants, and what protective factors assist older sub-populations (non-binary, male and female identifying trans people) to develop resilience.

The purpose of this study has been to fill these gaps. Under-researched factors for investigation were: (1) specific gender affirming and health needs, including aged care, that ageing and aged transgender people have; (2) health determinants in relation to good health and access to healthcare provision in Australia; (3) positive and negative issues impacting broad health and wellbeing of ageing transgender people, including the intersection of aged-related issues; (4) differences between specific transgender issues and those most reported for people identified under the LGBT umbrella; and, (5) differences of experiences associated with being trans women, trans men, and non-binary individuals.

3.1   Significance of the Study to Public Health

This study was designed to bring to light what and how health and healthcare problems are experienced by ageing transgender people. The following paragraphs highlight why and how ageing transgender people can be helped to acquire what is needed to overcome their associated individual, community, and population issues.

This is particularly necessary in the light of associated healthcare provision availability issues arising with a rapidly ageing population, which ageing transgender people over the age of 50 years are part of. Australia's ageing population, including those aged 50 and above, now make up 33.6% of the 24.6 million population or in other words 8.28 million people (at the time of writing) (PopulationPyramid.net, 2019). This figure is predicted to increase to 39.7% of a 33.5 million total population by 2050. These figures indicate that the ageing population will be approaching double (13.3 million) the current ageing population (PopulationPyramid.net, 2019).

This study is necessary for initiating investigations and motivating further research that uncovers the complex ways ageing transgender people in Australia experience health and associated inequalities. Identifying the unique health and healthcare challenges of older transgender people is also important for providing information to healthcare policy makers and contributing to the global knowledge base needed for stimulating health reforms. The information can further empower and support ageing transgender people by providing them with a voice and evidence-based inequalities.

A qualitative phenomenological approach has been used to explore, identify, and describe the context, challenges, and ranges of peoples lived experiences of health and healthcare, including

related residential care. This chapter will explain what qualitative phenomenological approaches were used and why they were chosen. Included are: (1) Significance of study to public health; (2) the research questions; (3) overview of research design and qualitative phenomenological approaches; (4) ethical clearance; (5) recruitment and sampling; (6) facilities and resources; (7) data storage; (8) participants; (9) data collection and interviewing; (10) data transformation and thematic analysis; and, (11) study limitations.

3.2   Research Questions

The above research gaps assisted with formation of the study research questions, which were:
(a) What experiences do ageing transgender people have in relation to health and wellbeing and healthcare services (including assisted living care)?
(b) What hinders or enables good health and access to healthcare services?
(c) What factors assist or hinder them to be resilient?

3.3   Overview of Research Design

A qualitative research approach using a phenomenological research design and thematic analysis was deemed appropriate for this study because of its versatility and ease of use. Qualitative research has been described as "primarily an inductive process of organizing data into categories and identifying patterns (relationships) among categories" (McMillan & Schumacher, 1993, p. 479).

A systematic process helped address research questions about the study's highly diverse target population. In a medical research appraisal, Kuper, Reeves, and Levinson (2008) explained qualitative research as "an umbrella term for a heterogeneous group of methodologies with different theoretical underpinnings and different ways of thinking about knowledge" (p.2). This description suggests what variability qualitative research offers. Variability has been problematic for HPs when evaluating the quality and validity of qualitative reports in comparison to quantitative results. These problems have sometimes resulted in research being denied publication by medical journals (Kuper et al., 2008). However, in qualitative researchers' defence, a literature review by Gleeson et al. (2016) found that, whilst HPs have sometimes been unwilling to act solely upon qualitative studies, they were also more likely to pay some attention to interesting and relevant (to their field) material.

HPs have good reason to take interest in this study. Phenomenology has origins in hermeneutics. Initial hermeneutics meanings related to sacred texts; however, over time these meanings have been expanded and include "understanding human action in context" (Willis, 2007; cited in Bound, 2011). Given the right purpose, a stand-alone qualitative investigation has a place in health research, particularly when gaining information from difficult-to-reach populations and small sample groups.

Reporting with a qualitative phenomenological approach primarily aims to accurately describe the researched phenomenon from the collective perspectives and common encounters of an entire sample group (Groenewald, 2004). In this study, it has the potential to explore people's shared experiences of healthcare and any shared outcomes (Tashakkori & Teddlie, 2010). Examples include uncovering what have been the most common psychosocial impacts of transitioning and what lived experiences difficult-to-reach sub-populations have shared and have been invaluable for educating HPs. For instance, professionals report that rich contextual explanations of a phenomenon have given insights into the broader issues surrounding unique patients' health concerns and clinical issues (Kuper et al., 2008).

Other qualitative approaches, such as interpretative phenomenological analysis (IPA) and grounded theory, were deemed inappropriate because both have less methodological versatility and have been theoretically bound to language or framework, or theory construction (Braun & Clarke, 2006; Creswell, 2007). Further, an ethnographic study would be problematic for a master's project because the approach requires longer timeframes and regular visits to the field to allow the researcher to immerse themselves in the daily lives of the participants (Creswell, 2007).

In this project, phenomenology has been specifically resourced to describe the "essence" of being an ageing transgender person, in relation to broad health and healthcare, by utilising a description that "consists of 'what' they experienced and 'how' they experienced it" (Moustakas, 1994; cited in Creswell, 2007, p. 58). This means that the participants themselves were the primary research instruments and the investigation's data collection strategies have not been bound to a theoretical framework. In other words, this study does not aim to disprove a hypothesis or provide evidence to support a hypothesis.

The qualitative enquiry method of gathering participants' thoughts, opinions, and experiences contrasts with a straightforward quantitative method of "how much" was encountered or "how many" experienced the same issue. Quantitative researchers commonly seek accuracy in their results by taking an objectivist approach. For this type of quantitative research, the underlying belief in knowledge assumes that real and factual knowledge will be gained by using an appropriate theoretical positivist framework (Kuper et al., 2008). Phenomenology contrasts with objective perspectives by maintaining that knowledge beliefs (epistemology) should adopt a constructivist perspective. In phenomenology, people's perceptions have been "constructed by our social, historical, and individual contexts, and so there can be no absolute shared truth" (Kuper et al., 2008, p. 2). In this case, phenomenological reporting would focus on the cumulative experiences of participants for a single phenomenon, whether it be momentary or lengthy (Bound, 2011). Additionally, a phenomenological approach can aim to uncover common opinions and feelings that are subjective and contextual (Creswell, 2007). In this investigation, subjectivity and context has included a socially scientific

exploration of the perceived reality of people who have common social and/or historical issues of discrimination, particularly in healthcare settings.

As phenomenological research processes are free from any theoretical constraints, the researcher can gain information from participants' "lived experiences in a language as free from the constructs of the intellect and society as possible" (Groenewald, 2004, p. 12); that is, to provide participants with an opportunity to explain freely their opinions, experiences, and feelings, with their own choice of words, expressions, and terminologies.

Qualitative researchers often include interpretive, deductive, or inductive approaches to understand data. An interpretive approach is bound to the researcher's view and has some flexibility to establish a logical framework for meaning making of issues not apparent on the surface (e.g., details embedded in the data such as ideologies of individuals) (Creswell, 2007). In contrast, deductive approaches commonly used by quantitative investigators largely rely on a pre-determined research hypothesis (Kuper et al., 2008).

This study takes an inductive approach and asks research questions to gain knowledge. It differs from other approaches because the researcher must attempt, prior to gathering information from participants, to relinquish their preconceptions of the phenomenon to allow meanings to emerge explicitly from the reports (Kuper et al., 2008). To do so, the interviewer engages with a bracketing technique to gain fresh perspectives on the subject matter, whereby they must regularly self-evaluate for neutrality during the information gathering and analysis process (Creswell, 2007).

3.4   Ethical Clearance

This study undertook an inductive analysis approach to identify and link themes or patterns within specifically gathered data. Braun and Clarke (2006) explained this approach as a "bottom up" (p.83) approach or, in other words, collecting data directly from the source (e.g., from an interview). In this study, face-to-face, semi-structured interviews investigated highly sensitive issues (experiences, behaviours, relationships). Therefore, this project required, and was granted, ethics clearance according to the ethical codes and guidelines set out in the *Australian Code for the Responsible Conduct of Research* (National Health and Medical Research Council, 2007a; Australian Research Council, & Australia Universities, 2007) and the *National Statement on Ethical Conduct in Human Research* (National Health and Medical Research Council, 2007b). Ethical issues concerned anyone involved in the study (researchers, supervisors, participants, key informants). The project received ethics approval from Curtin University on the 12th April 2017.

The researcher consulted the project supervisors to ensure the right course of action was always taken. This meant respecting and doing no harm to all involved. Participants were invited on a voluntary basis. The project was explained as comprehensively as possible, with clear explanations of

the participants' rights, as well as the purpose and objectives of the investigation. When all details were understood, informed consent was obtained. An opt-out provision was outlined to allow participants and key informants to withdraw at any time during the study. Although it was unlikely, due to the voluntary nature of the study, some interview questions may have unintentionally caused participants distress (e.g., recalling negative events). A contact list of support services was provided at interview in case needed.

Since gaining ethical clearance and gathering information (from the study participants), it should be noted that Winters, D'Orsay, and Sirenu (2019) created the Transgender Research Informed Consent (TRICON) disclosure policy. This is designed to increase research validity and overcome a variety of ways transgender people are negatively impacted when participating in research projects. The TRICON model compels researchers to use an approach which improves trust between trans communities and trans researchers. In this instance, the model increases transparency in situations where participants may have past experiences of "intolerance, bias, and psychopathological stereotyping in this speciality" (Winters, D'orsay, & Sirenu, 2019).

Unfortunately, whilst this TRICON model would have been utilised if it were available at the time of data collection, this study did not use the model. The recent release also relates to the comparatively small number of studies and research, concerning trans populations, currently available from health providers and trans scholars, which includes the TRICON protective measures for trans populations.

This project was determined as having reasonable risk in relation to the value that dissemination of the research findings may give to ageing transgender people. To comply with ethical guidelines the recruitment and data collection (interviews) included the following: (1) all documentation used clear concise language; (2) an information sheet provided to participants at interview advised them that their data can be removed until the point of analysis. In this event, their corresponding data was deleted; (3) data was non-identifiable, by using appropriate numerical coding; (4) audio recordings were deleted immediately after verbatim transcription. (See Appendix II: Research data management plan for further details.)

3.5   Recruitment and Sampling

To align the recruitment process with the study approach, according to Creswell (2007) it is necessary to first determine how to target participants who are most likely to have experienced the phenomenon. In this study the phenomenon for participants who are ageing (50+ years) includes those who have experienced health, wellbeing, and healthcare issues in both general and trans specific Australian contexts. The purpose of this is to uncover experiences that are common in relation to the

phenomenon or, in other words, experiences that describe the essence of being an ageing transgender person in relation to health and healthcare.

Reaching out to community leaders and social media platforms, as well as HPs who specialise in trans healthcare, would most likely raise awareness of the study. Recruitment included hard print and online flyers, emails to service providers, and a Facebook page advertising the research purpose and inviting individuals to volunteer to participate in the study (see Appendix II). An advisory panel (primarily the Transgender Research Interest Group [TRIG]) was key in providing information about possible recruitment sources. Members of this panel attended monthly meetings from 2016 to 2018. Attendees were academics and HPs in the field of trans health, students with a specific interest in transgender health concerns, and transgender community members (young, mid-age, and ageing adults).

The researcher consulted TRIG to gain information that assisted in recruiting research participants (via social media, HPs, community leaders and groups). The TRIG also provided information sources for gathering grey and other useful literature to assist with a broader understanding of trans health related issues and provided valuable target feedback regarding the study design whilst preparing for candidacy. In this instance, TRIG was able to mitigate research bias by giving both insider and outsider opinions about the project proposal. The explanation of the research standpoint as being inside, or outside, refers to a paper by Nakata (2015) who asserts that a research perspective should be categorised according to the positioning of those collecting and analysing the data. Most relevant to this study is that making a distinction between those involved in any given aspect of the study will assist others to understand how the study has taken its form, and why the study used a given methodology to achieve its goals (Nakata, 2015).

Examples of the ways in which both insider and outsider opinions were used were to establish: (a) the potential scope of the study; (b) the value of study to ageing transgender people; and, (c) an evaluation of the research questions. Although there was continued academic support, there was less insider involvement in the project after candidacy and during the data collection period. However, the TRIG group continued to provide advice to any questions asked in relation to cultural competency when communicating with participants. The research supervisors are also members of TRIG and continued the research support from thereon.

Contacts were shared to help connect with various transgender and LGBTI organisations (e.g., Transwest, The Gender Centre, GRAI, Connections). All recruitment material is displayed in the Research protocol section of Appendix II. Advertisements were released following approval by the Curtin Ethics Committee in April 2017. Capturing a range of ageing transgender-identified people required recruitment material to reach out beyond West Australia. Widespread advertising throughout

all the Australian states via support services and community networks was likely to increase the sample diversity of this study.

After much communication with specialised HPs and support staff it became evident that, outside of specialised LGBTI services, many providers had no, or very few, interactions with ageing transgender patients. However, when presented with the recruitment information, many professionals and providers were keen to assist by encouraging any known ageing transgender patients to take part in the study. This meant waiting for patients to attend their providers. It also meant that a study bias occurred. Most volunteering participants were recruited due to their close contacts with HPs. There were no participants involved in the study who were not receiving healthcare provision of some sort. Because recruitment mostly relied on the advisory panel and service providers' encouragement of individuals to step forward, invitations for interview remained open throughout the remainder of 2017.

The diversity of trans people influenced the number of participants to be recruited. The non-probability sample aimed to include up to 21 participants. Selection was based on age (50+ yrs), gender expression, and location (range to include all states of Australia). This number of participants enabled data from three smaller sub-groups. These were the: (1) non-binary group (NBG); (2) male identifying group (MG); and, (3) female identifying group (FG). Data from the groups of participants was triangulated (compared, contrasted, validated). This approach is like that of a recent Curtin University (WA) study. Cleasby (2015) conducted an exploratory investigation of two sub-groups of transgender people (*N=14: 7 per trans female or trans male group*) to gather specific information in relation to their sex at birth and affirmed gender identity.

Whilst the topic of sample size has been greatly debated by prominent authors (Creswell, 2007; Polkinghorne, 1989), there has been a general consensus reached by 14 renowned social scientists that participant and interview quantity is totally dependent on: how the research questions need to be approached; what method or methodology should be used; what time and resources are available; and, how the research material can be adequately assessed for accuracy, validity, and credibility (Mason, 2002). Qualitative sample sizes can range from between one to more than 100 without undermining the benefits this style of research offers (Mason, 2002).

Anticipated difficulties for recruitment related to the target population being hard to reach. A small sample has been validated for this specific type of study for the following reason: credibility and trustworthiness for this type of project was drawn from Polkinghorne (1989) who reflected on the importance of drawing on collective experiences by interviewing between "5 to 25 individuals who have all experienced the phenomenon" (cited in Creswell, 2007, p. 62). Whilst such a range (for a small sample group) might seem on the surface to lessen validity (e.g., when comparing the volume of material arising from 5 participants as opposed to 25), there is a justifiable validity arising from

"saturated" data. In other words, when the information arising from the participant interviews ceased to provide any new information or perspectives on the topic, the subject matter had been exhausted (Groenewald, 2004).

Saturation has been defined as a "research technique that is used during a study to inform the number of participants necessary for a given sample; data are analysed concurrently with data collection, and the sample is said to be saturated (so data collection can cease) when new themes stop emerging from the data that have already been gathered" (Kuper et al., 2008, p. 4).

3.6   Facilities and Resources

There was a possibility that the interview approach could cause the participants to experience emotions such as anger or distress. There was no anticipated risk to the researcher, and no adverse situations arose. However, to safeguard all parties, interviews were conducted in safe places at times and in settings that facilitated comfort in participation and disclosure. This gave participants the discretion to freely describe and give meaning to personal points of view and perceptions. Participants had the option of electronic (e.g., Skype) interviews, or personal attendance in an appropriate room at Curtin University, or at a place deemed appropriate and safe (by all involved). Interviews were not undertaken at respondents' homes after daylight hours or in isolated areas. Safety plans also included contacting next of kin prior to, and after, participant home-based interviews, to ensure interview times and location were known.

3.7   Data Storage

The data storage provisions are outlined in Appendix II's Research data management plan. Planning met the Curtin University Research Data and Primary Materials Policy requirements.

3.8   Participants

As the aim of the exploratory project has been to gain rich detail about the diverse experiences of ageing transgender people, information was gathered from 19 participants (see Chapter 4: Findings: Table 1). The sample included three sub-groups of people as follows: (a) non-binary group (NBG) [*N=3*]; (b) male identifying group (MG) [*N=5*]; and (c) female identifying group (FG) [*N=11*]. This approach had the advantage of developing grounded insights about experiences that may have been shared amongst a cultural group – regardless of their differing contextual encounters, perceptions, and problems (Bound, 2011; Mason, 2002).

3.9   Data Collection (Interviews)

Once invitation to interview was accepted, the researcher provided the participant with more details about the study (confidentiality, consent, data storage / analysis, telephone contact). The interview site was selected based on the participant's location. Consent was obtained at interview. At this stage the researcher included an explanation about the use of audio-recording and requested consent to initiate the session. A lengthy recruitment time resulted in 21 interviews being conducted from July until the latter half of November 2017.

Both recruitment and interviews were guided by the research protocol. Documents facilitating these stages have been included in the Research protocol, Appendix II, as follows: (1) Recruitment flyers and letters; (2) Participant Information Sheet; (3) Informed Consent and Skype Informed Consent; (4) Interview Guide (questions, domains, and permissible prompts); (5) Fieldwork Risk Identification Form, and, (6) the Curtin Domestic Emergency Notification Plan.

A qualitative phenomenological approach assists researchers to structure the interviews and questioning in such a way that participants can describe their experiences as "they are lived every day," as a way of "grasp(ing) the very nature of the thing" (Van Manen, 1990, p.177; in Creswell, 2007). Creswell (2007) asserts that in order to ensure the essence of the phenomenon is uncovered, there should be adequate information gathered from 19 participants to uncover any possibilities of experience. Increasing the efficiency of the data collection included careful selection of research questions to create a dynamic interplay between the researcher and participant that allowed any information to be gained from a fresh perspective and to be unbiased.

The literature review informed the formulation of research questions that could cover a wide range of answers, explanations, and descriptions of lived experiences. These broad questions were suitable for gathering information from all participants.

Prior to gathering information and at interview, a bracketing technique was used to maintain neutrality to gather impartial perspectives on the subject matter. Included in the considerations for researcher preconceptions in relation to the phenomenon, bias, and neutrality was the issue of being either: an "insider", or in other words the researcher belonging to ageing LGBTI communities, associations, or organisations; or, being an "outsider", in other words the researcher having no connections or links outside of the study to LGBTI communities, associations, or organisations. In this instance the researcher is an "outsider".

A reflexive journal was used to record personal values, subjective views, and other issues (e.g., negative feelings of anxiety or disengagement, or positive feelings of friendship) that may have interfered with suspending judgement about the research material. The researcher attended bracketing interviews with supervisors to uncover, and become aware of, any preconceptions and subject biases prior to, during, and after data collection (Tufford & Newman, 2012).

The research questions were aimed at gaining knowledge about participants' experiences of key events in relation to broad health and healthcare provision. This meant sharing information from their earlier lives through to recent times. As such, interviews began with demographic and milestone probing. For the latter, that meant probing with permissible prompts to assist participants in sharing information related to early memories of health and gender related issues, as well to those in current times. This also allowed them to discuss any general health and health determinant related information that has impacted or contributed to their current health and wellbeing.

The extent of reporting about the range of issues impacting ageing transgender people from their birth era was reflected in interview durations between 58 minutes to 1 hour and 58 minutes. Each participant was interviewed once. Two interviews were held in people's homes in the Perth area. All other interviews for people residing in Western Australia (WA) were undertaken in an interview room in the School of Public Health at Curtin University. Any interviews outside of the state of WA were conducted via Skype.

Each interview's duration was approximately 1-2 hours. To ensure no information could be lost, interviews were recorded with two devices. After transcription interviews were deleted to ensure confidentiality. Due to the flexible nature of the research approach, the number of questions and, thus, duration, varied across participants, but was typically 1.5 hours long. The researcher used a quasi-informal setting to share information in a two-way conversation. Open ended questions were asked to gather information without limiting the participant's responses, as recommended by Cohen and Crabtree (2006). A reciprocal interaction, in which "both researcher and research subject are engaged in the dialogue" (Groenewald, 2004, p.12), allowed supplementary information to be gained. Participants were given the opportunity to write down any answers too sensitive to articulate.

Average interview transcription lengths were 15 pages and 10,487 words in length. Interestingly, the female identifying sub-group's averages were slightly higher (1hr 35 mins, 16 pgs, 10,920 wds), and the male identifying sub-group's were slightly lower (1.14 mins, 15 pgs, 10,265 wds). Whilst the NB sub-group average word count was less, their interview times were higher (1hr 30 mins, 14 pgs, 9,271 wds). The total interview time for the entire sample was 27 hours 45 minutes. A possible reason for these differences has been that, in the lengthy interviews with high word counts, participants' answers to questions were quite long and needed little prompting. In contrast, where interview times were lengthy, but there was a lower word count, the quantity of probes and prompts used by the interviewer was higher. Appropriate permissible prompts and probing questions were used at times when participants were pondering or moving off track with their answers. For example, *"please can you tell me more about your experiences of..."* or *"how did it feel when ...?"*

The word cloud in Figure 1 displays 80 of the most frequently used words across the pooled transcripts (total of 199,258 words after eliminating years, names, and linking words). This was taken

from all the participant commentary. The word cloud gives an overview of the range of issues that arose in interviews and that were related to people's gender affirmation, health, and wellbeing.

Figure 1: Word cloud of participants' responses to questions

Additional material from participants was collected by email, before and after interview, for member-checking. This process known as member-checking is an essential strategy, used in qualitative research to increase data credibility and actively involve the research participants in the project (Adu, 2019). Examples of a member-checking benefit include if a participant had remembered an issue that would contribute to their information, or if a participant wished to remove detail from their transcript. All data was transcribed verbatim. Any modifications were done so for grammatical reasons (e.g., repetitiveness). All participants were offered the chance to read through the data and make modifications as necessary. Most participants member-checked their transcriptions to ensure that the data reflected their lived experiences. Most participants made small amendments to their transcripts, such as deleting sentences that they felt did not reflect their experience when viewed in text format.

3.10   Thematic Analysis

According to Creswell (2007) it is unnecessary to attach the participant's viewpoints to any theory, or theoretical framework, because the purpose of a qualitative phenomenological study is to uncover and understand the essence of their experiences. Thematic analysis is a commonly used method for analysing data when using a qualitative research approach. Thematic Analysis can give structure to participants' specific quotes, statements, and descriptions of their lived experiences, as well as retain the context of their lived experiences. This is achieved by categorising statements into themes, which can then be used to describe how participants experience the phenomenon (i.e., emotionally) and what participants experience (i.e., issue topic).

As the aim of the study was to uncover the universal essence of the phenomenon, it was not necessary to reveal the participants' identities, other than their gender identities and ages. Participants were therefore allocated a code and pseudonyms to ensure confidentiality throughout the writing. In the results, participant commentary includes the acronym and code name assigned to them. Only one participant withdrew from the study altogether, meaning 20 interviews were transcribed and entered onto NVivo software (QSR International) for analysis.

Collected data (by way of semi-structured interviews) allowed the researcher to capture the diversity of the lived experiences and perspectives of multiple participants; and also, to interpret a variety of aspects related to the research objectives (Boyatzis, in Braun & Clark, 2006). This type of exploratory investigation therefore provided rich, descriptive conclusions about the meaning (for multiple individuals) of people's experiences in relation to healthcare provision in Australia. Audio recorded data was transcribed verbatim and analysed with Thematic Analysis by following six-stage, step-by-step guidelines set out by Braun and Clarke (2006). The phases of the analysis are shown in Appendix II (see Thematic analysis).

Codes were determined collaboratively with supervisors and were allocated according to significant utterances, phrases, and ideas. Some codes emerged as main themes and others made up sub-themes. Any stray codes were stored in a miscellaneous sub-folder. Because emerging ideas were data-driven the most basic elements of the information were translated into themes and given descriptive names. Following a review, refinement, and any necessary re-working, themes were ready for naming and interpretation (Braun & Clarke, 2006; Moss, 2015). The explanatory names of the themes further allowed for ease of use and coding to be established and allocated. Different but complementary data collected from the three sample groups on the same topic allowed data to be triangulated. The integrity of the data sources was checked by supervisors to ensure derived conclusions were verified from multiple viewpoints (Schwandt, 2001).

Chapter 4.   Findings

Chapter 3 provided an explanation of how this study's methodology would facilitate the gathering and analysis of contextual information from a demographically diverse sample group. In this chapter an explanation is given of how the research protocol was followed, what the outcomes of recruitment and data collection were, and what data analysis was involved. Also included is how the themes emerged and how they will be set out in the following chapters. Each of the results chapters detail and summarise any common or significant participant reportage. Each chapter also has a corresponding appendix (digitally cross-referenced), which include all related quotes, not presented in the main body chapter summaries.

As well as contributing to the growing knowledge base about Australian healthcare provision, in relation to ageing transgender sub-populations, the findings provide a unique insight into the nature of ageing people's health determinants and resilience. The findings will also detail what protective factors assist older sub-populations to maintain their overall health and wellbeing, and support for identity expressions.

The number of comments should only be acknowledged as an indicator of people's most significant positive reports, rather than as a quantitative analysis of people's reality. This type of qualitative information has been a particularly important contribution to the Australian body of knowledge and, thus, may be of use to health system decision makers when initiating or planning related health reforms.

4.1   Sample Challenges

Recruitment was delayed because the male identifying group (MG) and non-binary group (NBG) participants were harder to reach than the female identifying group (FG) participants. Within the final sample of 19 participants, there was some diversity of origins, however not a full range of ethnicities. Whilst all efforts were made to specifically target ageing (50+ years) trans people, a lack of age, ethnic, and demographic diversity may have been the outcome of not specifically targeting specific groups, such as those living in Indigenous communities, or institutional care (aged care, prisons). This was because the focus of the study is to gain general understanding of some common ageing and related health issues experienced by ageing trans people. Gaining this information relied on participants volunteering for the study. Specific focus and recruitment would have required a more rigorous ethics clearance process and was beyond the scope of this study. Moreover, as the participants were particularly hard to reach, the study recruitment was limited (see Limitations section, 8.9) in its reliance on recruitment sources (social media, HPs, and community members). Some were white Australians, and several were second generation Anglo-Australians (English

descent) or had European ancestry. Only one participant was Indigenous. There were no participants of African, Asian, or Pacific Islander descent.

All FG and MG participants had preferences for their personal identifiers to be in the binary. In the FG group, some preferred to be referred to as women or trans women. Likewise, the MG group referred to their gender as men and trans men. In the NBG participants referred to their gender as diverse, gender neutral, and "not definitively in the binary" (NBG2: Jo). Most participants had medical histories that included changing their bodies with gender affirming surgeries (GAS) or gender affirming hormonal therapy (GAHT). The distribution and processes undertaken by participants (*N=19)* is shown in Table 1 according to their identity groups.

Table 1: Study sample by code and pseudonym

Female identifying Group (FG)	Age*	GAHT / GAS*
FG1: Ellen	65	GAHT
FG2: Amelia	59	GAHT / GAS (chest, lower)
FG3: Charlotte	66	GAHT / GAS (chest, lower)
FG4: Ava	65	GAS (lower)
FG5: Clara	51	GAHT / GAS (chest, lower)
FG6: Rose	60	GAHT
FG7: Abigail	55	GAHT / GAS (lower)
FG8: Chloe	59	GAHT / GAS (lower)
FG9: Mila	55	GAHT / GAS (lower)
FG10: Penny	52	GAHT / GAS (lower)
FG11: Ruby	66	Not at present
Male identifying Group (MG)		
MG1: Liam	53	GAHT / GAS (chest)
MG2: Dylan	53	GAHT / GAS (chest)
MG3: Oliver	52	GAHT / GAS (chest)
MG4: Dan	52	GAHT / GAS (chest)
MG5: Ben	56	GAHT / GAS (chest, pelvic clearance)
Non-Binary Group (NBG)		
NBG1: Toni	61	GAHT / GAS (chest)
NBG2: Jo	62	GAHT / GAS (chest)
NBG3: Charlie	59	GAHT / awaiting GAS (chest)

* Note: information as given at the time of interview.

Ages of all participants ranged from 51 to 66 years, with a mean age for the total sample of 58 years. The mean age of the FG was 59 years, whilst the mean ages of the MG was 53 years, and the NBG was 61 years.

There were two participants residing in Queensland (QLD), one residing in New South Wales (NSW), one residing in the Australian Capital Territory (ACT), five residing in Victoria (VIC), and

ten residing in Western Australia (WA) at the time of their interviews. Several participants mentioned that GAS and GAHT processes had only been available to transitioning (to male identifying) patients in recent times (e.g., last decade). Access to providers for the purposes of transitioning and engaging in GAS or GAHT prior to this time was reported to be virtually non-existent, due to the lack of diagnosis and scientific knowledge about gender dysphoria in the male identifying trans population.

4.2   Summary of Participant Histories and Lifetime Milestones

Many of the participants described their lived experience as a long journey. Of these, several said it was clear from a young age that they felt differently about their identity than others in their social groups and environments. Other participants did not associate their feelings of being different or confused to a gender incongruence. Some linked their lack of understanding to having no knowledge about transgender related issues. Confusion for some meant issues were not addressed until such a time when individuals were free to explore their sexuality or gender identity.

Some participants explained that feelings of being dealt the wrong body was apparent from a young age. An example would be, as very small children, querying parents about their mismatched genitalia and/or that they wanted the genitalia of the opposite (to their birth assigned sex) gender. When some individuals displayed their identity desires, their parents suppressed them, for example by forbidding any open expression of diversity. Parental correction may have involved gentle distractions and activities, but also often included beatings. Of the study sample, there were significantly fewer participants who experienced parental acceptance in their younger years. A lack of support and understanding caused many people in the sample to conceal their feelings, fears and anxieties, social diversity and gender questioning. Several described how they were able to do so by presenting themselves androgynously. Examples included dressing in a tomboy style and adopting fashions that emphasized a fusion of gendered styles (e.g., hair styles, make-up, clothes). Individuals also reported distracting themselves with activities such as study, sport, sexual relationships, or marriage.

Throughout these younger years, before the internet and information were available, most participants were not able to understand what (exactly) they were feeling. As time passed and society modernized, in conjunction with the sample moving into young adulthood, some gained knowledge by either going to their local library and reading of variety of publications – for instance, by learning from various media platforms about icons, such as Christine Jorgenson in the news headlines, Carlotta in Les Girls in the cinema – or reading literary publications that documented the lives of transgender people, such as *Orlando's Sleep* by Jennifer Spry (1996) (Bates, 1998). Multiple participants described this experience as feeling a connection with the person or people they were discovering. Moreover, they mostly used the information they had gained as a reference point for finally understanding themselves. Some learnt about what procedures and steps could be taken to affirm their gender from others; and further, learned whether they happened to be situated near places or locations

with some community. An example would be urban areas with known social spaces for people with diverse sexual orientation or gender identities.

Several participants encountered personal challenges to transitioning. Some of these were associated with past health issues (mental, social, economic) as well as to their current health and gender affirmation issues. Many attempted to explain why transition could not occur earlier in life, as is shown in the examples below:

> (FG3) Charlotte: "*We are talking about now 1998, I think, and being diagnosed as being transgender which, at that stage, was still fairly foreign. When I tried to get help from my GP it wasn't easy.*"
>
> (FG11) Ruby: "*At 16 years of age I was given electric shock treatment. It was their way of making you forget who you are. It nearly killed me … I can remember being strapped down on the bed … I can still remember the pain from after the shock treatment* [given] *because I was acting out as a girl.*"

Regardless of discerning of what steps could be taken, many had life complications and multi-dimensional obstacles that caused delays in transitioning. An example of this is having to prioritise family and work, or health-related issues. Moreover, many participants could not determine how to cope with their diversity issues immediately. Often this was because issues were conflated with sexual orientation and homosexuality. Some reported experiencing identity confusion when relating to their partners in same-sex relationships, even though they were in solid relationships with their partners. Also, several people did not wish to challenge the identities of their partners by changing their own gender identities. These issues were reported as being overcome after transitioning in situations where a partner could accept a participant's change of identity.

For many, but not all, gender affirmation meant their relationships with others deteriorated, often to the point of estrangement, even in the "coming out" (or revealing their gender dysphoria and true gender) and contemplation stages. There were reports of initial adverse reactions from close others, such as anger, bitterness, aggression, and/or sadness and grief. Several participants experienced their loved ones showing relief in finally gaining some truth; and further, some participants' family and close others had expressed feelings that the participants' happiness and wellbeing were the most important factors for consideration. Several participants were supported by their close others when family members underwent counselling themselves to cope with identity transitions. Not all succeeded, and the outcome sometimes meant separation and a new life. Several of the sample also reported a feeling of needing to delay transition until circumstances had changed with their close others (e.g., children maturing, parents passing away).

In work environments there were a range of reported experiences. Most participants had been employed in professional positions throughout their lifetime and gained relevant qualifications in educational or employment situations. Whilst some have now retired, most were in employment when their gender affirmation commenced. This meant the reported experiences of all participants were

comparable in some way, particularly if their employment ceased after affirming their gender. For instance, factors for consideration have been whether they were supported by colleagues, or people in senior positions or management; or their relationships with colleagues and employers disintegrated following their coming out or transitioning periods.

For many, the combination of previously mentioned complications meant meticulous planning of their pathways. Generally, people who were supported by employers, close others, or community were better equipped to undergo the rigorous assessment process. However, many experienced significant delays in reaching a situation that would allow them to come out to close or significant others and be open in society in their experienced gender identity.

Almost all participants felt that their use of feminizing or masculinizing hormones, since making the decision to affirm their gender, was necessary for their wellbeing and broad health. The one participant who did not feel hormonal therapy was a necessity did so because they believed their identity was internal and spiritually linked and, therefore, they did not continue with hormone usage beyond their younger years. A majority, but not all, of participants anticipate lifelong usage of hormones to maintain their gender characteristics. Hormones for most of the total sample group had been approved after rigorous assessment. However, three participants reported acquiring various gender affirming medications online or from other non-medical sources (at the beginning of their transition or later) to maintain their physical features.

In the FG most participants had undertaken or were awaiting GAS. Some were not regretful of not having had GAS and confirmed that, over time, they had felt that their anatomy was not reflective of their experienced identities, nor did it impact on their ways of feeling female. In the MG most had undergone chest reconstruction surgeries. However, whilst many expressed desires for lower surgeries, all commented on the difficulties involved in undertaking further surgeries due to unavailability or extremely high costs involved. The NBG had all also undertaken gender affirming procedures (GAS, GAHT, cosmetic). Relevant to their gender affirmation is their reports that if GAS or GAHT had been available to them in earlier life, they may have made a binary transition. However, in current times all three of the NB group participants felt the opportunity to make such a challenging gender transition had been missed.

Most participants also undertook other gender affirming activities to maintain their expression. Examples of these were electrolysis, laser, and feminizing cosmetic procedures in the FG; growing facial hair and using clothing packers in the male identifying group. Many participants also mentioned their need for others to use the correct pronouns when communicating with them.

4.3   **Ageing Issues**

Most participants mentioned their fear of accessing services for age-related healthcare or assisted living needs. In relation to gender affirmation this meant resisting invasive screening for chronic health issues and cancers, and assisted care, or entering residential ageing care systems. Whilst many had knowledge of historical prejudices encountered by others in care, they were unable to consider what safeguards would ensure safe pathways to inclusive and non-discriminatory care. Difficulties in finding pathways were related to their current (at the time of interview) health determinants.

Because participants rarely spoke about future foreseeable ageing issues, an additional question was added: *How are you planning for your future health and ageing care*? This allowed further probing into what concerns people had in relation to the previously mentioned services.

4.4   **Themes**

The following chapters will provide in-depth detail about the participants' commentary. Three themes emerged to explain and describe the lived experiences of participants. These were:
Chapter 5 (Findings: Theme One (T1): Experiences of Health and Healthcare Provision)
Chapter 6 (Findings: Theme Two (T2): Factors Enabling or Hindering Good Health and Wellbeing or access to healthcare)
Chapter 7 (Findings: Theme Three (T3): Resilience enablers or barriers).

Figure 2: Theme emergence and structure
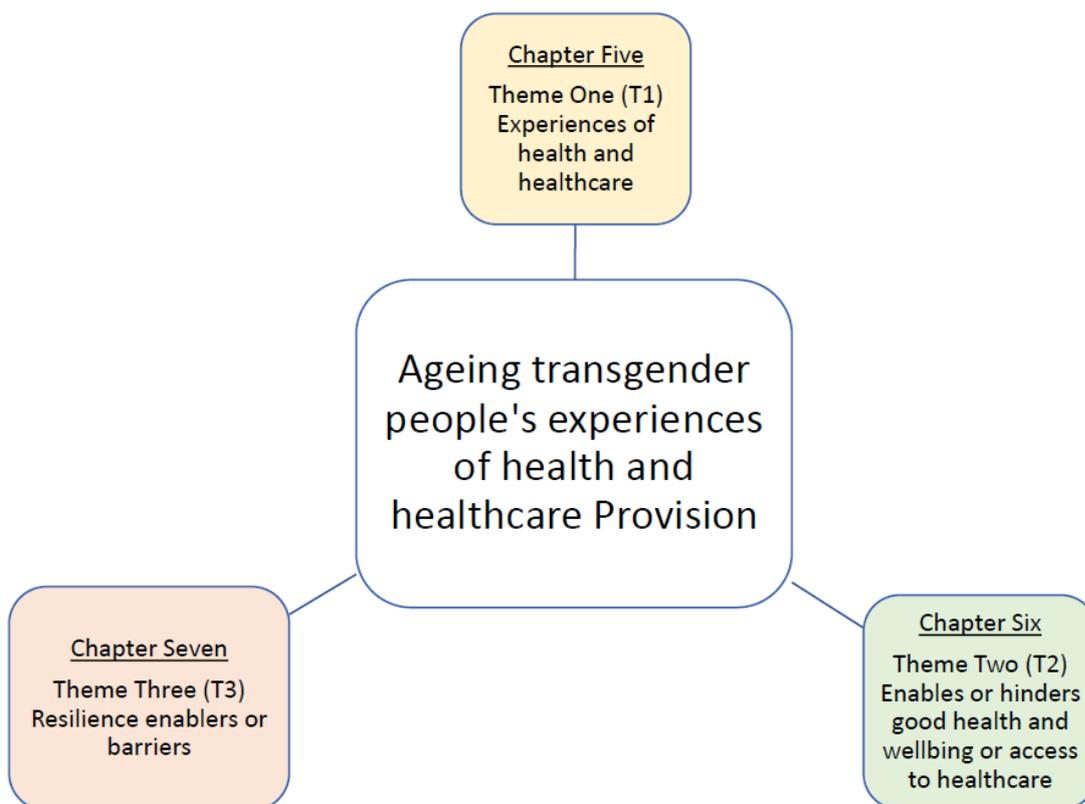
At the time of analysis, three themes emerged. The first two, Theme One (T1), *Experiences of health and healthcare provision*, and Theme Two (T2), *Factors enabling or hindering good health and wellbeing and access to healthcare,* were given descriptive titles for the overarching themes and sub-themes within. These were given explicit names for any content found within. Theme Three (T3), *Resilience enablers or barriers,* included a focus on a range of determinants for health.

Each theme includes sub-themes with titles describing the specific categories of information that have been detailed. For example, the first sub-folder included in T1 (gender affirmation and related healthcare) relates specifically to being transgender and specialised care. In contrast, the other sub-theme, reporting on general health, relates to health issues transgender people share with cisgender and general populations, including age-related issues and aged care. Categories of sub-themes are presented later (within their chapters) in a hierarchical order with those topics receiving the most commentary at the beginning. Topics towards the end received less commentary; however, have been equally as important as those receiving more remarks. This is because the nature of this study has been to investigate "what" and "how" participants commonly experience health and health provision, whether it is "some" participants, or "all" participants.

It should be noted that notable differences in reporting between the NBG, MG, and FG groups were apparent in relation to T1. This theme has thus been presented by gender (NBG, MG, FG), with each group reported by way of the above-mentioned categories. In contrast, T2 and T3 did not have

significant gender differences because the commentary related to common needs and issues, such as GAS, GAHT, service gaps, health systems, community, close others, and personal motivations.

The content within T3 (resilience enablers or barriers) required an additional framework for analysis. This needed to provide balance to the information shared by ensuring that each component of the participants' health reporting would be covered. As such, the content in T3 was comparable with a range of health determinant factors included within Davidson et al.'s (2018) eight concentric circles. In this study, the eight factors from Davidson et al. (2018) remained, however the elements were compounded to reduce the concentric circles to four in number (as below). This allowed ease of reporting and a clearer view of any interactions and intertwined issues occurring across the circles. Mostly these interactions only occurred outwardly or inwardly across one circle.

Figure 3: Adaptation of Davidson et al.'s Social Ecological Model Influencing Ethical Practice
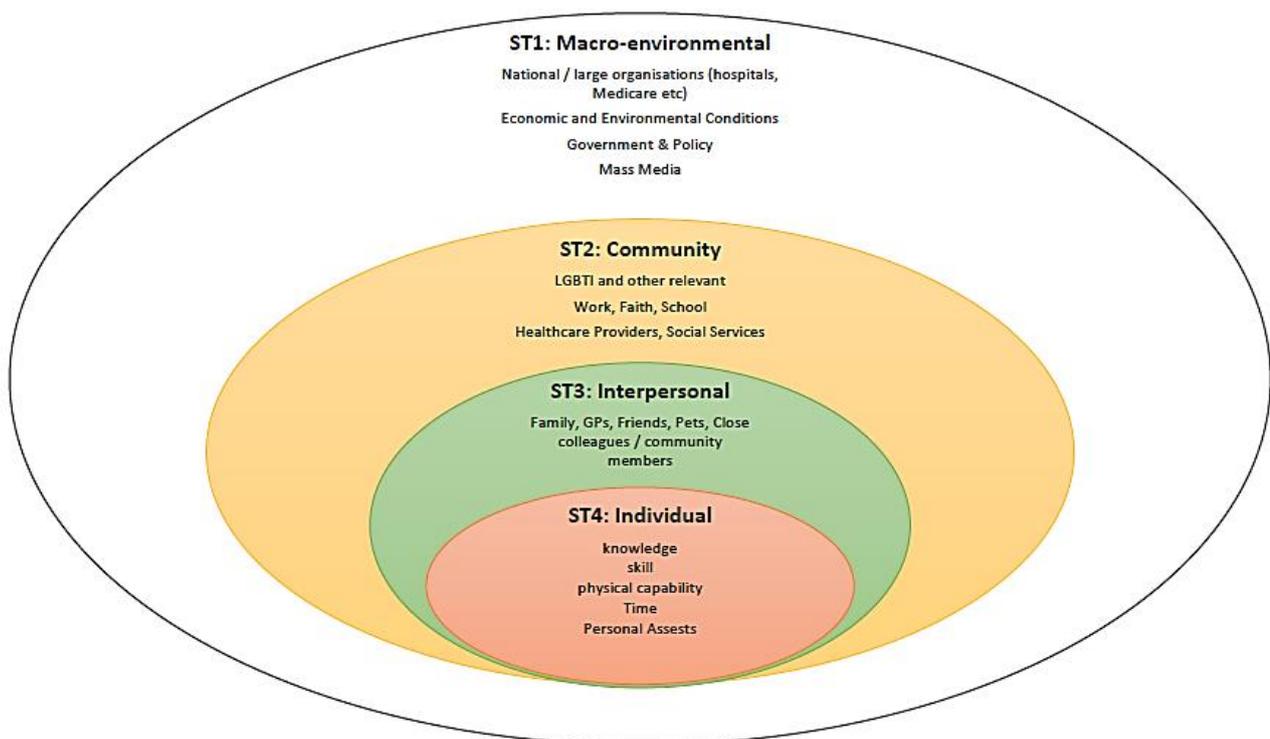
(Davidson et al., 2018, pp. Figure 1, pg e1237, 2018a)

The concentric circles have been set out in this way to give clarity to the multiple ways in which participants reported their issues. This has helped to determine what underlying factors have negatively or positively impacted peoples' lived experiences and potential for achieving overall wellbeing via their determinants for good health.

4.5   Summary

At the beginning of each chapter there is an informative opening about the chapter content. These introductions aim to assist the reader to conceptualise the origins and context of the questions. It is important to re-state that the study recruitment methods included methods of convenience, which led to snowball sampling and a study bias. The total sum of participants has not represented all ageing transgender people or all the target population's life circumstances per se. However, the intention of the study has been to uncover common and significant issues that may be shared by the ageing transgender populations in Australia.

Chapter 5.   Findings: Theme One (T1): Experiences of Health and Healthcare Provision

This chapter describes a range of common personal health and healthcare provision experiences encountered by participants. Large volumes of information were shared by all participants. The total sum (*Number [N]=937*) of comments for T1 made up 29% of the total data across the three themes. Not all the data has been presented in this theme (T1). However, because of overlap issues, data may have been included in the other Findings chapters. The variety of issues have been categorised according to topics discussed (sub-themes). Sub-theme (ST) titles were defined as: (ST1) gender affirmation and gender affirming healthcare provision (*negative N=271; positive N=283*); (ST2) general health and healthcare, including general, mental, sexual, and ageing care services (*negative N=164; positive N=122*); and (ST3) needs and suggestions (for all categories of health and service provision) (*N=92*).

Each sub-heading includes illustrative matter providing evidence for the summaries given. Not all the evidence is provided in this chapter. Where there are additional quotes, which are relevant and do not simply duplicate those provided in the text of this chapter, they are included in Appendix III: Findings: (T1) Experiences of Health and Healthcare Provision. The related commentary is presented in corresponding titles and numbered sub-headings. Additional commentary will be indicated within the text as "(see Appendix III)". The following model and table provide a complete overview of the structure and categories in Chapter 5 (Figure 4).

Figure 4: Chapter 5: Theme One (T1) sub-theme structure
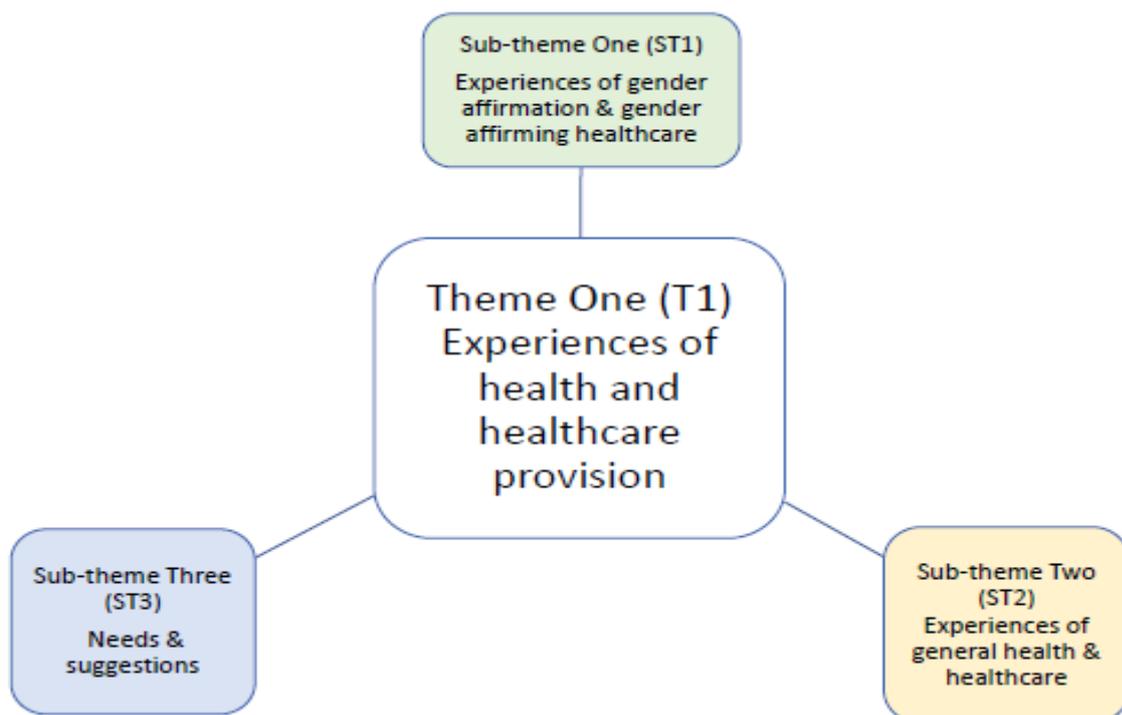
Table 2: Chapter 5 (T1) findings: sub-theme topics

Theme One (T1): Experiences of health and healthcare provision		
Non-binary group (NBG)	**Male identifying group (MG)**	**Female identifying group (FG)**
5.1 Sub-theme one (ST1) Experiences of gender affirmation and gender affirming healthcare (positive / negative)	**5.3 Sub-theme one (ST1)** Experiences of gender affirmation and gender affirming healthcare (positive / negative)	**5.5 Sub-theme one (ST1)** Experiences of gender affirmation and gender affirming healthcare (positive / negative)
5.2 Sub-theme two (ST2) Experiences of general health and healthcare (positive / negative)	**5.4 Sub-theme two (ST2)** Experiences of general health and healthcare (positive / negative)	**5.6 Sub-theme two (ST2)** Experiences of general health and healthcare (positive / negative)
5.7 Sub-theme three (ST3): Suggestions and needs		
Reported by topic	1. Australian Government and health systems (including insurers) 2. Identity and inclusivity needs 3. Upskilling health providers 4. Recommendations for better practices and availability from all healthcare and related wellbeing providers 5. Participation in community care to ensure consistency in healthcare practices and information delivery	

Information for ST1 and ST2 have been presented by gender, rather than aggregated, to highlight the most commented-upon issues for each group. This is because, as indicated in the previous chapter, there were some prominent differences observed between the female identifying group (FG), male identifying group (MG) and non-binary group (NBG) reporting in the first two sub-themes. Mostly, differences related to gender specific needs and healthcare services sought. As the data was explored according to any positive or negative aspects of health and healthcare, the differences are given clarity by presenting the findings in this order (see Table 2); this has been shown in table format for ease of navigation.

For presenting the data efficiently, where appropriate, the acronym "HP(s)" has been used to indicate all types of healthcare provision (including practitioners and professionals). In instances where the text refers to mental health professionals, such as psychologists, psychiatrists, counsellors, and associated service provision, HP will be prefixed with "mental" (e.g., mental HP).

Separating the data into STs containing well-defined areas of health and healthcare provision had various advantages. Firstly, in ST1, gender affirmation and gender affirming healthcare issues could be specifically related to the types of HPs or providers accessed, as well as highlight any positive or negative outcomes of specialised services. Secondly, in ST2, gender disaggregation would convey how and why participants sought care or have been impacted by HPs when trying to access services. Gaining specific HP detail allowed general health matters to be separated from gender affirmation matters. Thirdly, regarding both the previously mentioned STs, separating general health

from gender affirming healthcare helped uncover any intersections that occurred between gender affirmation, general health, and ageing. And, fourthly, articulating participants' recommendations in ST3 (needs and suggestions) gave voice to people's views on pathways to better health and service improvements.

Although the defined question for answering these sub-themes was, *"What are ageing transgender people's experiences of health and healthcare provision?"* most participants introduced their experiences prior to the question being specifically asked. This is because they were encouraged to share their early life and past experiences on commencement of interviews. Often this resulted in participants highlighting significant health and gender-related issues at an earlier time in their lives. A typical example was FG participants explaining recurrent healthcare provision visits: *"My GP knows me well and he's known for years that something* [which he eventually recognised as gender dysphoria] *is not right"* (FG10: Penny).

HPs may have detected a person displaying signs of gender incongruence but, in the absence of transgender education and knowledge, were unable to pinpoint issues or refer patients to specialised HPs. Without having appropriate specialist and trained HPs to attend, several participants encountered delays in attaining help. Delays in receiving professional support sometimes increased the impacts of participants' mental health issues.

ST1/ST2 (T1): Non-Binary Group (NBG)

5.1   ST1 (T1) NBG: Gender Affirmation and Gender Affirming Healthcare Experiences

NBG participants' total sum of all comments for ST1 *(N=81)* showed there were more negative comments than positive commentary (negative *N=53*; positive *N= 28)*. This difference possibly indicates an overall negative experience of healthcare provision.

ST1 (T1): NBG Positive gender affirmation and gender affirming healthcare experiences

At the time of interviewing all participants were, or in the process of, undertaking breast augmentation (or mastectomy, referred to by participants as "top surgery"), and were also using a form of testosterone. Several NBG participants' experiences (*N=28*) were like those of MG participants' responses. The most significant differences are shown in the comments and chapter summary.

ST1 (T1): NBG Positive gender affirming healthcare experiences.

Participants shared their positive experiences and associated opinions regarding interactions with HPs prior, during, and after, affirming their gender. Good encounters occurred in the stage of

decision making and initial contact with HPs. Related comments below show how participants were not deterred when approaching HPs with their specific need for affirming their gender. Good experiences were also associated with HPs being accepting of gender diversity. Some comments showed how willingness of HPs, even when they lacked knowledge, helped transgender individuals. However, NBG participants also explained their perceptions of good experiences related to attending experienced and knowledgeable HPs. One participant felt positive about their surgeon recommending and connecting them with other experienced transgender health specialists. Another participant expressed positive experiences and relief in dealing with competent, understanding, and supportive HPs (see Appendix III).

> (NBG2) Jo: "*He* [psychiatrist] *said, 'don't hide in the closet. If anyone else has a got a problem with it, it's their problem'. And, even though it is simple, it makes sense. He just said, 'be yourself'.*"
>
> (NBG3) Charlie: "*So, 13 months ago said to my GP, 'I want to start now,' and I said, 'how?' And, he didn't really know. So, I did the research. He was okay. He was supportive up to a point. He thought I was brave making that decision. But he was supportive in that he would do it with me".* Also, "*[When I got to see a specialist endocrinologist] So much better seeing someone who knows their stuff. Well, it means that I don't have to play games, and jump through hoops, and explain myself, and be looked at like, are you sure?*"
>
> (NBG1) Toni: "*When I went to talk* [to my doctor] *about breast surgery for my 60th birthday present* [it was good because] *she didn't blink.*"
>
> (NBG1) Toni: "*Dr XXX* [surgeon] *knows quite a bit about the gender dysphoria and so he has the connections* [with other local specialist HPs].*"
>
> (NBG3) Charlie: "*He* [health practitioner] *has been doing it for twenty years. He comes across trans and gender diverse people all the time".* And*, "But when you get there, and you find people who 'get it,' and who are supportive unconditionally, and know what you are going through, and they are incredibly experienced. And, they don't get offended that you only want to see them once!*"

During transition one participant who went for consultation felt they had good experiences when a recommended surgeon gave good explanations and provided a convenient day surgery solution, and a venue with good hospital staff (see Appendix III).

> (NBG1) Toni*: "He* [surgeon] *explained what he would do, and showed me some pictures, which was great."* And, "*It was going to be day surgery which, you know, suited me because, I mean, I was using my super*annuation [retirement fund] *to pay for it.* Also, "*The hospital staff were great.*"

NBG participants also reported good experiences with obtaining referrals; for instance, when they encountered a reasonably straightforward process towards gaining referrals and access to established networks of HPs. However, only one participant commented positively about their assessment period. They described it as a series of steps, involving multiple HPs and fulfilling WPATH (*SOC7*) criteria (see Appendix III).

(NBG1) Toni: *"She* [GP] *said, 'oh, gender non-conforming, that's, yes, ok. Well, yep, there's a GP in XXX Perth who works for a Sexual Health Centre. We make a referral to him'."*

(NBG3) Charlie: *"I made the trip to Brisbane, and saw him* [the psychologist]*, and jumped through all the hoops; and, got the piece of paper saying that I fitted the WPATH (7) criteria (or whatever it was), basically, gender dysphoria, and then I saw the surgeon in Sydney."*

ST1 (T1): NBG Negative gender affirming healthcare experiences

NBG participants all reported poor or negative experiences with HPs (*N=53).* Comments related mostly to lacking knowledge, sensitivity, and willingness (e.g., as gatekeepers), as well as marginalising participants from services and, thus, treatments also. They also spoke of HPs' roles as gatekeepers and the associated challenges they faced, such as not understanding the urgency of participants' needs (see Appendix III).

(NBG1) Toni: "*And this guy says to me, 'you are genderqueer'. And, I'm thinking, 'what are you going on with – don't throw insults at me?' Because in my generation queer is a derogatory term."*

(NBG2) Jo: "*My doctor, my God, it's funny, and laughable, but it wasn't. You know, here I was on benefits, trying to work out how I'm going to juggle everything. I've got this doctor that just looked at me like, 'you are mentally retarded. You are … I don't believe a word you say'."*

(NBG2) Jo: *"I don't think doctors like being questioned".* And, "*It's like they've got blinkers on, and they can't see any other health issues."*

(NBG3) Charlie: *"They* [psychologists] *told me that they weren't taking on any new patients. And, I said, you know, 'this is urgent, I've got to get this piece of paper for top surgery'. They said, 'we will, talk to so and so and see if they will get you in, we will get in touch with you as soon as possible'. And, I never heard from them again. I never got any leads."*

(NBG1) Toni: "*I wished to God I had* [been able to have GAS earlier in life]. W*hen I was in my twenties, and I went to see a GP (that's another thing about bloody GPs). I wanted a hysterectomy* [the GP said] '*well you can't have one of those'.* [I asked] *'now why not?'* [The GP told me] *'well you are a woman and you will change your mind'; and that was the attitude.* [The healthcare provider's attitude was] '*We don't do anything to a body unless it is absolutely necessary, and* [an elective hysterectomy] *would be mutilation. So, no, you've got to put up with these things called periods for the rest of your life'."*

At the time of interview, two of the NBG participants had undergone double mastectomies and one participant was awaiting their procedure. Only one participant made negative comments. However, they outlined multiple problems experienced prior, during, and after their procedure. Examples were: apprehension prior and during the procedure; unsatisfactory issues with the surgery itself; pain and a feeling of practitioner error post-surgery; the need for restorative surgery; and, being aware that recovery times can be prolonged with ageing (see Appendix III).

(NBG1) Toni: *"I was really apprehensive because I was thinking, 'holy shit'. You know? He could do anything. You know he could have drawn Micky Mouse ears on my breasts for all I knew, and I just thought, 'hmm, this guy is supposed to be one of the best?'. So yeah, I mean, I was really resigned".* And, "*I had to go back to get the drains out. And, the pain was all under my arm pits. It wasn't in my breast area. It was radiating down my arm as well… It*

was from the middle of my armpit across the middle of what used to be the breast to the centre of the sternum, and it was obvious to me that there was nerve damage. Especially under the left arm... And it's obvious that I'm going to have to have restorative surgery."

NBG participants discussed their concerns when undertaking GAHT. Examples included problems with hormonal dosages, or the difficulties involved in finding experienced GPs. Lack of knowledgeable HPs, or closely located services, may have correlated with participants residing outside urban areas (see Appendix III).

> (NBG1) Toni: *"Where I lived there was no-one* [HP] *experienced* [in gender affirming healthcare]."
>
> (NBG3) Charlie: *"The GP's knowledge was none, except that he gave those guys their shots of Reandron* [testosterone brand]". And, "*He* [the GP] *gave a me a script for Testosterone Gel, which I started using at that time with a daily thing. And, there were no significant changes after four months, so I then went to see the endocrinologist myself at XXX and he said, 'yes, that is often the case'."*

Negative experiences were reported when dealing with psychiatrists and psychologists, particularly in encounters where participants felt misunderstood. For example, one participant claimed HPs were challenged by their autism. The other two participants explained how living in a rural area was associated with difficulties in finding local specialist HPs to regularly visit (see Appendix III).

> (NBG2) Jo: *"They think that if you are a little bit autistic* [in addition to being transgender] *or you don't seem to be ... but you are really the same, but really, you know everything, and that's what makes it very hard. Because sometimes they pretend, or they ignore it, or, just don't acknowledge it.*"
>
> (NBG3) Charlie: *"I also looked into top surgery at that stage, so I was told I needed a clinical psychologist report or a psychiatrist report. I went to my* [original] *clinical psychologist and he'd moved on as well, but I tracked him down in XXX. ... Because I hadn't contacted him in six months, he wasn't very supportive, and said, 'I'm about to go on holidays,' and made it quite clear that I wasn't really welcome. I was shattered."*

5.2   ST2 (T1): NBG General Health and General Healthcare Experiences

NBG participants' total sum of all comments for ST2 *(N=27)* show that negative comments were more than double of their positive commentary (positive *N= 6;* negative *N=21)*. This possibly indicates an overall negative experience of healthcare provision.

ST2 (T1): NBG Positive general healthcare experiences

The total number of comments (*N=6)* for all positive ST2 (T1) commentary meant an average of only two comments per person for this section. Positive reports included a range of HPs and support services, and participants related wellbeing and screening issues. The examples given include reports regarding funding assistance for mental health needs, and non-judgemental, culturally competent, screening services (see Appendix III).

(NBG1) Toni: "*So, yeah, it was the psych helped me to get to see a counsellor through the Commonwealth rehab service. She was absolutely nice.*"

(NBG3) Charlie: "*The doctors then weren't judgemental*". And, "*I had to have a mammogram, which I'd never had before (because I didn't like the idea of pain), but that will all be gone with the top surgery.*" Also, "*I'd only been there* [screening clinic] *the once and it seemed welcoming, and they listened to my concerns, and performed the pap smear in a way that wasn't invasive way for me.*"

ST2 (T1): NBG Negative general health and healthcare experiences

NBG participants' commentary (*N=21)* described the types of adverse non-transgender specific personal health, such as mental health, issues prior to understanding their own diversity and physical health. All three participants had suffered from addictions (prescription and recreational drugs, and alcohol) before affirming their gender. Addictions were accompanied by confusion and self-questioning in young adulthood. Most of the NBG's negative general healthcare issues concerned HPs and health systems. Prior to transitioning, GPs sometimes had misperceptions of the participants' issues; for example, when failing to recognise gender dysphoria. Additionally, GPs had sometimes misunderstood that a participant may have encountered depression as an integral part of their gender dysphoria. Problems were exacerbated due to HP misunderstandings and by being challenged to undertake preventive health measures. Reports gave examples of actual or feared discrimination, such as being misunderstood and refused care by hospital and with HPs in screening situations (see Appendix III).

(NBG1) Toni: "*I mean it's sad, that GPs just dish out these prescriptions. In my case, you know,* [the doctor] *said, 'oh yeah, this is a new one – just try this, here's a freebie from the drug company. It's not addictive.' Well it bloody well was, and it was an absolute nightmare to get off because, every time you go and see a GP* [they wouldn't pick up on my gender issues and], *they would say, 'you've a tough life, you've gotta'* [take anti-depressants].*"

(NBG2) Jo: "[The HPs did not understand my gender identity issues because] *I don't think that my dysphoria was prominent. I think there were too many other problems … It's like they've got blinkers on, and they can't see any other health issues.*"

(NBG2) Jo: "*I had something called vestibular migraine, which is quite complex. Because, you can have all the symptoms without the headache, or, you can have … yes, it's quite bizarre… I went to the hospital to this particular hospital and they presumed that I was doing it just for drugs – trying to scam drugs out of them. So, they grabbed me by the collar and the seat of my pants and threw me out of the emergency department, and screaming on the top of her lungs, 'come back when you want to talk about why you are really here!' It destroyed everything. I had a job in XXX that I was going to. They called me on that day. I said, 'I'm going to the hospital.' Of course, nobody can believe that someone of my age can get thrown out of a hospital. So, I was just painted as a liar – a dishonest person. And, that's part of how autistic people in that spectrum are seen anyway: not to be trusted; not to be believed. It destroyed friendships, everything.*"

ST1/ST2 (T1): Male identifying group (MG)

5.3   ST1 (T1): MG Gender Affirmation and Gender Affirming Healthcare Experiences

MG participants' total sum of all comments for ST1 *(N=172)* showed a significantly higher number of negative than positive commentary (negative *N=119;* positive *N=53).*

ST1 (T1): MG Positive gender affirmation and gender affirming healthcare experiences

ST1 (T1): MG positive personal gender affirmation experiences

The MG commentary concerning positive personal feelings regarding gender affirmation processes (*N=3)* related to the positive aspects of GAHT. Examples were experiencing the anticipated outcomes of GAHT and making bodily changes that could prepare them for lower (genital) gender affirming surgery, if it were possible to access. Two participants also commented on recovering from surgery by using a surgical vest to help with pain.

> (MG5) Ben: *"Facial hair for one; my hair for another (I actually shaved it); periods stopped, that's a yay, let's celebrate; clitoris gets bigger. It also helps if you've got a pecker pump, the penis pump, because it not only stretches out the clitoris, but also the labia, so when time for surgery comes it gives them more skin for the scrotum."*
>
> (MG4) Dan: *"The feeling of finally transitioning was fantastic, essential, another wave of hope."*

ST1 (T1): MG positive gender affirming healthcare experiences

MG participants had much to share about the full range of healthcare issues (*N=50)* in relation to maintaining their gender expression, transitioning, and dealing with systems that can fulfil their needs. Utterances in this section were important because they described how HPs were helpful and supported them with appropriate treatments, cultural competency, and affirming their gender. Additionally, participants discussed HPs, and particularly the roles GPs played in gender affirming processes. HPs have actively sought information on behalf of their patients. One GP gave counselling sessions to a participant who was exploring transitioning possibilities (see Appendix III).

> (MG3) Oliver: *"I explored it. I was spending a lot of time sitting down with that GP who I knew really well… We had one-on-one discussions about, you know, what the process would be involved – to actually transition. We talked about issues around acceptance in the workplace, and generally in society; and, some of the problems you run into."*
>
> (MG3) Oliver: *"She* [doctor] *was extremely good. She was just – partly because she worked at* [sexual healthcare organisation and] *was just so switched on. It was like she had her finger on the pulse. She was years ahead of herself, and she was very open-minded, and she was really honest. If she didn't know something she'd turn around and say it. She'd say, 'look, I think that's a bit outside of my domain,' or, 'I can try find out for you' – all those sorts of*

things. Certainly, at that point in time, she could have referred me to, say, an endocrinologist if I wanted to go down that track."

(MG2) Dylan: *"He had treated a transgender woman (male to female transgender) in* XXX. *But he had no experience with female to male transgender. So, that's when he rang the gender clinic in Brisbane and got them to send him an information pack up."*

(MG1) Liam: *"She* [the doctor] *did know her stuff and she did know the information. Because I'd read a lot of stuff online. I could tell whether she knew what she was talking about or not. She did."*

All MG participants had one or two gender affirming surgeries (GAS). These included double mastectomies and pelvic GAS procedures. No participants had undertaken genital GAS, otherwise referred to as bottom surgery. Positive reports on this topic referred to experiences with surgeons themselves, and associated processes, including related service provision. Typically, participants commented upon these when referring to experience levels of HPs, health workers, and administrative staff involved in their GAS (see Appendix III).

(MG1) Liam: *"I got on with Mr* XXX, *who is the eventual surgeon (probably recommended, anyway he was the one my doctor liked)."*

(MG4) Dan: *"I'd been on the hormones a year, and then I got the surgery. I was very lucky".* And, *"The one I went to was a little private hospital called* XXX. *All the staff know what is going on. Their operating list is all trans people on the day, so they end up with the whole lot at the same time. It's actually really good…* [they do] *quite a bit for trans surgery here. It's fine."*

MG participants explained a range of ways they were assisted in achieving their gender affirming hormonal therapy (GAHT) goals. Their comments showed how endocrinologists, GPs, psychologists and psychiatrists have been key for opening communication channels between professionals, undertaking any necessary tests and authorising to start hormones and surgeries. Also mentioned was how helpful GPs were for handling injections and reassuring participants about any positive effects or remarking on how hormones and new outward expressions suited them (e.g., facial hair) (see Appendix III).

(MG3) Oliver: *"She* [GP] *makes jokes about how I'm growing a beard, and that I couldn't have two better white stripes. She really does make it feel comfortable, and I feel just so fully accepted there. And, her and I have this running joke. She says, 'I'm not going to mention trans prostate checks'."*

(MG5) Ben: *"When I was 30 my local GP, got my GP's name and contact details. She's been handling my injections for as long as I've been on them."*

(MG1) Liam: *"I've had to have them* [blood tests] *very often because they want to find out if anything is going on* [which might be detrimental to my health because I have been] *having the 'T' (testosterone."* And, *"When I had the Reandron (1000) shot it was on the way to work (It was ok but not painful) which was my only concern. When they assured me it wouldn't be, I was fine. I just noticed that I get more fidgety, but that's the energy thing."*

(MG5) Ben: *"I saw an endocrinologist and met the psychiatrist, and the psychologist. I had to do about five pages of test type stuff. I did all that and the endocrinologist rang me and said, 'Right, I am authorising to start hormones'; sent me the official letter to take to my GP;*

gave me contact details for Professor XXX, *who I think is still alive* [the endocrinologist]. *Saw him, he said, 'right ok, here's a script, your GP can handle it from there. So, once a fortnight on Testosterone'.* Also, "[A transgender person needs] *an assessment period, at least, before you start hormones, so they can make absolutely certain (before it's too late to back out) whether or not they are making the right choice, or the right decision. It also gives the doctors a chance to see how genuine that person is."*

Furthermore, helpful administrative and health system practices had contributed towards some MG participants' good experiences. For example, when gender affirming healthcare services and systems were associated with ease of use and good practices. These included funding assistances and a comment about health service staff providing helpful information or organising support (see Appendix III).

> (MG1) Liam: *"The administrative staff didn't mind answering different sorts of questions, cos I would stay there until I understood – however long that took."* Also, *"You can actually get a nurse to come around. There is a system. I never used but you can apparently get – it's probably hugely expensive to get a nurse to come and visit you, but you can if you have to."*

> (MG3) Oliver: "*You know my endocrinologist* [treating patients in a private practice] *is $320, of which I get $190 back off Medicare. But this is genuinely good, and with my health conditions I can't afford to be stuck in a public system where I don't know what I'm going to come up against in the clinic."*

Although assistance from mental HPs for referral and assessment issues had been experienced positively, these instances were not discussed by all MG participants. Moreover, there were significantly less per person than those of the FG. Comments provided important information about MG participants' experiences of gaining referrals, such as the ease of experience when mental health professionals and GPs were willing to assist in the process. Participants have recalled the significance of their visits to their psychiatrists and psychologists. Mostly, they needed multiple sessions to gain approval for GAHT. In one case, this meant gaining consent to continue treatment with a local GP as opposed to an endocrinologist, and in another to gain access to GAS funded by a group of mental HPs (see Appendix III).

> (MG1) Liam: *"I talked to Dr XXX* [my GP] *who put me onto someone at XXX* [psychologists]. *She was very good."*

> (MG2) Dylan: *"I went to a psychologist for a couple of sessions, then to a psychiatrist for a couple of sessions, and then they okay'd me to start the hormones, and then said that I had to find a doctor on the Sunshine Coast where I live to monitor me while this was all happening."*

> (MG4) Dan: "*I said to the psych, when I was going for approval for hormones, when they asked about what I'd like – whether I'd be after surgery and described what it was."* And, *"the guy said, 'There is a fund through the clinic. We get to choose some people each year. I can put you up for it because we have never done a trans man through the fund'. And I said, 'You are kidding?' And, he said, 'No. Do you think you could get a $1,000 together?'... and I thought, well I've just been getting that together permanently for your stupid sessions, so I will just keep working!! So, I said, 'yes, I will achieve that'. And, he put me down for it."*

ST1 (T1): MG Negative gender affirmation and gender affirming healthcare experiences

MG negative reports (*N=119*) for this section showed MG participants commented more frequently per person than any other group.

ST1 (T1): MG negative personal gender affirmation experiences

One MG participant stressed the importance of passing and of societal acknowledgement of their gender identify as separate from their sexual orientation. He also explained how being recognised in a different gender after transition was equally taxing on his mental wellbeing. This was because affirming his gender also changed his perceived sexuality from lesbian female to a straight, cisgender, male as follows:

> (MG2) Dylan: *"It is very important to me to be recognised as male. I think you want to know from me* [about] *identifying strongly as a lesbian to now identifying as a straight man? Well, that's interesting. It was a mind flip. I had been a lesbian for pretty much all my life – as long back as I can remember, I have always liked women and identified as a lesbian. And, to change my gender ... I still like women. But I'm seen as heterosexual man. And it literally is really confronting, and it's really hard to get my head around that."*

ST1 (T1): MG negative gender affirming healthcare issues

Participants' negative experience comments concerning gender affirming surgeries (GAS) ranged from information gathering, cost and insurance-related concerns, and contacts with specialist clinics and hospitals, to comparisons with overseas or out-of-state service provision, and travel difficulties. Commentary concerning negative HP issues mostly related to health clinics and staff. Participants were also commonly disappointed with lack of choice or high costs for surgery. Further, they mentioned some actual experiences and fears relating to specialists. These included: inappropriate attitudes to patients; non-acceptance of gender diversity; the outcome of surgery; and, needing restorative surgery. An example was a participant who reported the indiscreet and insensitive way his surgeon asked if he was pregnant prior to his GAS (see Appendix III).

> (MG2) Dylan: *"My only choice was my surgeon basically"*. And, *"I actually found her to be quite rude. No bedside manner whatsoever. Good surgeon, but yeah, as a personality, nah. I'd been marked for surgery and she came in and poked me in the belly and asked me if I was pregnant... probably pretty inappropriate to say to a 'T' Trans guy, just as he is about to go into surgery… She has a problem with overweight patients."*
>
> (MG3) Oliver: *"I certainly knew I wasn't going to come out like a six-pack Arnold Schwarzenegger from this."* And, *"When we* [my HP and I] *talked about surgery before, there's only one guy in Australia doing bottom surgery for trans men and you have to allow at $70,000 and four surgeries. And the success rate isn't that high with it because simply there's not enough of it being done."* [After reconstruction chest surgery] *"I've ended up with nearly orange size lumps under there which is now creating a lot of pain for me. It's created a lot of issues around sleeping, it's creating a lot of issues around activities or daily life and quality of life. It is a big problem. I can't afford to get anything done about it because technically* [the

surgeon] *wouldn't – if you explain it him to do something it's going to be six-months after my surgery, which will be the end of this year, or early next year."*

(MG3) Oliver: *"I went and saw my GP, and I said to her, 'I think I'm transgender, and I'd like to explore this'. She said, 'I won't treat you because I don't believe in it'… I went to see another doctor at the practice, and he verbally abused me for wanting to do it after having survived all my strokes."* And, *"I wanted to talk to the doctor about going on hormones he didn't really want me to do it. He just said, 'Oh, we will deal with that later,' and he kept putting it off."*

(MG2) Dylan: *"I signed up* [for health insurance]. *But, even up until the day before, I rang them to make sure I was covered (to make sure the Medicare number and that I was going to be covered) because I wasn't one hundred percent sure that they were still going to do it. And, even when I walked into that hospital and I had to sign those papers to get the health fund to pay for it, I was still not one hundred percent sure – but they did. So, going to the hospital was terrifying because I thought, 'If I have to pay for this? There's nothing I can pay for!'."*

Attending gender affirming healthcare specialists was important for MG participants to obtain referrals. Comments included negative attitudes during consultancy, confidentiality fears, deceit, non-compliance with regulations, and a lack of interest. A resultant lack of trust in HPs has led to various problems for some male identifying participants, particularly at the beginning of gender affirmation processes. MG participants reported having negative experiences when being challenged to explain their identities and dysphoria to HPs. For instance, this occurred when HPs misunderstood, failed to recognise associated issues, or refused to provide referrals because they disbelieved participants' male identifying identities. HP availability and travel obstacles were also an issue for some participants. This was particularly so if they resided in underserved areas, lacking in a broad range of healthcare services and specialist HPs, such as rural areas. Moreover, negative experiences were encountered during the assessment process itself for several reasons. Some MG participants queried the necessity of a gender dysphoria diagnosis when gaining a psychiatric assessment, which could cause considerable difficulties for transitioning (social, physical, identity documentation). Associated comments reflected on the costs and ambiguity involved in enduring long waiting periods and having to commit to unspecified quantities of visitations to gain consent from gatekeepers. This issue was linked to MG participants needing support whilst undertaking the assessment process and feelings of disempowerment, as evidenced below (see Appendix III).

(MG3) Oliver: *"I finally got a referral to an endocrinologist who just – and I'm comparing with what I've had recently here in Victoria over what I had in Tasmania – he was really vague, and just sort of like, going through a process of ticking a few boxes to be able to get me out the door."* And, *"He* [psychologist] *strung me on for five weeks until I got to two weeks before my surgery, and then he refused to write my letter to get my surgery through. Well, I knew he had a nervous breakdown over it."*

(MG4) Dan: *"They* [clinic] *told me I needed a GP referral, and I said, 'well, I can't just go to my GP' (you know, they know everyone else I know as well)."* Also, *"That is what they don't get. That's what they don't get about confidentiality. And, on a lighter note, it's all over the place."* And, *"I know they* [specialist clinic] *have got funds recently, and I believe their wait list is now down to about three or months, so ... And, there are private places you can now go, but then, I didn't have any money at that stage. I'd really got low… It's actually harder once*

79

you get to find where the pathway is, and then not have access to it." And, *"I think the GPs and the trans clinic were lost as well. There was nowhere to send me. There weren't any support groups; there wasn't anywhere."*

(MG2) Dylan: *"They had to say that I had a mental illness – and I don't think I do. And, I think that is crazy. I'm not mentally ill."*

(MG3) Oliver: *"There is no specific support or services. Like, they have targets for men's health groups, or women's breast, or migrant health, or, mental health."*

(MG4) Dan: *"You stumble across what you can do about it, then they will make you wait because there is not enough money."* And, *"It just seemed, at one point, very much like I was just keeping them, the psychs, employed. I'd had six visits and I got up to eight and nine, and thought, I can't see an end, I don't know when this is going to end, I haven't got endless money. When do I get through? And, just about when I was about to snap, I did."* Also, *"You don't want to rock the boat, you don't want to ask too much, you just want to get through. You don't want to be seen as a trouble client and put off. But it is difficult when you have got limited funds and it costs so much to go."*

Additional difficulties were encountered by MG participants even after gaining permission to begin GAHT. Examples included negative feelings of being controlled and reliant on HPs, and the outcomes of HPs being deceitful or unprofessional. For instance, explanations included HPs prescribing ineffective hormone dosages (described as sugar pills that could not produce the participant's desired bodily changes) or painfully administering an injection with an unnecessarily large needle. Also, participants have been disappointed with the delay in effects from GAHT (see Appendix III).

(MG3) Oliver*: "I finally did get on hormones they basically prescribed me a sugar pill. Through my endocrinologist here in XXX. The guy here, he just shook his head and said, 'I'm not surprised that they would do that to you'."*

(MG4) Dan: *"It's that permanent feeling that someone can actually cut off your meds, that they are in control of your life, and that can affect people varyingly, depending on their capacity, their resilience, their confidence within themselves to manage for themselves."*

(MG1) Liam: *"It was after* [surgery] *that I started trying* [testosterone] *with a gel. It's an Androforte 2 to start with (and I went to Androforte 5 only a few months ago). So, I was on that for about a year. It wasn't really doing enough. It's supposed to promote your male characteristics, as in muscle, some hair growth. More energy, which I didn't notice a lot of with the gel."*

(MG5) Ben: *"I would have been about 25 or 26. They would still have been giving it to me in the arm or in the back. He gave it to me right here* [Ben indicates to site of injection on his hip]. *It hurt, and I had a bruise there for the month. I said, 'I won't be seeing you again,' or something like this. Total inexperience doing transgendered people."*

Information issues, such as poor experiences with education or gaining and sharing information with HPs, were reported by all the participants. Most comments related to the difficulty or confusion of gathering or sharing information from transgender communities or HPs, or from seeking information themselves. These issues were linked to practitioners and professionals lacking the necessary training and cultural competency. A lack of interest also contributed towards health practitioners lacking in knowledge (see Appendix III).

(MG5) Dan: *"I could walk into a service and ask whether they are trans friendly, and have you been trained or not? And they will say, 'yes'. And, then their training is appalling, and it's useless. In fact, they don't know anything, so, even asking doesn't help. Or, they can get the one shift, the one nurse, like I did in the hospital. That's hopeless, and then everyone else is fine? And, the service thinks that they are fine."*

Poor experiences, such as discrimination and transphobia, were reported as an issue relating to Australian Government policies and health systems. Entering the health system had been daunting for some MG participants, particularly when they have felt misplaced within service provision because they were ageing as well as transgender. Participants also explained their issues with the health system in relation to HPs' knowledge and education deficits and how these might be linked to discriminative practices; for example, by being misplaced within assisted living services in later life was also a concern. Some MG participants described the extent and context in which discrimination occurs. Negative impacts were explained in relation to how it occurs in all types of services. One participant reported that all transgender people have been particularly vulnerable in one-on-one situations with HPs and staff; and further, even when most health workers are non-discriminatory, there will be a small percentage who are verbally or physically threatening. One participant also experienced discrimination from an HP who was unwilling to help him overcome obstacles related to secondary health conditions (see Appendix III).

(MG3) Oliver: *"When you go also in the public system you get lumped into Sexual Health; and, realistically sex, and gender are not the same thing. So, being trans just gets tucked off to the side of all these sexual health issues that, you know, it's great sitting there in the waiting room looking at photos of gonorrhoea on the wall, and chlamydia, and all the rest. It's like, that also makes it very uncomfortable, in dealing with that side of it, but what choice have you got?"* And, *"Then I went to XXX Sexual Health Services* [in] *2015. Generally, it was supportive, but I always got that intuitive feeling that again they weren't any good for dealing with older trans people."* And, *"Ironically, the day I was having my top surgery was probably another day that I felt transphobia. In the hospital that only ever deals with transgender patients… This female nurse referred to me as 'she', just as I was about to head to theatre! When I challenged her on it, she just laughed at me!"*

(MG4) Dan: *"There is still some systematic discrimination in forms and what have you, but, actual physical threats of treatment like that, it's a one-on-one case."* And, *"Of any employment* [for example in hospitals and clinical environments], *in any service, anywhere, at any time, I don't know whether I'm talking to someone who is the ten percent who wants me dead. There's my problem. So, even if ninety percent of the population are okay with me and will treat me well, because I don't know who the ten percent is, and that, their responses to me are not just unfriendly words – this is not just a psychological issue I've got, this a life-threatening issue – it never goes away. You can't relax anywhere at any time. And, I'm thoroughly aware of how vulnerable we are."*

5.4 ST2 (T1): MG General Health and General Healthcare Experiences

MG participants' total sum of all comments for ST2 *(N=69)* shows that negative comments were more than double that of their positive commentary (negative *N=49;* positive *N= 20).*

ST2 (T1): MG positive personal general health and general healthcare experiences

ST2 (T1): MG positive personal general health experiences

Most MG commentary concerning personal health issues reported potential or actual secondary health conditions, such as development of diabetes or past strokes. MG participants were aware of their screening needs, such as regular pap smears, bowel screening, and blood tests. They also reported awareness of age-related health issues, such as genetic cancer concerns or chronic illness. However, there were not remarks for every MG participant in this section. This does not necessarily indicate that participants did not report personal health issues, but rather any associated comments may have primarily belonged to other themes or sub-themes, such as T2's health enablers (see Appendix III).

> (MG2) Dylan: *"I don't really have any health issues. I've had a few in my past, but I'm pretty good at the moment."* And, *"for screening, yes, pap smears every two years as normal."*

> (MG5) Ben: *"At last blood test, when testing XXX* [my GP] *got back (I think it was last week or the week before I actually saw her), and everything was dickey dory."*

ST2 (T1): MG positive general healthcare experiences

Generally, MG participants did not discuss their general health issues unless prompted. However, good experiences with healthcare for general health issues mostly concerned HPs being good natured and caring, or how a doctor might be involved in overall care plans. Participants also remarked on good experiences being the outcome of long-standing attendances at their HPs. Comments related to a wide range of HPs, including GPs, psychologists or psychiatrists, and support services (see Appendix III).

> (MG2) Dylan: *"I've been seeing my doctor for just over seven years, from before transitioning."* And, *"Health practitioners involved in my health maintenance is just my GP."*

> (MG3) Oliver: *"Even as a female* [before I affirmed my gender], *you can just sense that difference in the way that you get perceived and treated. When you, for example, go to a doctor, they don't bang onto you about all these women's health issues, and you need to have this done, and that done, and it's like, God, I don't want to know about that… you know? I don't care about that stuff!"* And, *"I actually was suicidal. Do you know that within 24 hours my GP had not only seen me, but she'd rang me back twice to make sure that I was okay, and she organised a new psychologist to see me straight away."*

Only one male identifying participant gave a positive report regarding mainstream hospital or clinical services for general health issues. He experienced sensitive staff having awareness of toiletry differences and offering appropriate urination choices in hospital wards.

> (MG4) Dan: *"I woke up in an all-male ward, with the four beds, and the curtains in between, and I was getting my pain meds, and my food, and I was pretty happy… He was a nice man, but I didn't know how he would be when he found out – if he found out. And, he said, 'Here's your bottle'. And I said, 'Um …?' He stopped, and looked, and all I could come up with was,*

'I don't think I've got anything I need to use that'. And, I still don't know whether he thinks I've got some kind of micro penis or what, but he was a good staff member, and he said, 'How would it be if you pressed the buzzer if you need to go, and I will help you to the loo?' And, I said, 'That would be awesome,' and sunk back into the pillows thinking, just saved by the skin of the teeth!"

ST2 (T1): MG negative general health and healthcare provision experiences

MG comments surrounding personal health and related general healthcare provision (*N=49*) were similar in nature to NBG commentary.

ST2 (T1): MG negative personal health experiences

MG participants described some general health issues and how, as transgender individuals, they experienced more difficulties than cisgender people. Health conditions at the time of interview were: mental health, strokes, and screening (e.g., pap, breast) challenges. Outcomes of health conditions were fearing being refused GAHT or GAS after a stroke or struggling to have a post-mastectomy chest screened for breast cancer (see Appendix III).

> (MG3) Oliver: *"The day I can't look after myself I'm going to put myself down."* And, *"We have that laugh because, to trans guys, having to have pap smears is the equivalent of blokes having to have prostates. You know, it's like, 'urgh?'."*
>
> (MG4) Dan: "[problem] *The mammogram because you can't squeeze it in. There is not enough left under the armpit, you know. It's like doing a lump test."*

ST2 (T1): MG negative experiences of general healthcare

Two participants made multiple comments about their poor experiences of in-service discrimination whilst in hospital and clinical situations. One participant experienced hospital staff refusing to allow him to use male toilets and causing him to feel like he had been given medications and an assessment without consent. Another participant explained why he believes health workers have felt able to demonstrate high levels of discrimination in hospital or clinical settings. In his experience, he was rendered vulnerable in one-on-one situations, and, that these situations cannot be predicted in environments where there are untrained agency health workers and frequent changes of shift.

> (MG4) Dan: *"They* [transgender people] *can get the one shift, the one nurse, like I did in the hospital. That's hopeless, and then everyone else is fine? And, the service thinks that they are fine."* And*, "It was the staff supporting me afterwards* [surgery] *I was in danger from… There you are, meant to be recovering, being supported, and relaxed, and just healing. And, you don't. You lie there like a stiff tense ball waiting for the next attack. I know, it was hell."* Also*, "*[at the dental clinic] *she said, 'We don't offer services to people like you'."* And, *"I had no leg to stand on to bring it to any head because she would just say that I was highly sensitive, and I'd misinterpreted what she said, and that she didn't say that at all. It would never go anywhere. It is always one-on-one. That's where it happens, so you can't do anything about it, so there's the frustration, there's anger, there's despair."*

(MG5) Ben: *"Using a loud speaker to communicate with the patient when they are in the observation ward. Because, they had a camera on me. And, they were using a PA system, so it wasn't just – I wasn't the only who heard them. Everyone on that bloody ward heard them. Then being told that if I needed to go to the toilet, I had to use the female one. I tried to go into the male toilet first. The door was locked. I thought, ok. I had no other option, it was either that, or try to get out of the observation ward, and find a toilet elsewhere. So, I used that one against my will."*

MG participants also reported HPs demonstrating a lack of willingness, discrimination, or insufficient knowledge to understand specific (transgender) patients' needs. This occurred for one MG participant being refused knee and hip replacement surgery whilst on GAHT (see Appendix III).

(MG1) Liam: *"I get the feeling that whatever I'm there for, it's, 'get on the scales'…You know, it could be an ear infection."*

(MG4) Dan: "[There was a problem with] *The mammogram because you can't squeeze it in. There is not enough left under the armpit, you know. It's like doing a lump test."*

(MG3) Oliver: *"I'm due for a knee and hip replacement. I went to see this* [orthopaedic] *specialist privately, and he turned around, and told me that while I'm on testosterone he will not treat me."*

Health systems and organisational problems were associated with some of the negative experiences and issues MG participants encountered in general healthcare and service provision settings. Examples detailed biased system practices, issues with general public in mainstream settings, how health staffing's lack of education and awareness impacts service provision or confidentiality, and staff identity issues in relation to questioning ethical practices.

(MG5) Ben: *"There is a reason staff are given ID. Bloody well wear it! And, it's also common courtesy to say, 'Hi, I'm Dr so and so;' and, nurses only give their first names. No-one bothered doing that when I was at* XXX *hospital."*

(MG4) Dan: *"I had to go for a pap smear at the GP the other day. This is the LGBTI clinic. This is the people who should know better. The receptionist said, 'What's it for?' (on booking my appointment). What am I meant to say standing at the counter at the front of the entire waiting room? 'I need a pap smear love?' You know, come on! I can't answer the question because there are people listening! And, that's what they don't get."*

ST1/ST2 (T1): Female identifying Group (FG)

5.5   ST1 (T1): FG Gender Affirmation and Gender Affirming Healthcare Experiences

FG participants' total sum of all comments for ST1 *(N=349)* show that positive comments were similar per head that of the negative commentary (positive *N= 198;* negative *N=151).*

ST1 (T1): FG positive gender affirmation and gender affirming healthcare experiences

ST1 (T1): FG positive personal gender affirmation experiences

FG participants' personal issues made up approximately a quarter of all positive transgender health related commentary. They remarked on positive mental and physical benefits of GAHT on personal health, successful treatments and changes (e.g., hair), and personal feelings or decisions regarding the levels of transition made.

All FG participants experienced the positive effects of gender affirming processes from the full range of services, including non-clinical procedures. Not all participants felt they needed GAS, however most used GAHT and clothing, and/or make-up, as well as wigs, non-clinical treatments such as skin softening treatments, and laser hair removal (IPL). Several started the gender affirmation process with self-acceptance. Moreover, some participants felt themselves fortunate to have smooth transitions, which helped with their mental wellbeing. Others felt their journey has been ongoing and constantly evolving (see Appendix III).

> (FG6) Rose: *"You've got to exist within the boundaries of what you are and who you are ... SRS – for me, it's not a necessity."*
>
> (FG1) Ellen: *"I've certainly feminized, but* [I am more feminine] *with a wig and full make-up."*
>
> (FG10) Penny*: "I started affirming my gender by stopping being someone who I wasn't."* And, *"All the time you take this* [feminizing hormones] *it does to you, make your skin softer, you start to feel your hair grow back (which is good). It totally feels right."* Also, *"I will probably do one more IPL, and start electrolysis on the white ones* [facial hair]. *And, that is fantastic."*
>
> (FG6) Rose: *"[Before I committed to affirming my gender I experimented] I went to all the trouble of getting some clothes and other bits and pieces, and she* [Transgender female friend] *did a make-over, and then we went out for the evening. And, she took me to a few different things, and by golly I got hit on by boys. I don't know what it was, but I just felt free. I felt more together about who I was."*
>
> (FG5) Clara: *"I've been lucky with my transition… Not everyone has had bad experiences."*

ST1 (T1): FG positive gender affirming healthcare experiences

The volume of comments per head (*N=14)* in the FG commentary regarding positive gender affirmation and gender affirming healthcare issues was significantly more than the MG (*N=11 per head)*. However, it should not be assumed that the MG reported fewer positive experiences, but simply that they reported less overall healthcare attendance. To exemplify this, some FG participants have undergone multiple (genital and non-genital) GAS. In some cases, female identifying participants' GAHT and associated care increased after transition to safeguard against secondary health concerns.

FG participants mostly reported positive encounters (*N=47)* with a range of HPs. Included in the commentary were GPs, endocrinologists, support people and mental HPs (psychologists and psychiatrists). These issues had similarities to the MG because they shared similar referral and assessment steps towards transitioning. Commentary showed that participants built good relationships and experienced positive attitudes, and support, during their visits to practitioners. Examples were feeling comfortable, trusting their practitioners, and reporting good experiences when receiving holistic treatment, which included considerations for any psychosocial impacts on a patient's physical and mental wellbeing during and after transition (see Appendix III).

> (FG3) Charlotte: *"I've had the same GP, probably for now, more than 10 years. And, I'm very comfortable in that environment."* And, *"I guess* [a good encounter with a health provider requires] *someone who accepts where you are at, and doesn't challenge where you are at: and, is a good listener, and helps to work through the issues that I guess I, largely, brought up."* Also, *"I guess, the major step for me was finding a psychologist that I could work with to clarify what gender meant to me, what gender identity meant to me, and what gender expression meant: and to, reach a conclusion that I needed to, and could, live as a woman; and so, through that process I gained the confidence that I could do what I needed to do."*

> (FG1) Ellen: "[My experience of gender affirming healthcare is positive] *I'm on antiandrogens, spironolactone (200ml of that per day), and 0.75 mg oestradiol, so it's sub-cutaneous, which is consistent with my health profile (they shouldn't be passing through my liver at my age)."*

> (FG11) Ruby: *"I've been looked after by health care professionals."* And, *"Well, they asked me about my life, and what it was like for me to be a person who identifies as being female, you know."*

> (FG4) Ava: *"I see* [my GP] *every six weeks. She* [my GP] *weighs me and takes my blood pressure, and asks me how my mood is, and how things are going for family, because I've got one daughter that won't have anything to do with me."*

Mental health professionals were specifically discussed by ten of the eleven participants. Included were comments detailing how psychiatrists, psychologists, and online or face-to-face counselling helped them to work through their issues prior to, during, and after affirming their gender. Participants were helped with day-to-day matters such as employment issues, understanding themselves and their gender, social issues, and coming out. Their comments highlighted the importance of having good connections with mental health professionals (see Appendix III).

> (FG8) Chloe: *"There are some websites that just help you from one end to the other. They are just so very, very, helpful, especially for people who are coming out nowadays, or people who have just come out."*

> (FG10) Penny: "*I was caring for my son, and me. But, they* [online family support counselling service) *have been totally supportive as far as gender is concerned."*

> (FG5) Clara: *"She* [the workplace psychologist employed by company whilst I affirmed my gender] *said, 'Well, I do help companies do this, and it will cost (this much)'. And, she told them how it all works, and gave a talk to the other employees."*

> (FG6) Rose: *"I sort of mentioned it to one of the doctors, this situation with what I was going through, and she said, 'You should talk to one of our counsellors'. And, there was a*

counsellor there. Well, I had a bit of a chat and she was quite friendly. She was great. She, sort of, got me on the idea of looking back over my life as a pathway to see what things may have indicated towards it." And, *"It's because I had this male/female trait. And, I was having complications with it, and he* [my psychiatrist] *was able to assist the girl."*

Healthcare provision experiences in relation to gender affirming hormonal therapy (GAHT) were discussed by all FG participants. Most were using hormones for feminization at the time of interview and described good experiences with gaining prescriptions and finding HPs willing to bulk bill (reduced fees paid directly by government under Australia's Medicare health scheme); or, interacting with HPs and having appropriate treatments, and enjoying the positive effects of hormones. Less frequent comments related to self-medicating or not continuing to use hormones into later life (see Appendix III).

> (FG10) Penny: *"They* [US doctors] *provide them* [hormones and information via the internet]. *So, you know, if you are going to well at least do it* [self-medicate] *safely and here's what you should, you know."*

> (FG10) Penny: *"One way I can describe it* [having testosterone in my body prior to taking GAHT] *– it is like having poison in every cell of your body. You know? And, getting rid of that* [with GAHT], *it just feels so fine, it really does. The difference in the feeling is the difference of from being dead to alive. Yes, it's like that."*

> (FG6) Rose: *"My endocrinologist prescribed my hormones. Well, again, luckily enough he also took Medicare and bulk billed."*

> (FG1) Ellen: *"I have a recommended endocrinologist which I am happy with."* And, *"My endocrinologist gives me a prescription."* Also, *"I have an arrangement with my local chemist, and I have quite a good one now."*

> (FG9) Mila: *"The hormone situation has not been too bad for me. I have been pretty happy with the way I've been treated."*

Many of the FG participants reported satisfactory or good experiences of genital and non-genital surgeries. Interestingly, several comments detailed people's experiences in Thailand and some advantages of travelling to Thailand. Whilst these are not Australian experiences, they were most significant to this study because they gave clear insights as to why and how ageing transgender people compare overseas costs, services, and technologies, with Australian gender affirming HPs and services. Participants reported advantages of Thai specialist HPs included: more willingness; lower costs; superior technologies and experience levels; and, better environments due to increased hygiene in hospitals and clinics.

Some participants had reported their positive experiences of having GAS in Australia. One participant was able to have a fully funded orchiectomy through the Australian health system when she was unable to cover the costs of having a neo-vagina. Having this procedure meant she no longer needed to use hormone suppressors. Other commentary related to the importance of feminizing surgeries that have been particularly necessary for the target population's age group (see Appendix III).

> (FG1) Ellen: *"I've had my hair treatment, which is has truly went well, because I was having some balding here. So that has been the most expensive part of me."*

> (FG2) Amelia: *"2014, nine months after I started hormones, I went Thailand and had surgical transitioning. Four months after that I went back and breast augmentation."* And, *"The hospital was brilliant, and the anaesthetist was very caring and consulted me on everything. The* [Thai] *surgeon consulted me on everything and made sure I was very happy with what I got, and with what I was doing, and what they were doing; more than helpful. They were consular and professional."*

> (FG4) Ava: *"Well, all they did was remove my testicles; so, then I didn't have use hormone suppressors – testosterone suppressors."*

> (FG9) Mila: *"It worked pretty well for me because I had been meticulous in my planning. So, I had all the documents all lined up. I had my passport, my driver's license, my Medicare* [Australian Government's health scheme]. *Everything was feminized correctly."*

ST1 (T1): FG negative gender affirmation and gender affirming healthcare experiences

ST1 (T1): FG negative gender affirming healthcare experiences

Negative reports (*N=145)* related to experiences of daily experiences of societal discrimination impacting participants' daily functioning, geographical and economic location concerns, internet and information issues, gender affirmation and transition difficulties or barriers, and regret.

FG participant reports regarding negative experiences with HPs included doctors and GPs, endocrinologists, psychiatrists and psychologists, surgeons, chemists, and even online helpline counsellors. Commentary also included issues with HPs and specialists misunderstanding and not identifying people's dysphoria, particularly if HPs demonstrated little or no experience with transgender people prior to their first visitation. Other comments included not having rapport with patients, breaching confidentiality, misgendering and discriminating, being insensitive and lacking cultural competency (see Appendix III).

> (FG5) Clara: *"I refused to see my family GP at the time. I had told them (I had implied) that I was depressed, and he* [my family GP] *said I needed to just harden up, and that was really disappointing. I refused to see him again."* And, *"I never trusted the psychiatrist: also, what happened at the gender clinic, they broke my privacy. They showed my ex-partner the letter that I had written them… I was very upset about that, and that also hastened the break up in the marriage."*

> (FG8) Ellen: *"I had trouble at the chemist. They kept on calling up the wrong name, even though we had the obvious discussion."*

> (FG9) Mila: *"I had sat and gone through it with that doctor, who was very nice to me (through my own doctor obviously). And, to see that she just said that I was having sexual confusion – sexual identity confusion. I wasn't having sexual identity issues. At the time we spoke, I was a woman in a man's body, and I told her that. I felt bad. I felt marginalised."*

(FG8) Chloe: *"There is still quite a few psychiatrists out there that don't understand, and who don't want to know us."*

Some FG participants reported difficulties associated with gaining referrals or undertaking assessment periods. This was often due to the challenges of understanding their own dysphoria and not knowing whether HPs would help them through the referral and assessment process. Participants also described the referral process in a number of negative ways, such as feeling misunderstood, enduring lengthy waiting lists to see gatekeepers and not trusting or feeling comfortable with key HPs involved in gatekeeping roles. Reluctance to see key HPs arose from feeling their attendance was unnecessary, or because they were reluctant to share their personal issues with a HP (see Appendix III).

(FG10) Penny: *"I ended up self-medicating was because I knew, just from reading, there would be issues with oestrogen and my blood clots."*

(FG9) Mila: *"The psychiatrist was very nice. I don't think he really understood the problems that I was facing: and, I was feeling so scared – terrified, of myself and everyone around me – that anyone should discover my secret, of who I was. And, I just panicked. I just totally, completely, panicked. I got all the way there; past the GP; explained who I was to the GP; got to the psych, and then failed. They felt that it was a sexual orientation issue."*

(FG3) Charlotte: *"I thought the whole period of assessment was almost a delaying tactic from my perspective: and, as I say, because I had done the hard work through the psychologists, that didn't help me at all with my process. A waste of time."*

Participants further shared details of the high costs involved in undertaking gender affirmation, assessment, and other gender affirming needs. As well as GAS and GAHT, FG participants needed visits to beauticians for hair removal or dentists, clothing and shoes, and hair transplants or wigs. In some examples, the need for expensive services, such as counselling, has been necessary for close others (partners, children) also (see Appendix III).

(FG3) Charlotte: *"My wife ended up with a couple of years of counselling as well, so that process was fairly expensive."*

(FG4) Ava: *"I went to a beautician in XXX that used to do a laser treatment. It was some special way, that was supposed to work on white whiskers and all that sort of thing. I'd go out there, and I spent about $3,000."*

(FG8) Chloe: *"Clothes and shoes! Shoes are expensive. I've got bigger feet, so shoes are very hard to get here. I was spending $250 or $300 for a pair of sandals like this."* And, *"Some people I know have spent $30,000 or $40,000 or more on transition."*

(FG1) Ellen: *"I have spent $300,000 on my dentures* [to help feminize my face]."

(FG6) Rose: *"I've got wigs. They cost upwards of – anywhere between $280 / $300. I did try to acquire (Wren) hair, which is human hair, rather than synthetic. Synthetic only lasts so long, and then it starts splitting, and also, you can't condition them or anything like that. Normal hair ones last a lot longer."*

(FG9) Mila: *"I called a doctor in Melbourne – a Dr XXX. He said, 'Ok, well the surgery cost is about $15,000, plus hospital, which was another $9,000. So, that's $24,000. Out of all that you are going to get about $3,000 back through Medicare, unless you have got private health, you are going to have pay for your hospital too. Plus, you are going to have six months of*

electrolysis on your genitals, to get rid of the hair'. No-one was keen to do that in WA. I could not find anyone to that."

Participants also explained some poor experiences and hazards involved in undertaking GAHT. For some, HPs and lack of expertise has caused problems. For others, issues have arisen from biological complications and adverse reactions. Also, one participant feared they would not be able to gain a prescription due to co-existing health issues (see Appendix III).

(FG5) Clara: *"After I had SRS, I saw an endocrinologist, because I had had issues with hormones, certain things not working and fluctuating hormone levels. My body is very bad with things like that."*

(FG1) Ellen: *"At my age, with my full development with my male skeleton, the effects are going to be limited."*

(FG10) Penny: *"If you can't do HRT, the only alternative is orchiectomy* [castration].*"* And, *"Ok, well he* [my GP] *(naturally) referred me to* [XXX]*, the endocrinologist. He got me in early, which was great. I was going to have to wait three weeks, and it was terrible, it really was. Yeah, it was, thinking that I couldn't transition. I was in tears all day. Just, all day."*

(FG9) Mila: *"I've seen some GPs dispensing hormones to people without that* [endocrinologist authorization for hormonal treatment] *(which I think is dangerous and stupid). And, I've seen people come a cropper. Close people that I know, not getting the right psychological back up."* And, *"That person ended up trying to commit suicide ... And, they'd been given double doses of the hormone by the GP, with no referral letters from any psychologist or anyone."*

Additionally, FG participants discussed the negative issues and experiences they encountered in regard to acquiring and undertaking GAS. Problems commented upon were feeling apprehensive about the process and feeling too much uncertainty around after care and recovery processes, in the event something went wrong. Some participants described negative issues arising after their surgery; for example, if an individual develops an infection and/or has difficulty going to the toilet. Discussions around undertaking GAS also involved the high costs, forcing transgender people to travel overseas (see Appendix III).

(FG1) Ellen: *"I'm kind of ambivalent about having surgery you know?"* And, *"It's all just guaranteed to confuse. So even though you can get it and it's slightly more expensive here, there is very rarely a safety net when not doing it in this country if things go wrong – like my friend that's just experienced that. She is now in* [hospital] *... because the job was done over there* [Thailand].*"*

(FG2) Amelia: *"When I had my breast augmentation, the only place that I was able to find that might have considered it was based in Sydney in the West in a plastic surgery place, and they said, 'You will have to have chest expanders and it's multiple operations'* [and so I went to Thailand instead and had one operation].*"*

(FG9) Mila: *"*[The Australian surgeon advised me I would need to have laser treatment on my genitals to remove the hair] *I went for the most agonizing IPL sessions I've ever had to remove that hair, it was more money down the drain because I didn't need it, and I really hurt myself, and the doctor made me stop."* Also, *"They* [the Thai health workers] *were very good, very organised, but the difference in hospitals* [between the one I and my friend had surgery with] *was dramatic. My hospital was spotless. This* [my friend's] *hospital was old, and ... It*

was XXX *which is a very common gender reassignment hospital. And, you see it quite commonly in a lot of the TV programs and movies. It's very well known."*

5.6   ST2 (T1): FG General Health and Related Healthcare Experiences

FG participants' commentary for ST2 *(N=159)* was similar in number for both negative and positive content (positive *N = 89;* negative *N=70)*. There were fewer positive comments per person than for the MG.

ST2 (T1): FG positive general health and related healthcare experiences

ST2 (T1): FG positive personal general health

Participants related their positive general health situations to general and aged-related health issues, such as cancer and mental wellbeing.

> (FG7) Abigail: *"I haven't had any breast scans or anything like that. There is not a familial predisposition to breast cancer or anything like that."*
>
> (FG4) Ava: *"He* [GP] *said, 'I can't put you back on this medication until you give up alcohol'. So, I had half a carton of 15 cans at home. So, I went home and drank all of them that night. And I haven't had a drink since."*
>
> (FG1) Ellen: *"My story* [in terms of health and wellbeing] *is positive. You know, it's clear of mind."*

ST2 (T1): FG positive general healthcare

Commentary relating to positive experiences with GPs and other HPs were more than double *(N=39)* that of other topics, such as hospitals or health systems, in quantity. From the statements given it was clear that these good experiences were with caring and knowledgeable HPs. GPs who had holistic health views (such as considerations for psychosocial health) were highly valued by participants. Positive hospital or clinical services needed for non-transgender specific health issues were discussed positively by only seven of the 11 participants. Some who had positive experiences expressed feelings of good fortune if their HPs demonstrated inclusivity or competency. Interestingly, several positive remarks related to specific interactions with female health workers or patients (see Appendix III).

> (FG7) Abigail: *"But, no he was just a really nice GP guy. You could tell he really cared. He would, like the doctors I have now. They will treat you, with all the presenting issues that you go in there for. And they will say, 'ok, that's good, that we will talk about…, or whatever: And, now, how is else everything else in your life; are you feeling ok about things as well: is work going ok?'."* And, *"Yes, when I see the doctors, they will prompt me towards dieting which is great."*
>
> (FG5) Clara: *"I went to see a colorectal surgeon and a urologist, and I hadn't seen a dentist for 30 years at that stage… I've had to come out to the whole lot. The colorectal surgeon,*

which I've had to see a few times since, I had to say that I was a transgender. I remember seeing him a month ago for ongoing problems, and he's seen my bits – no real issues."

(FG10) Penny: *"All round my medical experiences have been fantastic. It's been supportive."*

(FG2) Amelia: *"I mostly wear a wig. I asked* [the dentist], *'Do you need me to take it off?' They went, 'No, no, that's fine – don't worry about that, we'll fix it'."*

(FG6) Rose: *"The staff* [breast screening] *were fine. They said my name, put it on, and said, 'You might feel a little bit of pain'. Then said, 'Nothing visible. You will get the results'. Then out the door I went. They never batted an eyelid. I think I might have presented really well, and they just took it all in their stride."*

(FG11) Ruby: *"The medical services were wonderful. Wonderful, so open and so accepting. They looked after me. That's been my experience in my life. I've been looked after by health care professionals.* And, *"XXX* [WA hospital] *was wonderful. They were brilliant. Because they have a lot of trainee doctors there."*

Five participants have made multiple comments positively describing how they were supported by HPs (psychiatrists, psychologists, GPs) during previous or current times in their lives. For example, when HPs demonstrated competency by identifying participants' dysphoria, even before participants recognised their own gender issues (see Appendix III).

(FG4) Ava: *"He (my psychologist) used a lot of photos of how I felt as I was growing up, and which photos best fitted my feelings. And, all that came back that I was transgender and stuff."*

(FG5) Clara: *"I saw a psychologist – a free one at the hospital. After a while I told her I used to go in girl clothes (after half a dozen sessions) and she said, 'that is important'. I said, 'no it's not!'... she* [my psychologist], *sort of, tried to help me more with the anxiety and depression... She* [my psychologist] *realised I was in a bad way and she just was sort of there to support and be someone to talk to."* And, *"She* [my GP] *just basically psychologically supported me, and I had done therapy with Dr XXX... If I was suicidal, I would go to the clinic."*

(FG8) Chloe: *"A lot of the psychiatrists, who have been around for years, definitely want to know, but it's the education. I think a lot of the education out there* [now] *happens when they are training – about transsexuals, and about other things as well."*

Health systems and related government services were also regarded positively by seven of the 11 female identifying participants. They spoke of how favourable experiences arose with general health issues when assisted directly or indirectly by HPs and health systems. Most remarks related to the importance of legal documentation, ease of use, and funding issues (see Appendix III).

(FG8) Chloe: *"I've been in hospital; I've been in the female wards and there have never been any problems. Well, I didn't have to make sure, they just did it. Because if they didn't, they would've certainly found out because I would have been jumping up and down. Because, legally, it was all written down. I went in and I was 'Miss' and the rest of it. And, of course, all my paper work and everything else says that I am Miss. So, it's pretty hard thing to mess up."*

(FG5) Clara: *"I got some letter the other day about screening. And, I had to think about whether I should go or not because I've only had breasts for a short time at that stage... I thought, yes, and booked in. I said who I am, and you know, I'm transgender, or whatever. And, I got in there and they were fine with it. They didn't really care."*

ST2 (T1): FG negative general health and related healthcare experiences

ST2 (T1): FG negative general health and healthcare

FG participants' commentary (*N=70*) concerning negative issues surrounding their general health and related healthcare provision was similar in quantity to their positive commentary, however demonstrated less per person than the MG or NBG.

ST2 (T1): FG negative general healthcare

The most negative commentary in this section related to HPs (*N=39*). Mostly, these included health providers discriminating against participants or lacking cultural competency and/or knowledge. Sometimes participants were reluctant to disclose their identity to HPs. Legal changes in documentation meant having to change identity and labelling with every healthcare organisation. Some participants mentioned how emotionally draining life was when dealing with administrative workers. Also included were participants reporting their experiences during visits to regular HPs or clinics (hospitals, screening services) and related examples of what attitudes or behaviour create poor experiences for participants. Some also asserted that HPs' lack of knowledge, education, and experience is a major factor when misunderstanding transgender bodies. Emphasis was placed on the impacts of misgendering, misunderstanding specific issues (e.g., assuming patients as being drug addicts and/or sexually perverse), stigmatization and discrimination, and safety issues. Most participants considered these issues to be significant problems in general healthcare (medical clinics and accident & emergency [A&E] departments) (see Appendix III).

> (FG1) Ellen: *"It can be like a drip torture – and you are dealing with so many people and so many* [healthcare and other] *organisations that the stress becomes accumulative. I've found that on the smallest of occasions that the smallest thing can set me off and I get quite – not aggressive or hysterical but I get very upset. At that point I have been sick."*

> (FG4) Ava: *"I went to the local XXX doctor, and he never knew, and I never told him anything about the transgender stuff."* And, *"I never told the GP in XXX because that was an emergency situation."*

> (FG2) Amelia: *"As soon as she* [nurse] *found out I had a prostate gland that the whole attitude* [from the HP] *was like that.* [She's] *just a dirty old man."*

> (FG7) Abigail: *"When he* [clinician] *came to see me the first time, he basically said, 'oh, 35-year-old trans woman, what drugs were you doing to have this drug (stroke) that you had? I'm guessing you are a sex worker, aren't you?' I was livid."*

> (FG3) Charlotte: *"There was severe bleeding. It was a haemorrhage and a risk of dying. The hospital deliberately misgendered her* [transgender female]*, they bullied her, they misgendered her visitors, and despite requests from ciswomen and others to modify their inappropriate behaviour, they refused to, or were unable to do so – perhaps refused."*

> (FG11) Ruby: *"A lot of Aboriginal people do not like to access mainstream service providers ... because they feel that they are talked down to, and talked over, and discriminated against. That may be that the doctors and nurses are racist."*

(FG9) Mila: "[When I went to hospital, with the HPs they communication] *was almost a subject of, 'Have you seen what is in there – oh look at that hole! Oh my God, they are good surgeons, aren't they?'."*

(FG3) Charlotte: *"*[When I broke my leg] *I was in extreme pain, so I was high on drugs for pain. And, she said, in the course of being in Accident and Emergency (before I went off for an operation), virtually everyone that was on duty that night, came in to have a look at the trannie. I was appalled!"*

Outside specific transgender related issues, such as referral or assessment periods, participants have sought support in various ways. Poor experiences, often relating to misunderstanding, inappropriateness, rejection, and prejudice involving a full range of support givers (psychiatrists, psychologists, counsellors, help lines), were reported. Negative remarks included insensitivity from mental HPs and helpline counsellors, inappropriate therapies, and mistrusting mental HPs (see Appendix III).

(FG10) Penny: *"I could not find one help line that is dedicated to transgender people. The closest I could find were LGBT: and you know, the old alphabet soup."* And, *"She might as well have said, 'get out of the way why don't you, you trannie?' And, you probably know 'trannie' is just the worst."*

(FG5) Clara: *"W*hen I was on anti-depressants, I had a really bad time". *And, "It's traumatising, and that went over seven months, with psychologists and psychiatrists not listening to me. Turning up at hospital, some said that there was nothing wrong – things like that."* Additionally, *"Then psychiatrists turned up to my house at times and told me to take medication and I said, 'Get away!' It was mostly mistrust.*" And, *"That can totally … It's traumatising, and that went over seven months: with psychologists and psychiatrists not listening to me: turning up at hospital. Some said that there was nothing wrong – things like that".*

(FG2) Amelia: *"Most people don't know, and I have to educate most people – psychologists or psychiatrist. I have to mostly educate them to help me. Some have not been able to do that."*

Participants also experienced a lack of understanding from organisations and health systems. Systemic problems have included hospital system labelling and not being able to make name changes when a former name was already present in a computer system, and health insurers not accommodating transgender identities or healthcare needs (see Appendix III).

(FG1) Ellen: *"Once the hospitals have your name, it's very difficult to get them to change your details* [on their labelling systems]*."* And, *"Nothing in our care system has been wilfully disrespectful. Things come as a result of peoples' complete ignorance. I just mean, they are just totally unaware, and even that there is an awareness to be had. So, it's really annoying that this thing is even going on. In that respect, they are really just actually acting naturally."*

(FG9) Mila: *"I've got the issues of private healthcare* [and health insurance issues]. *Should I want to do it, I think I've got a – obviously now, I would be classified with a pre-existing condition of being transgender, which would mean that the private healthcare isn't going to be very friendly, so that is a bridge to cross. I need to confront that."*

(FG3) Charlotte: *"I think some of the treatment that I know about – and I'm involved in terms of human rights complaints – are absolutely appalling."* And, *"I don't think that our public hospitals are doing a good job."*

5.7   ST3 (T1): Needs and Suggestions

The final section of this chapter will highlight all viewpoints (*N=94*) regarding how participants can be helped to achieve or maintain good general and gender affirmation health. Most participants made recommendations for current and future health practices. These included potential improvements throughout the spectrum of HPs, to create better, wider, ranges of services to better meet their needs.

1. *Australian Government and health systems (including insurers)*

Commentary (*N=28)* for this topic included suggestions related to the Australian Government and the Department of Health's (DOH) role in providing Medicare assistance and funding. These included bulk billing or rebates for all clinical situations, as well as for specific services. There was an emphasis on the importance of considering the relationship between risk of mental health conditions and assistance to transition. For instance, governments fund suicide prevention programs to help prevent suicide, but not GAS to avoid developing severe SMI, which might lead to suicide ideation. Participants suggested that a balance of both would likely be more effective for avoiding SMI in the trans population.

Suggestions for health insurance and funding included: provision of clear information about health policies needed; eliminating penalties after periods of receiving Department of Human Services (DHS) assistance; and, assistance to pay for treatments and surgeries by way of instalment payments. Additionally, one participant raised the issues arising from inadequate surgical remedies for NB and transgender male identifying people. That is, there have been no lower surgery technologies to produce satisfactory surgical outcomes (see Appendix III).

> (NBG1) Toni: *"If the doctors are saying that you have Gender Dysphoria, then it* [GAS] *is as necessary to somebody like as reconstruction* [surgery] *is to somebody who has got arthritis. And if that* [GAS] *is necessary to give them quality of life, then why is that not deemed necessary to give me quality of life?"*

> (MG1) Liam: *"It would obviously help if they* [health fund/insurance organisations] *were clearer about what level is required to get the cover for this? Is it cosmetic, is it not? If you can get* [funding] *through* [insurance organisations] *…*[as] *essential to your wellbeing – on a mental health level."*

> (NBG3) Charlie: *"There is someone – a trans guy – working on a prosthesis which I'm more inclined to want to go that way; either that or, you know, stem cell technology in the future. But, until those things happen, I'm not willing to settle for what is available at the moment."*

> (MG5) Ben: *"Be good if there were subsidies out there and Medicare could cover, at least a part of it – particularly in my situation. If you could say, 'right, ok, I'll pay such and such, and you pay the other half.' But you can pay it off in instalments, like, maybe, direct debit? Instead of having to… XXX had to come up with over $15,000."*

2.   *Identity and inclusivity (needs) in institutions and organisations.*

The largest portion of the comments in this section related to service provision, societal attitudes, and aged care. Most participants conveyed the importance of needing to be recognised in their gender identity by having universally recognised definitions. Several expressed the need for society, and particularly in aged-care institutions, to respect and accept them without judgement (see Appendix III).

> (FG7) Abigail: *"I wish societal attitudes would change."* And, *"I'm not saying that we wipe out gender* [identity definitions] *entirely. I think it should be extended."*
>
> (NBG3) Charlie: *"I have had fantasies in the past of* [entering a facility such as] *an older age LGBTQ nursing home type thing. You know, an elders' village. It is a fantasy, but it needs to be a reality because there are so many on that spectrum that are ageing; and, there is nothing, you know, even for LGB people."*
>
> (FG3) Charlotte: *"We need to have a society where having a body that doesn't meet expectations is accepted, and it's not challenged, and people feel inferior because they are different."*

3.   *Upskilling healthcare providers*

Participants have outlined multiple areas of healthcare provision requiring upskilling and training, and education, for the full range of HPs. Issues outlined were that many HPs are unable to be culturally competent without training, and that training should demonstrate the variations of identities. Some participants also highlighted the need for training to either use overseas peer examples, or transgender advocates themselves, to deliver training programs themselves, to ensure that community members will be ensured safety and appropriateness in healthcare and assisted care environments.

> (FG9) Mila: *"The only thing I really wish they would do is look at what they do in the UK now. And, they have a formal training process to help people to understand how to treat a trans person with care."*
>
> (MG4) Dan: *"If you won't educate service providers, then fund us! Fund TGV* [a transgender advocacy organisation], *or a couple of organisations, or one (at the bare minimum) to actually be able to have assistance, or ambassadors, or people go in to hospital with our population. To be able to speak for them and look after them."*
>
> (NB3) Charlie: *"I just think that there needs to be more skilling up of GPs. If they don't know themselves, at least having the resources there to be able to refer."*

4.   *Recommendations for better practices and availability from all healthcare and related wellbeing providers*

Participants made multiple comments related to gaps in service provision. The range of examples included service standardisation, with a more holistic approach from HPs, specifically for transgender people. One participant also requested that transgender people with counselling qualifications, that are not covered by Medicare, be granted health funding as a way of relieving the financial burden on community members, patient transport schemes, hospital injection programs, more prevalence of rural specialist services, consideration for NB identities in transgender related

care, and consideration of cosmetic care needs for transgender people (see additional comments in Appendix III).

> (FG2) Amelia: *"In terms of your health it would be nice to ask you about your cosmetic care because that is part trans health – provisions that you have had that have helped your health in that sense?"*

> (NBG3) Toni: *"I don't really fit anywhere! I would if there were places that had services for trans and gender diverse people, that would just cater for us in this area."* And, *"That there be more services available in rural areas I think is really important."*

5. *Participation in community care to ensure consistency in healthcare practices and information delivery.*

Participants called for participation, by way of increasing the prevalence of trans professionals working with trans people. This may assist in reducing long waiting lists in clinics, providing less costly care, and, promoting best practices to HPs and health workers (for example, by sharing ways of helping and providing information about transgender people's general health and gender affirmation needs). An example given is to validate and support transgender individuals acquiring certifications that would help others (such as a counselling diploma). Another suggestion was to standardise the practice of creating a transgender patient portfolio. Such portfolios could include a patient's background and would assist HPs and patients by way of avoiding difficult first meetings or interview situations. Additionally, some participants asked for better universal sources of information, to give them peer-reviewed or evidence-based information, to help them on their pathways to transition. This could guide them with their health matters, particularly when experiencing health adversities (See Appendix III).

> (FG6) Rose: "[Some transgender people have qualifications that can help the community]. *I'm not saying I've got the same qualifications* [Diploma of Counselling – not covered by Medicare]*, or perhaps the same extreme, more involved knowledge (through university courses or through psychologists). Yet, there are so many people out there screaming and in need. And yet they don't have the finances even to see me."* And, *"Who can they turn to? How much money have they got to spend on their mental health? And yet, here we have got a situation where we have got somebody who is qualified enough to be* [and if there was some support for participation and involvement, we could help each other]."

> (FG10) Penny: *"I was thinking, it's not just for your GP, but for anything you need to do ... you know, name change, gender marker. You have, basically, a portfolio, and something like this – and it's basically the story of your life – of your real life, you know? Concise but covering all the questions that the doctors and other professionals would ask. And, instructions for your real self, so they can read and avoid all the questions before we start talking."*

> (FG10) Penny: *"Stuff that's scientific and honest."* And*, "The ABCs of beginning your transition. How to make it easy for yourself."*

> (MG3) Oliver: *"I think there needs to be more, clearer, and holistic, information about the things that can go wrong. Like, you know, pictures and things like that, so people can actually visualise that, and understand that this is what can wrong."*

5.8   Chapter Summary

From the evidence shown there was clearly an overlap of health and healthcare issues occurring across the gender identity groups. For instance, all groups reported a link between good relationships with HPs and having good health and healthcare experiences for both gender affirmation and general health. Also, all groups reported a correlation between being challenged in healthcare situations, and encountering obstacles to affirming gender, wellbeing, and healthcare. Common examples of this were interactions with HPs who were unwilling or lacked cultural competency. Lacking support has been linked to negative personal feelings of diminished control, resilience, and self-determination. These feelings ultimately impacted people's mental and functional wellbeing.

Throughout the chapter participants suggested that gatekeeping, a significant source of negative experiences, was unnecessary when other HPs were shown to provide adequate and competent services when given adequate education and shown willingness to be culturally competent. An end to a gatekeeping approach and regulation is particularly justified when considering that transgender people, mostly, must cover the cost of private healthcare provision such as endocrinology and GAS. Another possibility, as suggested with this chapter, is for community participation and funding for the planning and delivery of services. Implementation of a community steering group to provide advisory services regarding the work of HPs would likely reduce the problems and challenges of discrimination and prejudice discussed by participants.

Such common experiences of health and healthcare provision are relevant to this study because participants' lived experiences provide the basis, such as evidence of discrimination or effective HP practices, for the next theme, presented in Chapter 6. Findings: Theme Two (T2): Factors Enabling or Hindering Good Health and Wellbeing and Access to Healthcare; this summarises participants' commentary about their health and healthcare needs or deterrents, and how they can be best supported to improve their experiences of health and healthcare provision.

Chapter 6.   Findings: Theme Two (T2): Factors Enabling or Hindering Good Health and Wellbeing and Access to Healthcare

This theme includes participants' explanations (*Number [N]=796*) of what factors enable or hinder good health and wellbeing, and access to related healthcare provision. Not all the data has been presented in this theme. However, because of overlap issues, some data may have been included in the other Findings chapters. The issues have been categorised into sub-themes according to topics discussed. Each sub-theme includes illustrative matter providing some evidence for the summaries provided. Not all quotes are displayed; additional quotes, that are relevant and do not simply duplicate those provided in the text of this chapter, are included in Appendix IV: Findings: (T2) Factors Enabling or Hindering Good Health and Wellbeing and Access to Healthcare. Indications of additional quotes are shown as "(see Appendix IV)".

A wide-ranging view of these health matters required investigation of both general and gender affirmation health-related needs. These issues have been important for revealing what benefits or negatively impacts participants' overall health and wellbeing. This overarching theme, *Factors enabling or hindering good health and wellbeing or healthcare access*, demonstrates the broad range of information provided. Because of the variety it was necessary to divide the data into defined sub-themes according to whether comments were related to health or healthcare access.

Participant commentary in this theme has not been presented by gender identity as it was in T1. Instead, STs in T2 present participant reporting by topic and in a hierarchical order. This is because of the way the data gathered fell. In other words, the most discussed topic is also the first to be discussed in each section. The least discussed topic is the last to be discussed. The order of STs relating to people's personal health and wellbeing (see Figure 5 and Table 3) is presented as follows: (ST1) *Factors enabling good health and wellbeing (N=210)*, and (ST2) *Factors enabling access to healthcare (N=109)*. Sub-themes associated with negative aspects of health and access to care are (ST3) *Factors hindering good health and wellbeing (N=281)*, and (ST4) *Factors hindering access to healthcare (N=196)*.

Figure 5: Chapter 6: Theme Two (T2): sub-theme structure
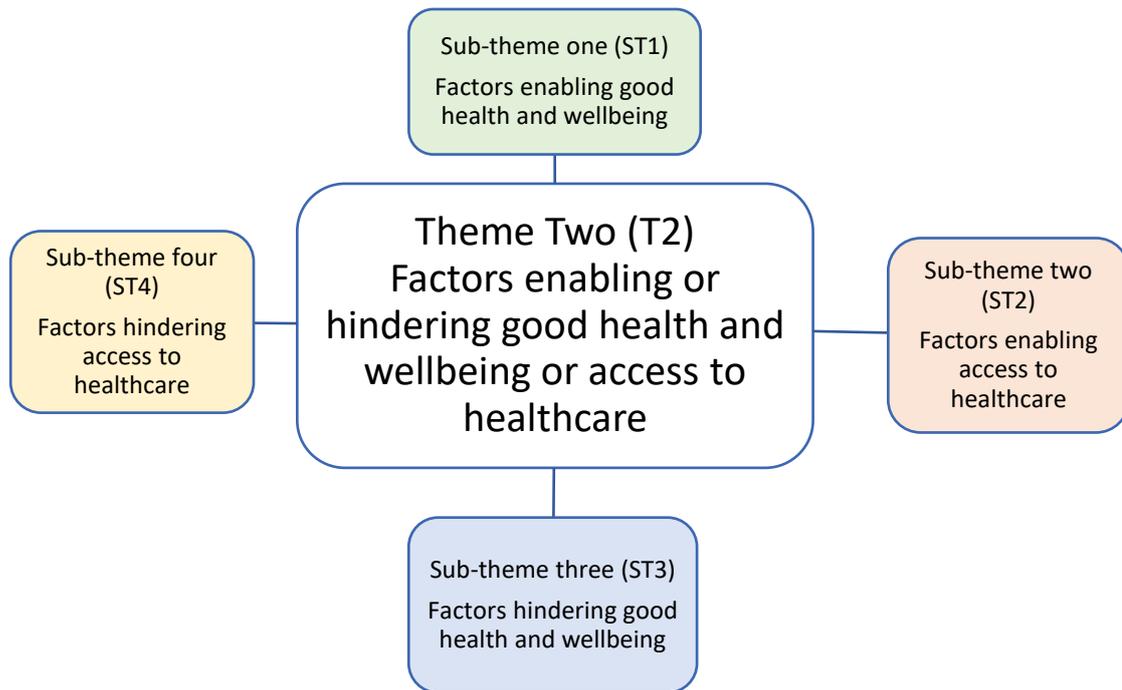
Table 3: Chapter 6 (T2): findings: Sub-theme topics

STI	ST2	ST3	ST4
Factors enabling good health & wellbeing	Factors enabling access to healthcare	Factors hindering good health & wellbeing	Factors hindering access to healthcare
1. Having the means to feel authentic 2. Good social connections 3. Understanding preventive health 4. Being able to gather information about trans-specific health issues 5. Participation in health and age-related care decisions	1. Gaining funding for services & prescriptions 2. Gaining recommendations from online communities and health provider sites 3. Access to referrals, service availability, and good relationships with health providers 4. Access to affordable care 5. Encouragement to transition	1. Concealment and experiencing or fearing discrimination or misgendering 2. Having age-related, co-existing, or secondary conditions 3. Barriers to gender affirmation 4. Adverse side-effects of gender affirmation processes 5. Difficulties understanding health concerns & gaining related information 6. Past alcohol & substance issues	1. Health provider access issues 2. Gender affirmation healthcare affordability 3. Mistrusting health providers and discrimination fears 4. Travel & transport problems 5. Fear of change, health provider competency, or safety 6. Delays caused by specialist health providers

Each ST gives insights into participants' perceptions, viewpoints, and experiences. Yet, ST1 and ST3 are distinctive because they detail an individual's unique and personal reality in either the positive or negative. In contrast ST2 and ST4 are mostly ageing transgender people's common needs or common issues in relation access to services (positive and negative).

6.1   ST1 (T2): Factors Enabling Good Health and Wellbeing

Participant commentary (*N=210)* mostly involved health determinants (physical health, mental health, identity, expression, appearance, gender affirmation). Participants also mentioned the relevance of individual or groups of health providers (HPs), healthcare organisations (e.g., hospital, health insurers,), and Australian Government agencies. Commentary included the following:

1. Having the means to feel authentic

Commentary aligning to this topic (*N=88)* exceeded any other topic within the ST by more than 20 comments. All 19 participants explained either the importance of outward expressions of gender identity or detailed which aspects of gender expression were significant to them. Examples of their associated needs included aligning outward expressions of gender, including any personal documentation, with internal feelings of identity. Participants also commented on the transition process itself. Some explained the positive impact of GAHT on wellbeing. Benefits were experienced when achieving a desired gender affirming outcome (appearance, bodily features), or when varying types of GAHT were physically suited to an individual; or, that hormones benefitted their mental health. For example, participants experienced more energy or confidence with GAHT. A common example for GAS was how it helped participants to align their bodies with how they feel or how they wanted to be perceived by others. Sometimes participants commented on good fortune and voiced relief in reducing previous worries. Content included: cosmetics and related care; wigs and hair transplants; matching legal documentation; the importance of voice; hair removal (including waxing, laser treatments, electrolysis); GAS (e.g., facial modifications); binders and packers; chest surgeries; and, acknowledgement or recognition of outward expression by others (see Appendix IV).

> (NBG3) Charlie: *"Well it* [top surgery / reconstruction chest surgery] *means a lot to me. I spent my whole life stooped over trying to disguise my chest, and, you know, I'd to be able to walk on the beach without a shirt on, you know. I think I would just stand up taller and feel just so much better about myself instead of being sexualised and gendered from it."*

> (FG5) Clara: *"After legally changing my gender I felt excellent! … Because I thought of myself as a girl, and I didn't care about my name so much. I needed to get it* [because] *Society looks at that."*

> (MG4) Dan: *"It* [a chest binder] *was absolutely essential* [to present as male in public]. *I was a big double D girl – very large chested, not small."*

> (FG10) Penny: *"I would like to wear a nice pair of knickers. I'd just look so right."*

> (FG8) Chloe: *"Hormones just helps me to keep a feminine face… that has changed a lot over the years… If I don't, then slowly but surely, your face will back down?"*

> (MG2) Dylan: *"I was 44 when I started* [to affirm my gender with GAHT]. *My entire life has changed. I'm a lot happier and a lot more confident."*

> (MG5) Ben: *"Bottom surgery means it will make me feel whole, for a start."*

> (FG7) Abigail: *"I remember waking up after SRS, and thinking, 'Thank goodness for that! This means I can now just get on with my life'."*

2. *Good social connections: strengthening feelings of authenticity and wellbeing*

Several participants explained psychosocial issues that helped with gender affirmation and overall wellbeing. Commentary included the importance of relating to people in their true gender whether in public situations, social group situations, or in friendships or close relationships. Some participants experienced improved interactions with others after making a social transition, whether they had GAS or not. Other comments reflected on how participants viewed mental wellness or age-related issues and preparation for mental stealth in later life. Factors contributing to wellness included needing mental health HPs or GAS to assist with any mental challenges associated with affirming their gender. One participant felt that gender affirmation itself created positive changes such as providing a reward system for the potential risks (physical, mental, and social) involved. Other comments of interest reported engaging in social activities or having pets for general wellbeing (see Appendix IV).

> (MG3) Oliver: *"Whereas, as a butch female I was still perceived in the world as a female. Whereas, as a trans guy I cough up laughing at just the way I see blokes even talk to me and interact with me now."*

> (MG4) Dan: *"If you live it, and you work it, and you educate in it* [transgender issues], *and you tell your story about various aspects of it, then it's taxing… I have to put in regular counselling, I find, to de-brief myself from some sessions, to keep myself strong."*

> (NBG2) Jo: *"Planning for old age really means trying to find an activity that you enjoy doing.* [There are] *some people that you get some enjoyment being around, and they can cope with you; and, finding humour in how things are."*

3. *Understanding good preventive health measures*

Some participants felt that preventive health measures or activities were important for good health and early detection of adverse conditions. Most significant was identifying how they avoided any impacts of secondary conditions associated with gender affirmation or with a hereditary nature. FG participants explained a range of health conditions an ageing transgender person might encounter. Examples of these were chronic conditions, such as hepatitis resulting in liver damage, cancerous melanomas, strokes, issues from previous addictions, and hereditary health risk factors (cancer). Some examples showed how participants positively addressed or overcame their issues by attending healthcare and knowledgeably undertaking self-care. Most demonstrated reasonable awareness about the need for screening (e.g., cancers), good nutrition, avoidance of weight gain, and associated obesity health risks (e.g., diabetes). There was also awareness of the interplay between physical fitness and age degeneration, and GAHT. Some participants felt that good relationships with HPs were necessary. For others, good health was self-motivated, such as exercise and weight management. Participants also described physical health in relation to reduced alcohol consumption (see Appendix IV).

> (FG9) Mila: *"So looking and moving forward I'm trying to keep myself very fit. I'm always going to the GP to keep an eye on blood pressure: continually going back to the endocrinologist every three months for full on blood checks, and heart checks, everything. So, really on top of that."*

(FG10) Penny: *"I stopped drinking, completely."*

(MG2) Dylan: *"I actually started getting mammograms done, and I have done every year up to the surgery."*

(FG7) Abigail: *"I went to the doctor and I asked to have a prostate check-up (my dad had a run in with prostate cancer). So, I thought, at aged 52 or 53 (a couple of years ago) it would be sensible just to get checked out. Because even though, with the surgery that I had, obviously, they create a neo-vagina, they leave the prostate gland – so I thought I'll get it checked, just to be safe."*

(NBG1) Toni: *"I eat very healthy food. I have an exercise routine every day."*

4. *Being able to gather information about trans-specific health issues*

Some sources of information have helped participants' wellbeing and saved lives by alleviating suicide ideation related to gender questioning. Participants reported increased understanding by communicating their situations, particularly when discussing issues with friends, or by gathering online (forums, HP sites) and documented information (hard print articles).

(MG1) Liam: *"The internet. It's fantastic. You can look stuff up and just read it and send an email and – quite often – you can work it out for yourself."*

(M5) Ben: *"I stumbled by accident on this article* [about a transgender person]*; and if hadn't, then I probably still, I probably would've… because life wouldn't have been worth living."*

5. *Participation in health and age-related care decisions*

Some comments were direct answers to questions probing what enables good health, rather than what a healthcare experience was like. These answers at times referred directly to HPs being inclusive and competent with gender affirmation matters, such as understanding identity needs, particularly in aged-care, health programs, and resilience building.

(NBG3) Charlie: *"My choice would be to be able to age in my own home with* [health and assisted living] *support."*

(MG3) Oliver: *"It was through conversations with her* [my GP]*, and the other medical staff at XXX, that I really understood that there was … why people really do exist who have been born in the wrong body."*

6.2   ST2 (T2): Factors Enabling Access to Healthcare

Participant commentary *(N=109)* regarding what is most helpful for accessing healthcare related to gender affirmation and gender affirming healthcare, general healthcare, and associated organisational issues, involved all 19 participants. Commentary included the following:

1. *Gaining funding for services and prescriptions*

Participants' largest topic commentary in this ST (*N=35*) explained their access to services in terms of how they were funded or subsidised. Participants shared a variety of ways Australian social support services assisted them with daily life and throughout transitioning periods. Examples given included: using their healthcare card and the PBS for prescriptions when on a low income (social

security benefits); or, gaining additional funds from superannuation, Medicare, or insurance to pay for services or surgeries. Participants related the importance of economic wellbeing and being able to afford the cost of living by prioritising finances to pay for gender affirmation processes and procedures or maintain broad health. Some included how government support systems, such as housing, also related to their costs and ability to pay fees. Commentary regarding raising funds also included selling property, borrowing from family, or drawing on pay or superannuation. Participants did not relate any information belonging to this topic to their general health needs. However, comments regarding a range of healthcare services related to inclusivity and covering all gender affirmation needs (see Appendix IV).

> (FG8) Chloe: *"I've always had private healthcare and that helps with, better hospitals and that. So, a bit of acceptance because I'm paying for it and they are not on the Government system."*

> (NBG1) Toni: "[Without being able to draw on my superannuation to have surgery] *it would have meant, taking up private health insurance for 12 months. So that would have delayed having the surgery. Knowing my luck, they would have changed the bloody rules in the meantime, and I thought, no, bother it, I will just take it out of my super."*

> (FG7) Abigail: *"I believe that the government will provide me with some government housing to live in when I'm older* [and can no longer care for myself]*."*

> (MG5) Ben: *"I get hormones on the PBS* [Pharmaceutical Benefits Scheme] *fund. Instead of costing me over $100, every time I have one, it costs me $6 something. Whatever the funding is for pensioners."*

> (FG5) Clara: *"I had plenty of money. I had a huge pay out from the previous company at that stage, and I owned my own house and everything."* Also, *"I got to a stage where I said, 'Well my mental health is worth whatever I pay'."* And*, "My parents had said they would pay for the surgery – the SRS."*

> (MG5) Ben: *"I had my chest surgery and pelvic clearance done here. Medicare paid for it, so it didn't cost me anything."*

> (FG11) Ruby: *"No costs. No, because they are funded. They* [Aboriginal Medical Services] *provide all those services."*

> (MG2) Dylan: *"Most needed for trans people is cheaper surgery. If this is a mental illness, then surgery should be free."*

2. *Gaining recommendations from online communities and health provider sites*

Participants explained how gathering information helped them gain access to trusted HPs. Comments related to the internet and online information channels, such as community forums and HP sites. Also, there were other remarks demonstrating that ageing transgender people used a variety of sources and platforms to acquire information about accessing appropriate care, such as newspapers, the library, and HPs themselves (see Appendix IV).

> (FG5) Clara: *"The first on the* [Victoria-based transgender closed group contact] *list was the electrolysis person who had been dealing with trans people for like 25 years. She knew a lot about it* [recommended healthcare providers and gaining advice via local transgender networks]*."*

(FG10) Penny: *"There are some doctors* [online]*… it's back in the US, but they provide them. So, you know* [the doctors say on the site]*, 'If you are going to* [self-medicate] *well at least do it safely and here's what you should know'."*

3. *Access to referrals, service availability, and good relationships with health providers*

Referrals, needed for entering the assessment process, appeared to be directly linked to HP willingness, knowledge, and good arrangements, or good relationships with HPs. From the reports made by FG participants it was clear that these were key for beginning gender affirmation and gender affirming healthcare. First contact GPs had been particularly helpful in fulfilling these functions. Being connected with such HPs had assisted individuals to pursue assessment pathways to GAHT and GAS, specialised care, and then sustain affordable care or feel safe when accessing services. Also reported were how HPs broadened service availability by being well-resourced or well-connected and providing information for all aspects of gender affirmation, including non-clinical gender affirming needs, such as hair removal. Also, in these reports were participants' explanations of how access to services relied on prevalence and costs of appropriate specialists for diverse populations, as well as duress of waiting lists for HPs and services. Distance and affordability were associated with access to service possibilities. Participants needed to be suitably geographically located to receive treatment, or have the necessary up-front money to cover fees, particularly when needing services for recovery and support. Most commonly, in regarding to fees, participants reported positively where they experienced service cost reduction (e.g., surgery in Thailand), or subsidy assistance. Conversely, one participant commented on Australia being the best value for money (see Appendix IV).

> (FG1) Ellen: *"I can go to my psychiatrist and say I'm looking at electrolysis, right, and because he is experienced with so many other trans people he has a list of people who do electrolysis."*
>
> (FG3) Charlotte: *"I think, in fact, they* [doctor and psychologist] *both came to the conclusion ahead of the 18 months, and I then went on the waiting list for surgery."*
>
> (FG10) Penny: *"I think my doctor really went out of his way to really find the right person. It's that long-term relationship we'd already had that I think helped a lot. Dr XXX put me onto Dr XXX. He is an endocrinologist. He's been treating transgender since the 70's I think?"*
>
> (FG4) Ava: *"I was referred to the [XXX] clinic, and to the psychiatrist, and all the staff. I think they saved my life."*
>
> (FG11) Ruby: *"They* [Aboriginal peoples' service providers] *provide you with all the services. If we have doctors' appointments that have to be made – to have x-rays – they book the appointments and then their transporters pick us up from home and take us to wherever we have to go to. If they can't come back and pick us up, to bring us home, they provide us with cab charges."*
>
> (FG5) Clara: *"I've got a good GP that's really helpful and would listen to me. If I said I want a referral to see this person or that person, they would say, 'Oh why that person?' And, I'd say this or that, and they'd say, 'Yep'."*

(FG3) Charlotte: *"Fortunately, I live in* XXX, *close to the* XXX, *which is one of our more LGBTI inclusive medical providers, and I was able to find a doctor who was (I dare say) sympathetic and informed on gender identity issues and was eventually very helpful."*

(FG11) Ruby: *"The Aboriginal Medical Services is open to providing services to the Indigenous LGBT and gay community."*

4. Access to affordable care

Some participants related their ability to access services to the cost of services. This sometimes meant travelling out of Australia to get the most affordable care.

(FG1) Ellen: *"Thailand is known to be cheaper* [for GAHT].*"*

(FG5) Clara: *"I just thought I would get the best value for money, so that meant doing it in Australia."*

(MG2) Dylan: *"Why I chose the* XXX *Clinic* [for gender affirming healthcare]? *Because it was free! Money was an issue."*

5. Encouragement to transition

Participants described how social connections prompted or encouraged them to access healthcare or provided information that helped understandings of how to access services (see Appendix IV).

(FG1) Ellen: *"I needed someone to say, 'Why don't you?' Then that sort of played out in my mind, and I thought 'wow'. And, then I looked into it."*

(FG6) Rose: *"I had another trans girlfriend of mine who had been seeing this clinical psychiatrist* [which encouraged me to go]*... He did it all on Medicare, which is unusual but, for me, it worked out brilliantly. He was the 'go to' psychiatrist there for any gender individuals, so he had a really good reputation I think."*

6.3   ST3 (T2): Factors Hindering Good Health and Wellbeing

ST3 included the most commentary within T2 from all 19 participants (*N=281)*. The total number of comments was highly variable. Every participant made comments fitting this ST, however some made more than 20 comments, whilst others made less than 10. Topics of conversation and accounts concerned historical and current issues creating barriers to good health as follows:

1. Concealment and experiencing or fearing discrimination and misgendering (prior, during, post-transition)

Eighteen of the 19 participants made comments about social vulnerabilities within healthcare environments and when merging with society, and how this impacts them mentally and physically *(N=76)*. There were many examples of participants encountering stigma, and insensitive or humiliating and discriminative attitudes from others, including HPs. Furthermore, there were instances where participants feared rejection in circumstances where HPs had become aware of their gender transitions. Most typically people knew that once they came out in society, they could not "go back in". Outcomes of suppressing gender identity were reported as non-disclosure, concealment,

misunderstanding, and confusion. Fears of rejection and misperception of gender expressions mostly caused participants to delay and conceal their gender questioning and dysphoria. Loneliness was an outcome of not knowing others and not knowing how to acquire knowledge discreetly. Concealment also negatively impacted participants' experience of health issues by preventing them from being active. Additionally, some also felt that "passing" in public situations was mentally challenging, either because a participant's interaction with others felt wrong in their previous identity, or when fearing that others (i.e., cisgender people) would react adversely. Several participants reported their decision to transition was challenging because it was not made from choice but necessity; for example, if they had a related serious mental health issue. The process of transition resulted in difficulties of being in an intermediate situation. In other words, when outward expressions did not yet match inner identities. This sometimes led to societal misunderstandings, such as being perceived to be butch lesbian instead of a male identifying trans person (see Appendix IV).

> (MG4) Dan: *"It was at least a year of hell. I refer to it as the 'year of hell'.* And, *"I was not a lesbian, I didn't want to look like a lesbian – or be seen as one. It had nothing to do with who I went out with; nothing that I was. And, it was this fear that I would have to go through it. And, I did have to go through it. It was impossible to not end up looking like a butch lesbian."*

> (FG3) Charlotte: *"I guess three times in the last month, has been transmen in hospital being offered bottles for them pee into when they can't, and hospital staff not recognising different physical characteristics of different bodies. That can be embarrassing particularly if it happens in a public environment."* Also, *"Many of our transmen are reluctant to get pap smears."*

> (NB3) Charlie: "[With] *Medicare I had to be male to be able to be on the PBS for testosterone, which meant having to have a letter from a clinical psychologist, and that was an incredibly shaming experience. Not actually getting the letter, which was fine, but standing in a Centrelink queue and having to say what I was there for."*

> (FG2) Abigail: *"Most people say going to female, or to male, because they feel like that is them on the inside. I didn't want to be male. I would have given anything to not be male".*

> (NBG1) Toni: *"If you come out, hmmm, that's all very well for you, but once you come out, you can't go back in."*

> (FG9) *Mila: "I saw people like me in Sydney who I could relate to. It scared the hell out of me, because I knew that, if that was who I was, I was in a lot of trouble explaining that to the world."*

> (MG4) Dan: *"I did not know another trans person on the planet* [that could help me identify my gender issues]. *None. Male-to-female or female-to-male, nobody."*

> (NBG1) Toni: *"If I had been born 30 years later, I would have absolutely been to the doctor, and said, 'listen I want to stop this now'. But you didn't have a choice in those days. I actually ended up conforming, if you like, because in those days, in a country town, on a farm in XXX, it was just unheard of basically, and it was a case of 'make the most of what you have got'."*

2. *Having age-related, co-existing, or secondary health issues*

Participants commented on concerns relating to ageing health matters or co-existing (previous or current) health conditions and how they impacted overall health. Those concerns with a higher

comment per head count indicated participants who had experienced serious health issues earlier in life. Some co-existing conditions meant gender affirming therapies were modified to suit participants' medical issues. Interestingly, no participants were prevented from GAS or GAHT due to other health concerns. However, a few mentioned HP apprehension due to co-existing conditions. Interestingly, even if the health issues that were experienced by participants were caused by the secondary effects of GAHT, the health issues themselves are also experienced by cisgender people (see Appendix IV).

> (FG7) Abigail: *"I've had a few UTIs* [urinary tract infections] *... because of course, quote, my plumbing has been altered."*

> (MG3) Oliver: *"I've almost ended up with Asperger's as a result of it* [stroke].*"* And, *"I've got mobility issues as a result of my strokes."*

> (MG5) Ben: *"I've got Type II diabetes, and high cholesterol."* And, *"My urethra is a wonder; that is, it's not what a biological female's should be.*"

> (NBG1) Toni: *"I do know that the older you get it the harder it is to recover. And whereas, once upon a time I would have loved to have had the male genitalia. Nah – getting rid of one lot of dangly bits, for other bits. Nah – it's not me."*

3. Barriers to gender affirmation

Commentary provided evidence for the range of ways ageing transgender people were, or can be, impacted by gender dysphoria. Some participants related supressing or concealing their identity to being prevented from affirming their gender. Most incidences were historic and arose with participants' gender questioning. Some described how their mental health was impacted; included were feelings of wanting to commit suicide. Others explained how they suppressed any alternative identity feelings, as well as denying or fearing gender questioning. This was sometimes described as a feeling of being absent. Additionally, participants separated some SMI issues from those linked to gender dysphoria; for example, by having a mental health condition as an outcome of the difficulties of being transgender. The variety of reports referred to mental health conditions, such as depression, anxiety, panic attacks, self-harming or suicide ideation, Bipolar disorder, Asperger's syndrome, ADHD, and serotonin syndrome (see Appendix IV).

> (FG8) Chloe: *"You get to the stage where you can't go on fighting your female side* [mentally, against your male side]*, so you end up with two choices. You either do something about it, or, you are probably going to end your life."*

> (MG3) Oliver: *"Lashing out all the time: like a lot of highs and lows, and a lot of anger, and a lot of confusion, and certainly a lot of high and low of emotions; and, it was just a case of just probably total confusion."* And, *"And then, of course, when you start to really think about it, and look around, it was like, 'Christ this is too scary to even contemplate thinking about going down that track'."*

> (MG5) Ben: *"I stumbled by accident on this article* [report detailing the transition of a transgender person]*; and if hadn't, then I probably would've* [committed suicide] *... Because life wouldn't have been worth living."*

> (NBG1) Toni: *"I'd had suicide attempts over my life because I hated the body I was in."*

> (FG1) Clara: *"I just blocked it* [my gender dysphoria] *out."*

(FG2) Amelia: *"My life was based around absent presence. How people are not present by the fact that they are absent."*

(FG7) Abigail: *"*[Some] *people* [develop an SMI because they] *are isolated you know, and they don't have much money, and they can't go out, and they can't do things, and perhaps they don't even have enough money for the bus to go and see the doctor who might bulk bill. We do see people who are staying at home in their rooms, playing video games, withdrawing from society. One woman recently who was in that situation, because she wasn't getting out, she wasn't walking, she wasn't doing anything, she ended up getting VVTs* [varicose vein thrombosis] *because she wasn't mobile at all. You know so, yes, she ended up getting hospitalised for that in the end. Yet that wasn't what she thought she would be doing, by getting out of the house and going to the hospital, obviously. And she is somebody who suffered from, you know, terrible depression and anxiety, and panic attacks, and things like that as well."*

(FG3) Charlotte: *"*[Before transitioning] *I guess, from a mental health point of view, I was certainly very up and down… Well, certainly when I was down, life was too hard, and, it would be easier for everyone if I ended it. And, therefore, there were a lot of sleepless nights, and a lot of struggling at work: a lot of times when it was just awful."*

(MG1) Liam: *"I think I've probably had it* [depression] *since I was a kid. I had a lot of anxiety problems."*

4. *Adverse side effects of gender affirmation processes*

Participants made comments regarding how their health was, or can be, negatively impacted by any side-effects of transitioning (GAHT and cosmetic treatments). Several reports related to mental as well as physical risks associated with their treatments (see Appendix IV).

(FG10) Penny: *"I've just started with IPL* [intense pulse light treatment used to permanently remove hair]. *I don't have many black ones* [hairs] *anyway. They were leaking* [due to infection] *like this last week. You can try and imagine what it's like. I just go, 'yes, yes'. You know, from the day you first start* [treatment]. *And you go, it's terrifying having it on your face. It's just awful."*

(NBG1) Toni: *"I'm pretty sure there's not many people who are older than me that are (transitioning)… Chemicals can mess around with your body. I mean, for HRT, when women on the pill, how much damage are they doing? Do we ever know? The testosterone that a lot of transgender people take, the dosage, what sort of damage is that doing to your body. Again, do we know?"*

(FG8) Chloe: *"The side effects* [of GAHT] *were just being teary. Yes, feeling a bit suicidal, or a bit lonely sometimes. The hormones can really play with your mind."*

(MG1) Liam: *"Doctor XXX says there is a heightened risk of cancer. They recommend, but they don't insist on, that you have a hysterectomy. But since I've just heard of somebody, that is a trans person dying from that, I'm not mad keen on the idea at this precise moment, because it freaked me out."* Also, *"My cholesterol level shot up, not long after I'd started taking testosterone, so I'm now actually on Statins to lower that cholesterol level. But it was not an issue before. What else? Oh, weight gain."*

5. *Difficulties understanding own health concerns and gaining related information*

Comments in this section show how participants were unable to help themselves with health situations. For example, some lacked enough knowledge about gender affirmation issues and the type

of information that would assist it, such as finding age specific help. Other issues were what sort of information to seek from specialist HPs. Also, this occurred when struggling to find information that might otherwise indicate possible health concerns associated with gender affirmation. Typically, participants mentioned online and information validity challenges, as well as social isolation issues. A few reported experiences of not being motivated or caring for themselves. Most comments related to not attending HPs for screening and health checks. Problems for gathering information about accessing services were also discussed by participants in relation to any challenges faced when using the internet or online websites. Difficulties and inexperience with computer technology were common, as was accuracy of advice from online forums and information websites (see Appendix IV).

> (FG10) Penny: *"I don't know where I could go where I could find information that would tell me what I should expect – and give me hints, and pointers, and give me help in how I should behave when I first approach my doctor?"*
>
> (MG5) Ben: *"It's not like you can go through the phone book and go, 'ok, so and so deals with this / that, oh, and transgendered people'. They don't advertise what the speciality is in that way in psychiatry* [and] *endocrinology."*
>
> (FG3) Charlotte: *"Fairly clearly, having grown up through the sixties without computer, without internet, without having access to what it meant to be questioning one's gender – I didn't* [question my gender even though I felt I was different]."
>
> (NBG3) Charlie: *"Seeing that* [Youtube] *video* [of a transman's transition] *planted the seed but I still thought I was too old. I guess because I saw that representation, and all the media representations were of young people."*
>
> (FG3) Charlotte: *"They* [older transgender people] *were struggling to find a medical provider who was going to assist with what they wanted done: and some of them weren't on the internet, so they were finding it very hard to make connections and find out more about their new community. And, so I think for a lot of older trans people it's a struggle."*
>
> (MG1) Liam: *"Well the group online, trans group, did have lists of surgeons. I could go there and get names and try them for myself. They weren't always accurate. One came back, and said no, they don't do that surgery, and I was thinking, 'why are you on the list then'."*

6. Past alcohol and substance issues

Some participants reported coping strategies involved use of substances such as alcohol, smoking, or drugs in past times. Whilst these issues affected their health in the past, commentary suggests that, for most, these issues were not ongoing. Moreover, most participants overcame their addictions well before the time of interview (see Appendix IV).

> (FG4) Ava: *"I used to drink and smoke. It was almost I had a death wish. I just wanted – 'if I can't be what I want to be I will die drinking and smoking'."*
>
> (NBG2) Jo*: "That heroin addiction probably gave me an escape to socially isolate myself."*

6.4   ST4 (T2): Factors Hindering Access to Healthcare

All participants commented on ST4, however there was less commentary overall than for other STs in Theme Two (*N=196)*. Most negative remarks arose from MG participants (*N=16 per*

person [approx.]). NBG people reported a similar number per person, however FG participants made significantly less *(N=8 per person [approx.]).* The volume of participant comments was varied. All MG participants made between nine and 25 comments, whilst females made between one to 14 comments. What is interesting in this section is that the MG participants and any individuals who had been in collaboration with others as an activist, advocate, or support worker, had higher numbers of commentaries. Remarks from these participants included commentary on other people's healthcare access barriers, as well as for themselves.

1. *Health provider access issues*

Service access issues were reported by 16 participants *(N=58)* and their comments were significantly more than even the second topic in this ST. Several participants made multiple comments. The types of service issues ranged from lack of availability for culturally competent healthcare providers or gender affirmation healthcare specialists to long waiting lists. Service gaps were associated with participants' geographical location and housing or assisted care. Some participants from WA (see FG1 below) remarked on the disparity of local specialists compared with Australia's eastern states. Also, service gaps existed because there was a lack of willing HPs; for example, when services only made provision for young people, or because untrained or non-culturally competent HPs could not assist ageing transgender people with their gender affirmation needs. An example of this was cosmetic professionals specialising in laser hair removal (see Appendix IV).

> (FG1) Ellen: *"W*ith *a full facial you see you are not just getting the typical things done. You need an axial skeletal surgeon because they do the bones and stuff."* And, *"You can't just turn up to the local cosmetic surgeon."* Also, *"Services are less available here* [than those] *that are available in Victoria for example…* [such as] *referring clinics / gender affirming clinics…When I was trying to find first contact?* [I struggled] *it's reprehensible in Western Australia.* [In comparison] *when you look up trans and trans doctor* [in the eastern states of Australia] *there is 50 of them* [specialist providers] *in Melbourne, and there are 150 of them in Sydney, and there is 1,000 on the Gold Coast! First of all, you think oh, good grief, how much easier would life be* [to have multiple providers in a region]*? And they are in house… Whereas here, you have to, actually search out meagre pickings* [gender affirming health services] *and then you have to go and do all these other things yourself."*

> (FG1) Ellen: *"I rang up his* [psychiatrists] *rooms. They said he was not taking anyone on. Because he* [psychiatrist] *does solely trans people so he gets very busy. And they said he is not taking any more people on. I and said to myself 'well that is unacceptable'."*

> (FG3) Charlotte: *"Our Indigenous colleagues in Northern Territory find it almost impossible to find an educated medical provider. I'm told that it is almost impossible in Alice Springs."*

> (FG6) Rose: *"Once you start getting over 30 or so, you pay for everything. There's just no easy access."*

> (FG7) Abigail: *"Dr XXXX and his people, who are really good, for a while, they had to close their books because they were completely full."*

> (MG3) Oliver: *"Well generally one of the things that I'd wished was a lot more available is access to speech pathology for voice training."*

(MG4) Dan: *"There's few guys of that age group who are, like me, but even a few years older, who have only transitioned two years ago. So, they are still young in terms of trans years, and they are just mixing in with everyone else. There's nothing for us as 'older people'. I don't know if you got a section for it, but the biggest problem isn't transitioning, the biggest problem is normal medical care – and getting it safely, as a trans person."*

(NBG3) Charlie: *"The surgeon I'm seeing does it on Medicare, so there's a public waiting list. He's the only one in Australia that I know of. It's a teaching hospital and the surgery is done by a registrar. You have to be a NSW resident. The waiting list is about a year."* And, "[LGBTI] *Aged care facilities – there are none, anywhere."*

2. *Gender affirmation healthcare affordability*

Participants explained their personal economic barriers to financing HP. Participants were impacted accessing healthcare economically due to the high costs involved. The below commentary demonstrates what kind of high costs are involved in HP and describes services that have commonly caused participants to struggle to pay without assistance or good funding (e.g., psychiatry, psychology, counselling, surgery, electrolysis, IPL, speech therapy, endocrinology). There were several remarks about health insurance and Medicare subsidies. For instance, there were remarks that these sources of funding did not cover the high costs of care or had been missing altogether. Other commentary explained that other life expenses absorbed the money necessary to access services (see Appendix IV).

(FG4) Ava: *"I can't afford to have any more surgery. I spent a lot of money trying to get rid of my whiskers* [for a more feminine face]*, and all that."*

(MG1) Liam: *"I can't afford a gym at the moment* [to exercise as a way of avoiding weight gain]*."*

(NBG1) Toni: *"It's* [GAS] *not covered any other way unless you've got private health insurance, and they still only pay a fraction. It would have mean taking up private health insurance for 12 months. So that would have delayed having the surgery."*

(NBG3) Charlie: *"I'm a student. I couldn't afford private health insurance* [to assist with HP and GAS fees]*."*

(NBG3) Charlie: *"Well, it's having access to a car, and paying for the petrol. That can be a big expense, and something you have to plan and save for."*

(MG3) Oliver: *"There's only one guy in Australia doing bottom surgery for transmen and you have to allow at least $70,000 and four surgeries."*

(FG6) Rose: *"Unless I win lotto? No way in the world would I be able to afford a hair transplant. It was up to $15,500!"*

(FG7) Abigail: *"I had never actually had any electrolysis or laser because, at the beginning, it was too expensive."*

3. *Mistrusting health providers and discrimination issues*

Discrimination and avoidance of prejudice were mentioned in relation to avoiding healthcare services, particularly when discussing aged care and Accident & Emergency (A&E) hospital units. Participants also reported related experiences of not fitting criteria when trying to access services and how this acted as a deterrent for any contacts with HPs. Additionally, they described how negative

112

feelings about HPs' specific characteristics, such as being unwilling, lacking empathy, or misunderstanding transgender health issues, may have increased their reluctance to access services (see Appendix IV).

> (MG4) Dan: *"There are good surgeons working in the UK, in America, and Serbia … The difficulty is knowing someone in the country, getting into the country, having the funds in the first place, having enough time there for recovery... Our surgeons won't do any work with anything foreign. Like, when you are trying to come back* [from surgery overseas] *you cannot get on the plane to get back, but you can't get any help here. It's not practical. It's not okay. It's* [surgery] *not actually, really, viable for someone my age: from a financial point of view, from a physical point of view, from every angle."*

> (NBG1) Toni: *"I mean, when you have got people who are gender non-conforming, it just doesn't fit in the box. And so, you know, if you are feeling a bit miserable or something because you are being discriminated against a medical condition ... that needs to be medicated."* And, *"The negative one* [example] *would be the GP who kept telling me, 'you've got to take more medication'. I actually changed GPs because I was frightened that she was going to take steps to have me involuntarily committed* [for mental health reasons]. *I was very, very anxious. Physically, my body was constantly shaking, and I was absolutely suicidal."*

> (MG5) Ben: *"It would be nice to not have people, particularly so called, medical professionals – 'ah ok, fine' – who you tell what the situation is* [and] *then they don't want to know. I've made up my mind. I'm not going into a nursing home. Just the attitudes of staff. You don't really know how they are going to react. If you are unfortunate enough to have dementia or whatever (and being elderly of course with all the reports of nursing home abuse and all the rest of it) a nursing home is probably a good a place to try and stay out of if you can."*

> (NBG3) Charlie: *"What most hinders access to healthcare is not fitting criteria. Well, more in terms of technologies."* And, *"At this stage I don't intend to have bottom surgery because I don't think the technology is adequate and I don't like the idea of having huge scars on other parts of my body."*

4. Travel and transport problems

Several participants struggled with transport and travel issues. Sometimes this was due to distance or costs of travelling, but other times due to a lack of transport service provision. Also, some participants' own mobility problems restricted them from accessing services without additional assistance (see Appendix IV).

> (FG11) Ruby: *"Because I've got walking sticks and I've got a walker there it's about the convenience of getting from here to there."*

> (MG5) Ben: *"I will probably say goodbye to lower surgery; because, unfortunately, for most of that you have to travel overseas. Because, I really can't fly."*

> (NBG3) Charlie: *"Well, having to travel so far is inconvenient to say the least… So, it's going to Sydney, or going to Brisbane."*

5. Fear of change, health provider competency, or safety

Participants reported personal issues causing them to be apprehensive about accessing services. Sometimes this was due to life circumstances and fearing how gender transition would impact others. Also, comments related to either doubts in HPs, or the actual process of gaining access;

113

for instance, when travelling away from home and the security of being close to known medical services. Other issues related to the quality and cost of services, such as lower surgery for MG and NBG participants. One NBG participant felt that current technology could not guarantee a successful outcome and even if it was affordable, they would be reluctant to undergo genital surgery. However, they also believed entering an aged-care institution without having undergone genital surgery would increase the risk of discrimination because their genitalia would not match their identity (see Appendix IV).

> (FG4) Ava: *"I'm grappling with that* [joining an exercise group for transgender people] *because I don't really feel like I need anybody else."*
>
> (NBG3) Charlie: *"At this stage I don't intend to have bottom surgery because I don't think the technology is adequate and I don't like the idea of having huge scars on other parts of my body".*

6. *Delays caused by specialist health providers (gatekeepers)*

This topic provides participants' past experiences of hindrances to accessing healthcare provision and being denied a transgender identity by gatekeepers (see Appendix IV).

> (MG4) Dan: *"So, there was no treatment. There was no transition. So, looking for us in a population ... we* [transgender males] *are not there because we weren't given any space to be there."* And, *"The queue to get into a psych, to be able to get hormones back then was (I think it was) nine or ten months."*
>
> (MG5) Ben: *"Most hindered access to healthcare* [historically] *is getting the run around. Having to go to bloody Melbourne every 6 months for two years."*

6.5   Chapter Summary

The combined information provided in this theme (T2) informed this study about what factors ageing transgender people have needed to achieve good health and wellbeing. This is because the participants' quotes commonly gave context to ageing transgender people's lives. Reports on factors enabling good health and wellbeing and access to healthcare (ST1, ST2) were not necessarily direct reports about medical or clinical services. Participants discussed a range of health determinants. Included were many social, economic, geographical, and environmental issues.

Many participants commented more about needing to feel authentic in their gender to achieve wellbeing than relating wellbeing to good physical health. Authenticity received significantly more commentary than other health enablers, such as taking preventive health measures to be well. Commentary regarding healthcare enablers often combined any funding (for healthcare) matters, support from others, and interactions with HPs facilitating access to service. In the related health and wellbeing, and healthcare access (hindering), sections commentary also related to authenticity; however, in such a way that participants being prevented from affirming their gender felt their health and wellbeing was negatively impacted. Likewise, funding (for healthcare), support from others, and interactions with HPs, if negative, are likely factors that hinder good health and wellbeing, and access

to healthcare provision and services (ST3, ST4). As such, health determinants will be discussed and described in more detail in the next chapter: Findings: Theme Three (T3): Resilience enablers or barriers.

Chapter 7.   Findings: Theme Three (T3): Resilience Enablers or Barriers

This theme included a significant portion of the total data collected. Commentary for Theme Three [T3] (*Number [N]=1,266*) made up more than one third of the total commentary.

Not all the data has been presented in this theme. However, because of overlap issues, the data may have been included in the other Findings chapters. Large volumes of information were divided into topic sub-themes (STs) that specifically focused on any important positive influences or negative impacts to participants' personal health and gender affirmation goals. These are: (ST1) *Macro-environmental systems;* (ST2) *Community systems;* (ST3) *Interpersonal systems;* and (ST4) *Individual systems.* The following illustrative material (Figure 6 and Table 4) provides an overview of T3's structure in more detail.

Figure 6: Chapter 7: Theme Three (T3): findings: sub-theme structure
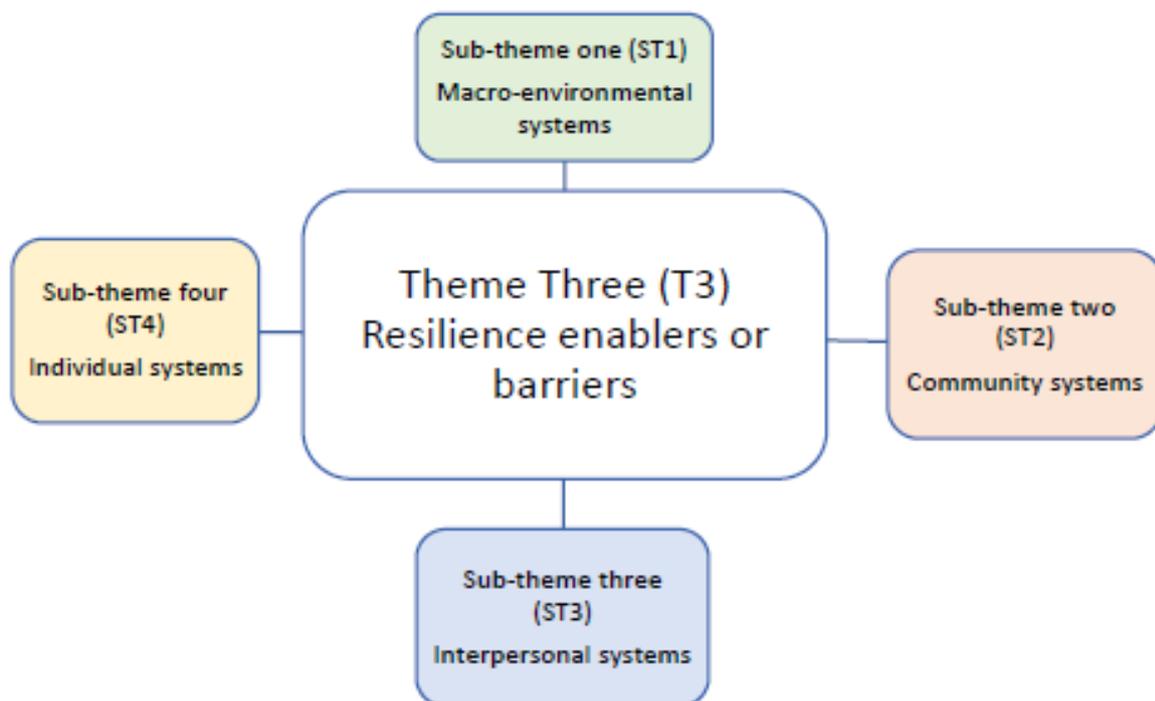
Table 4: Chapter 7 (T3): findings: sub-theme topics

Resilience Enablers			
STI Macro-environmental systems	ST2 Community systems	ST3 Interpersonal systems	ST4 Individual systems
1. Living in well served regions 2. Feeling included & accepted in society 3. Simple pathways to legal changes of gender 4. Educating & training service providers 5. Good healthcare & government systems, management & operations 6. Positive role models & social media influences 7. Employment support	1. Local community inclusivity 2. Cultural competency: health providers (HPs) & support workers 3. Communication with online communities 4. Socialising and psychosocial support from local transgender & LGBTI communities 5. Involvement in trans & LGBTI community organisations, training, and advocacy	1. Families being accepting & supportive 2. Friends that accept, support, and assist with gender affirmation 3. Partners & spouses being accepting & supportive	1. Empowerment 2. Concealment from society
Resilience Barriers			
1. Societal discrimination & misrepresentation 2. Exclusion from health & government systems, support or legislation 3. Funding problems 4. Employment discrimination 5. Aged care fears 6. Human rights abuses	1. Participation barriers (broader communities) 2. Misunderstandings within LGBTIQ groups & community health providers 3. Being misunderstood & not fitting into mainstream employment roles 4. Family-related community problems 5. Community information sharing difficulties 6. Difficulties using public facilities	1. Family struggles &/or rejection 2. Partners & spouses: negative reactions 3. Friendships: negative judgements &/or feeling distanced	1. Gender dysphoria 2. Delaying transition 3. Personal vulnerabilities & resilience issues

Each sub-heading includes illustrative matter providing some evidence for the summaries provided, however not all. Additional quotes, that are relevant and do not simply duplicate those provided in the text of this chapter, are included in Appendix V: findings: (T3) factors enabling or hindering good health and wellbeing and access to healthcare. The related commentary is presented in the corresponding Appendix V titles, sub-headings, and numbered categories.

Each ST was categorized according to factors enabling or creating barriers to participants' resilience and capacities to overcome negative situations. Investigating the relationship between participants' circumstances and any risks of discrimination, marginalisation, stigmatization, prejudice, bias, and other abuses, was particularly important. For instance, the outcomes have supported understandings of how broad health determinants concern all aspects of an individual's private and public life. Examples of how far reaching the range has been include uncovering what apprehensions

people have when living and working in society, and revealing any associated outcomes, such as the compounded or knock-on effect of impacting health and access to services.

Participants' responses were not solely regarding personal experiences. Reports included assisting others (in advocacy or activist roles) and explaining psychosocial and economic impacts of experiences with health providers (HPs), as well as issues with interpersonal relationships and resilience capacities. HPs in T3 included health insurers, Medicare, and the PBS. An example was: *"I had that discussion with the CEO of that hospital in terms of trying to get a better place for LGBTI people to be treated and supported."* (FG3: Charlotte)

ST1 (T3): Macro-Environmental Systems

Macro-environmental systems (*N=371)* impacted or assisted participants in varying ways. For example, individuals had experienced societal discrimination, stigmatization, or marginalisation, but were aware that education and training programs have been put in place to help awareness and inclusivity. Additionally, Australian health systems sometimes unintentionally discriminated against individuals; for instance, by misgendering them in circumstances where there was unforeseen name change issues with long-standing hospital patient identification labelling technologies. Other examples were economic barriers that aggravated a person's situation when Medicare was not offered for services, or when an individual could not anticipate or determine what health funding policies and level of care they might need. The latter may have been overcome by finding the internet very helpful for gaining better insights into sourcing HPs who bulk bill or which health funders had useable policies.

7.1   ST1 (T3): Macro-environmental Systems: Resilience Enablers

Macro-environmental system influences, detailing positive remarks (*N=182)* about what helps people's health determinants, showed less commentary in quantity but a much broader range of categories than its negative counterpart (resilience barriers). Commentary included the following:

1. *Living in well-served regions: support organisations, healthcare provision, and inclusive state legislation*

Participants' comments (*N=41)* were not significantly more in quantity than for other topics. Commentary often related to their viewpoints. These were linked to geographical location and acceptance in society or the resources or services they could access, as well as governmental backing. Examples given were: in regional NSW and Sydney participants related their resilience to experiencing cultural acceptance and Medicare availability; in ACT due to the provision of specific services; in South Australia (SA) due to having political backing and inclusive legislation; and, in WA for providing Indigenous services catering also for LGBTI non-Indigenous people. Several

participants also talked about past or present involvement in, or use of, larger scale community support and how these were able to help them in respect of social health determinants. Most helpful were support systems such as communication forums and education systems to support transgender issues and influence reforms. Examples of recent resilience enablers have been amendments to birth certificate or marriage legislation, or raising awareness of issues that required governmental attention, such as Indigenous diversity affairs (see Appendix V).

> (NBG3) Charlie: *"*[NSW has] *the largest LGBTQ population outside of the Capital Cities. So, generally, trans people are probably more accepted here than in the other regional areas… I think because there is a large population; and also, a large politically active population. That's not just with Queer politics, but with all sorts of politics... It's just a sort of area that's really vibrant and vocal, right, so there's lots of events throughout the year. There'd be lots of events that cater for the LGBTQ community."*

> (FG7) Abigail: *"*XXX [support organisation] *have also done a lot of work with getting laws changed, (X) on passports, (X) on birth certificates. So, they do a lot of stuff at the legislative level."*

> (MG4) Dan: *"The* [Victoria] *State Government has mental health care area of funds that has been given to an organisation on* XXX *that run a program they call* XXX *and I've been to get funded counselling by people through them who actually do understand trans, so it's a good service, and it isn't costing me."*

2. *Feeling included and accepted in society*

Nearly all participants described interactions with society and how positive experiences helped overall wellbeing. Societal acceptance was reported as helpful during transitions. Examples included not feeling harassed or conspicuous whilst moving around in public spaces and trusting that younger generations would be more accepting. Some participants felt supported and encouraged by others around them generally. Also explained was how raising awareness helps the community as a whole, for example with research (see Appendix V).

> (MG3) Oliver: *"All my own* [current] *generation* [have been very accepting]. *Probably 95% are all like, 'about bloody time you did it' and 'congratulations'."*

> (MG2) Dylan: *"No-one had a problem.* [However, in society] *I get treated differently by people.* [Mostly] *differently by other men. That was weird!* [Since transitioning] *I get more respect, more comradery."*

> (FG6) Rose: *"As far as buses, trains, and so on, I think once you sit down there nobody actually looks anymore anyway basically."*

3. *Simple pathways to legal changes of gender*

Commentary detailed how gender markers were changed on legal documentation in some jurisdictions prior to Australian state legislation revisions. Several participants expressed relief that reforms have since changed legislation prohibiting identity changes without GAS. Some also described how they went about changing their identity by gaining permissions through a Gender Reassignment Board. Other topics were changes of gender labels or codes in hospital systems, Medicare, the Australian Tax Office (ATO), passports, and Births, Deaths, and Marriages registries

documents. Some changes were completed in person or on the telephone and related comments included positive interactions with administrative staff. One NBG participant had not changed their name, only their gender, and felt good fortune in undertaking a less arduous process than other transgender people. Another case described was that holding citizenship certificates also helped with providing identity without any gender complications (see Appendix V).

> (FG7) Abigail: *"When I got my citizenship certificate, it doesn't have a gender on it. That was a fantastic help because it meant that I can use that in a lot of cases, rather than birth certificate. So that helped with other changes of documentation because, you know, the hundred proof of identity documentation thing that you need to do for bank accounts etcetera."*
>
> (MG5) Ben: *"My GP is on the board for the reassignment committee. It was good. It was a comfort when I actually knew."*
>
> (NBG3) Charlie: *"Because I wasn't changing my name, all I needed was the letter stating that I was male gendered, and to change it on my Medicare record straight away. If I was changing my name it would have been more complex, I think. Like a birth certificate or change of name document."*

4. *Educating & training service providers: health, aged-care, and support*

This topic differs from the previous topic because it specifically relates to the education needs of organisations, institutions, and society, as well as showing what challenges transgender people face, and can become resilient to, in daily life. It also provides information about educational or training activities that have helped transgender people. What is important about this section is that the voices are from ageing transgender people themselves explaining some most effective ways to help all of society understand transgender people. These include funding for education, platforms for presenting programs, aged care sector needs, addressing discrimination bias in services, and detailing how programs in schools relate to understanding all transgender people (see Appendix V).

> (FG9) Mila: *"I've got* [transgender] *friends, who I work with actively. Who I try and help through it* [gender affirmation: GAS, GAHT, social transitions]. *They are often in tears because, for whatever reason, they are not comfortable. You know, they might not feel comfortable with their face, with their body. They might be tall, they might be … whatever they might be, whatever their issues are, they are struggling, so. The training of all nursing staff* [should enable nurses] *to be able to understand how to identify and treat a trans person, or any LGBTI person, but particularly trans persons with care and dignity."*
>
> (FG10) Penny: *"I was failing in how I was going to tell my son. And, my son came home, and we were playing in the swing, and he said, 'I'm going to change my gender'. And I realised how he must have had the Safe Schools thing because he was talking, sort of, you know, what's that about? And so … and I said, 'Oh, well you know what? I am changing my gender'. And, he said, 'Really?'."*
>
> (MG4) Dan: *"We* [an organisation] *are providing* [education and training] *services into the family violence sector."*

5. Good healthcare and government systems management and operations

Comments for this topic were also highly relevant to how people were enabled to access care; for example, when accessing government screening programs. Comments also related to inclusive and culturally competent behaviour from HPs and other health related organisations such as Centrelink (see Appendix V).

(FG1) Ellen: *"They don't (call out my male name) now because I've changed my name, but until you do* [the appropriate legal name changes] *there is an impetus. They can put a serial number next to it* [on your medical documentation] *(and that's a lucky dip). Now they call out my name, because that is my name."*

(FG7) Abigail: *"I got a bowel cancer testing kit from the government* [allowing non-invasive and easy access to healthcare that would otherwise be challenging to undergo in mainstream service provision].*"*

(FG10) Penny: *"The first time the Centrelink staff member called out my name, 'Miss XXX,' I thought, oh there's another Miss in here. And, yeah, I just didn't expect it. It was a really, really – it was fantastic! That's that name official. You know, my preferred name is used as my official name, which is great."*

6. Positive role models and social media influences

The comments included below demonstrate how several participants' wellbeing and identity questioning was helped by discovering role models in the media. Examples of such role models were public figures, such as politicians and authors, or young people who had been documenting real-life transitions online. These were people who transitioned and live(d) in the mainstream, meaning the participants could relate conceptually (see Appendix V).

(FG3) Charlotte: *"At the time I transitioned, there was a New Zealand member of Parliament who was a transgender person – Georgina Beyer – and my New Zealand colleagues identified with me much more than my Australian colleagues because they knew about this member of Parliament, who was trans, and doing a good job from a community point of view."*

(NBG3) Charlie: *"I saw a YouTube video – a young person* [trans man] *who was documenting their transition on You Tube ... If I was younger that could have been me."*

7. Employment support

Participants explained how employers and workplace management accommodated diversity. Adopting inclusive company policy strategies and supporting gender affirmation helped people mentally, psychosocially, and economically. Examples described companies employing a psychologist to assist participants and staff and using situations to reinforce diversity policies (see Appendix V).

(FG7) Clara: *"He* [my manager] *said, 'You talk to the psychologist who actually specialises in helping companies with transitioning'... I talked to my manager. He talked to her, and she* [the psychologist] *said, 'Well, I do help companies do this, and it will cost (this much)'. And, she told them how it all works, and gave a talk to the other employees."*

(FG3) Charlotte: *"The company used my transition as a reason to reinforce their diversity policy."*

7.2   ST1 (T3): Macro-environmental Systems: Resilience Barriers

This ST shows any negative challenges and problems people faced (*N=189*) when dealing with organisations, government and associated agencies (e.g., Medicare; Births, Deaths, & Marriages), and general society. Commentary included the following:

1.   Societal discrimination and misrepresentation

Participants' commentary for negative issues (*N=71*) related to societal attitudes and behaviour towards them, which impacted broad health, such as social, mental or physical health. Some participants reported negative societal behaviour including being misgendered or people using derogatory terms, as well as being feared, feeling unsafe, being threatened or touched without giving permission, lack of acceptance, and being misrepresented (e.g., being accused of self-mutilation). Most participants encountered discrimination with organisations. This was reported for situations where they experienced negativity whilst attending services (e.g., beauty therapy, Centrelink) or being exposed by others in general population environments, or lack of inclusivity when trying to gain legal or identity documentation. Another way participants felt troubled was by media presentations and high-profile people misrepresenting their situations (see Appendix V).

> (MG4) Dan: *"We still have discriminative law differences that lesbian and gay people* [LG] *don't, and health to the same degree. There is a whole list of things that make our lives different and difficult."*

> (FG11) Ruby: *"The one I absolutely hate is Queer… It was derogatory term and people got bashed for being that way – being gay you know. They were referred to as Queers, poofters, and all those horrible names… It's okay for people who live in safe environments to say, you know, 'I am queer'. That's okay, but, if you are in an environment where you are at risk, you don't do that sort of thing you know?"*

> (MG3) Oliver: *"The position of a man in society (bio-males as I prefer to call them – like in cis-males)? You know, because they are first in-line for the pecking order there is that order – acceptance and stuff – and if you get outed as a trans man, you end up in this void space where you are not seen as a woman, but you are not accepted as a man either."*

> (FG3) Charlotte: *"We had comments that the whole aim of the* [birth certificate] *legislation was to enable men dressed as women to go into the women's toilets and rape and pillage young people. Effectively, likening us to paedophiles."*

> (MG3) Oliver: *"I ran into probably the worst case of transphobia / homophobia at the XXX store, and that matter is before the Human Rights Commission in Victoria. I needed to get a new SIM card issued for my phone… I said, 'Yeah, the name needs to be changed,' and he said, 'I can't accept that,' and I said, 'Well would you please just go and get the manager'. …. About five minutes later this manager came out in public, and bellows out for everybody to hear, 'So, you've had a sex change operation?'."*

> (FG11) Ruby: *"As a sister girl, the healthcare organisation* [that] *was available to me but weren't able to accommodate me as an Indigenous Person."*

> (FG9) Mila: *"We are still treated as second or third-class citizens by a lot of people."*

(NBG3) Charlie: *"Managing my pronouns with documentation is a pain in the bum. At university, I told them that my title was Mx. And, they said, 'Oh we don't have Mx in the system, we will just leave you untitled'. Well, I think they should have Mx in the system."*

2. *Exclusion from health and governmental systems, support, or legislation*

This topic details what challenges and obstacles participants encountered when dealing with Australian healthcare or government legislation. These occurred when there were gaps in the system that undermined their ability to be resilient. One example given showed that social systems had not been protective of individuals whilst undertaking gender affirmation processes or attempting to make changes to their gender. Moreover, some systems had not accommodated participants' needs due to: lacking government support; lack of support for community incentives; issues with criteria specifications (e.g., mental health diagnosis); health system approaches; and, health system discrimination (see Appendix V).

(FG1) Ellen: *"Someone will change it* [your name], *and not pass it down the* [administrative] *line. Within the hospital service people don't know how serious it is. That is your problem… It can be like a drip torture – and you are dealing with so many people and so many organisations that the stress becomes accumulative, and I've found that on the smallest of occasions that the smallest thing can set me off, and I get quite, not aggressive or hysterical, but I get very upset* [and] *at that point I have been sick. I've gone through all of this, and I tell you it is considerable, to change your identity with everybody that you ever have to deal with. You don't realise how many people – the library, the paint shop – twenty, thirty, forty people – and there's departments* [you have to change your name or gender with] *within that* [each organisation].*"*

(MG3) Oliver: *"*[Having a disability decreased my ability as I age and must consider housing options and stigmatization] *Even with the disability one of the issues about public housing, for example, if I wanted to go and get accessible housing, I'm going to be stuck in a high-density complex, maybe stuck in one bedroom with unknown people around me so… There are* [housing] *affordability issues across the board regardless of what demographic you fit into."*

(MG4) Dan: *"I realised the Government didn't realise that some of the biggest users of testosterone were in fact trans men. They didn't know that, and letting them know that could, in fact, get us struck off completely. Because, if you've got the drug through the PBS for a particular cause, or use, they can say they won't fund it for any other use. And, my* [hormones] *on 'other use' was for testosterone."*

(MG4) Dan: *"Breast Screen XXX has told us that they are funded as a women's service only, so if you've changed your Medicare Card, that they are not interested in you."*

(FG10) Penny: *"We need more help than the young kids. We* [transgender parents] *are the ones made homeless, with children… But we get left behind."*

3. *Funding problems*

More than half the participants reported funding problems for the high costs of gender affirming healthcare or other gender affirming needs, such as clothing. Financial issues specifically related to being deterred from overcoming obstacles, particularly for transition procedures. Most comments were associated with the expense of health insurances or Medicare assistance being insufficient to meet needs. Moreover, the expense of transitioning had impacted some participants in age-related ways. Examples given were having: to use all their financial resources and reducing funds

needed for later life issues; to sell all one's possessions and homes; to endure long-waiting periods whilst gaining funds for healthcare; or, fear of losing anything that provides economic stability (when coming out). Health insurance was a significant issue for several people. For instance, with affordability issues surrounding policies or penalties incurred whilst not having enough income to pay into a health fund. Some participants explained how they were impacted by heavy insurance penalties and having to pay huge premiums to avoid consequences of discrimination in services such as aged care (see Appendix V).

> (MG3) Oliver: *"You really could see that there could be so many hundreds of potential scenarios. You know, things could go wrong. You could lose your house; you could lose your job."*

> (FG10) Penny: *"I don't know how I will pay for it now. I had a fund. I had a tax-free fund in the Isle of Mann. But I spent that on the mortgage."*

> (FG9) Mila: *"Oh, it's a nightmare for all of us. I mean it took me a lot of money. I sold everything I owned."*

> (MG5) Ben: *"You just have to hope they bulk bill, otherwise they charge an arm and a leg. Two to three hundred dollars ($200 - $300) if not more. And you don't get very much back from Medicare."*

> (NBG1) Toni: *"When you become unemployed you can't afford to have health insurance; and then, if you find any employment again – if there has been gap – they hit you with this whacking great big (what do they call it?), it's like a penalty. So, your premiums are effectively double what it would have been if you hadn't had the gap."*

> (MG3) Oliver: *"I can't get private health insurance because of my pre-existing conditions, and because of my age the penalty loadings are just – you know, over 50."*

However, there were clearly other expenses as exemplified by this comment:

> (FG8) Chloe: *"Clothes and shoes! Shoes are expensive. I've got bigger feet, so shoes are very hard to get here. I was spending $250 or $300 for a pair of sandals like this!"*

4.   Employment discrimination

Participants reported discrimination issues impacting employment opportunities. Applying for jobs, gaining interviews, and attending interviews presented challenges such as facing rejection, hostility, and being ridiculed by prospective employers. These forms of discrimination negatively impacted participants' capacities to make economic progress in life, as well as reducing resources needed for funding expensive gender affirming treatments (see Appendix V).

> (FG2) Amelia: *"Another phone interview,* [I attended for a job] *packing surgical supplies for theatres. I voluntarily spoke, 'I'm transgender,' and didn't get a call back basically. Not interested. I went to a nursing home, near where I am, delivering meals to people's beds, and taking them away. In fact, they kept saying, 'Do you have any other medical conditions you wish to report to us about?' And I said, 'No', and they would ask it again, 'Do you have?' And it happened about three or four times."*

> (FG7) Abigail: *"Once I started affirming my gender, I couldn't get a job in* XXX [a large Australian city] *because it was well known* [that] w*hen you are affirming your gender it's not something you can hide. You know, you look … So, that was obviously a barrier."*

124

5. Aged care fears: stigmatization and abuse

Several participants commented on fears and concerns about aged care, particularly after witnessing others' experiences in institutions. Included were doubts about aged care workers' awareness and knowledge and fearing a lack of acceptance in care situations. One participant involved in advocacy witnessed overt prejudice from politicians who lacked cultural competency and understanding of ageing transgender people's care needs in later life (see Appendix V).

> (MG5) Ben: *"Nursing homes, at least until I've had downstairs* [lower surgery / phalloplasty] *taken care of, even if it's only the metoidioplasty on its own and it's only, maybe about that long* [a small measurement]. *As long as it* [penis] *functions, which it will. Be a lot easier than having the wrong bit, particularly if you need assistance with bathing. Be a bit strange to look male from here to there; but, to there and just have that part that doesn't correspond with the rest of you. I would hate to imagine what could happen. Possibly discrimination, God knows what else. Elderly abuse."*

> (FG3) Charlotte: *"I think it's appalling that the commitment to LGBTI ageing is waning with this term of Government. We have about 60 percent, maybe more, of LGBTI people not wanting to disclose that they are when they are accessing aged care service because they will be treated in an inferior way."*

6. Human rights abuses

The final category in this section demonstrates the human rights abuses and fears people encounter when accessing any health or non-health service (such as healthcare, employment and social places). Discrimination, marginalisation, and stigmatization were feared because of the negative impact of their intersecting minority status and impacts on participants' health and health determinants.

> (FG11) Ruby: *"We are Indigenous people first. We have the problems that mainstream Indigenous people have, first and foremost. Then we have the problems that come with being LGBTI, whilst we are fighting for our rights as Indigenous people."*

ST2 (T3): Community Systems

In ST2 participants' reported how communities have impacted their health determinants and enabled or hindered their capacities to be resilient. Comments relating to positive and negative community systems (*N=269)* were often associated with being ageing transgender people. For example, not all participants established relationships with GPs or LGBTI communities in a desirable or useful way for assisting with the specific intersection of ageing and gender affirmation health needs. In contrast, others may not have acquired knowledge without the specific help or resources of HPs or transgender specific support groups. Participants often gave contextual explanations about relationships with HPs or workers and how wellbeing was impacted as a result of negative or positive interactions. Negative issues, such as exclusion or lack of willingness and knowledge were only included in ST2 if they were not relevant to other sections (e.g., enabled or hindered good health and wellbeing or access to healthcare). Also, family, friends, LGBTI communities, or work colleagues

were included in this sub-theme if the circumstances described were explained in relation to wider communities such as hometowns, online forums, or employment.

7.3   ST2 (T3): Community Systems: Resilience Enablers

This section provides important evidence of how positive community systems helped ageing transgender people (*N=154)*. This component of the participants' health determinants was significant because there were almost twice as many positive comments made than negative ones. The evidence suggests supportive community systems are important for participants' broad health. Commentary included the following:

1. *Local community inclusivity (including workplace & organisations)*

Comments in this section were only moderately higher (*N=41)* than other most commented upon topics in this ST. Most remarks related to interactions with the public or colleagues in the workplace. They reported the various ways in which people have been accepting, supportive, respectful, and inclusive. For example, some participants talked about ways they have been helped prior, during, or after transition; or, have been defended in situations where others have wanted to be abusive. Other similar descriptions related to demonstrated inclusivity from sporting clubs, supermarket staff, hobby groups, and local residential places (see Appendix V).

> (FG1) Ellen: *"Everyone who I've met* [since my transition]*, and spoken to, in small businesses or services, and things like that: the ladies at the bank, all those things, they've been fantastic. They've been really, genuinely, accepting and inclusive."*
>
> (FG2) Amelia: *"The two clubs I'm at now doing* XXX and XXX [craftsperson skills] *are very positive. Occasionally I have been misgendered, but they instantly said sorry."*
>
> (MG2) Dylan: *"[My boss] has not even misgendered or misnamed me since* [coming out]. *Same with my co-worker… I only had problems with one customer and my co-worker actually stood up for me and told him to pull his head in basically."*
>
> (FG4) Ava: *"There were XX flats in my group of flats. I printed a letter for every tenant in the group that knew me, so they knew me. I said, 'This is me; I'm going to be* [female name] *from now on, and if you see me around in dresses and what have you, you will know what is happening'. So, I did that. They all responded pretty good."*

2. *Cultural competency: health providers and support workers*

Many participants talked about how they were helped by the positive, respectful, and inclusive behaviour of local HPs, other providers, and support workers (e.g., counsellors, assisted living workers, volunteer companion workers). Some described direct contact experiences; for example, when receiving help from their child's school counsellors. Other descriptions generally concerned the overall knowledge levels and good nature of providers, as well as welcoming service provision environments (e.g., receiving home assistance from culturally competent care workers). Forming good relationships with GPs was common. Additionally, some psychiatrists and counsellors

were willing to uncover pathways to other providers. Finally, participants described how interactions with HPs have helped build confidence to progress (see Appendix V).

> (FG11) Ruby: *"My doctor is great, but also, I've got to say this – about the other doctors that work with him – that they have to want to work with Aboriginal people. So, that is what our Aboriginal medical service provides. So, it's a safe environment for me, which is important. If I didn't feel safe as an LGBTI trans person I wouldn't go there."*

> (FG7) Abigail: *"She* [psychiatrist] *said, 'Oh you will make a very presentable woman'. Well, I felt good about that, at the time, because I was right at the beginning of my journey. So, I was very unsure of myself at the time."*

> (FG10) Penny: *"I'm actually seeing the school counsellor next week* [about my child and I's circumstances and transition]. *They were having a good laugh, but they have been fantastic in supporting us with what we've been going through."*

> (MG4) Dan: *"The doctors have been instrumental in helping us* [form community support systems].*"*

> (FG7) Abigail: *"*[We have] *our local transgender support group for gender diverse and intersex people to, so they can provide a lot of help, but they tend to provide more help for people who are more in crisis, I suppose, or, who might be having terrible problems with family or might need housing, accommodation, and things like that. And, generally it's people who are the beginning of their journey. So, they do a fantastic job."*

> (FG2) Amelia: *"I have* XXX [transgender related support services]. *That is a monthly meeting. I've been going to now for three or four years. And there is* XXX [transgender related] *community meetings which I have been going to for a few years."*

> (MG4) Dan: *"I was very lucky to be in a supportive clinic. They were working through the problem with me rather than, sort of, throwing up the reins and saying, 'No'."*

3. *Communication with online communities*

Participants described how contacts with online communities have helped with overcoming potentially difficult situations. This was particularly associated with avoiding having to ask for sensitive information in face-to-face situations. Most, but all not all, commentary involved transgender specific communities. Many used Facebook as a platform for communication. The information shared through the internet related to all areas of health determinants, such as where best to live as a transgender person, or where someone could find assistance in a crisis, as well as much needed information about transgender specific services. Participants further told of ways in which online community group support and social forums can help with providing much needed companionship. This was particularly relevant to experiences where gay or LGBT community groups failed to be supportive. Participants also explained the significance of validating service providers, obtaining ideas, and counselling (see Appendix V).

> (FG7) Abigail: *"*[Our secret Facebook group] *we run a series of contact lists for GPs, counsellors, hairdressers, makeup artists – whatever you need – at gynaecologist, surgeons, etcetera, the whole works."*

> (MG1) Liam: *"I got a lot of* [surgeons'] *names* [and support] *via the* [community] *guys online. As in, 'So and so is good', or they knew someone who had seen this other person."*

(NBG3) Charlie: *"They were really supportive actually in those* [Facebook and Google] *groups. You could ask really dumb questions and people didn't mind answering you."*

4. *Socialising and psychosocial support from local transgender and LGBTI communities*

Discussions concerning wellbeing revealed how participants protected each other or understood personal identity and needs through others. This often occurred when attending safe community social spaces or talking and learning with others via support groups. A good example of this showed how a local community helped individuals experiencing financial difficulties with a breast binder exchange program. Participants also recounted ways in which social health determinants, such as belonging or meeting with LGBTI communities, helped them in the past or in current times. Some found that interaction with any groups identifying within the LGBTI spectrum or in minority groups was an inclusive experience and/or helped them to feel safe. For others, relating to all LGBTI people helped understanding their own diversity. One participant talked about the future and needs for LGBTI workers in community specific aged-care services. (see Appendix V).

(FG3) Charlotte: *"We, at social events, at the club nights, we were in a library hall that was very secluded and safe."*

(FG11) Ruby: *"We do not, unlike our non-Indigenous Sisters, for the most part, we do not necessarily seek to undergo gender-reassignment. But, some of us take female hormones (estrogen mainly) and some of us have breast enlargement. Otherwise we are comfortable as you saw me. We are spiritually enhanced* [and] *do not think that it is necessarily important. In some instances, we just dress up for special occasions."*

(MG4) Dan: *"When we set up* XXX, *the support group, one of the things we put in was a clothes exchange and a binder program. So, we now have guys who – when they have their surgery – donate their binders, because they don't need them anyone. And, we give them out free to new guys."*

(FG3) Charlotte: *"[For later life planning] we've got many nationalities* [within our LGBTI network], *and people who are interested in sustainability; who are interested in health; who are interested in community; so, we see that as being the best thing we can do for our future together."*

(FG11) Ruby: *"We have our own hotel if you like – if that's where you need to go anywhere – you know, where it's LGBTI safe."*

(NBG3) Charlie: *"Because it is a regional area and small, there aren't that many events specifically for trans and gender diverse people* [but] *there isn't a lot of animosity between sexuality and gender identities."*

5. *Involvement in trans and LGBTI community organisations, training, and advocacy*

Participants provided evidence of the contribution they, and/or others, have experienced through involvement in LGBTI and specific transgender matters. Involvement had also helped non-LGBTI people to understand individual needs, challenges, and health determinant issues. This had been particularly relevant to ageing issues (see Appendix V).

(FG7) Abigail: *"[The training program we deliver is as follows:] It's statements that are backed up in biological fact, etcetera. Intersex people, transgender people, gender diverse people; we've been here forever, throughout human history. It is not something new."*

> (FG1) Ellen: *"He* [employer from LGBTI support organisation] *said 'We can employ you because of who you are. Working will contribute to our people, the support group'."*

7.4   ST2 (T3): Community Systems: Resilience Barriers

This section, detailing how community systems have caused barriers and impacted participants' resilience in negative situations (*N=115)*, presents accounts of the most significant issues impacting their wellbeing. Information includes the following:

1. *Participation barriers: broader communities (general societal, all age trans, LGB)*

Participants' commentary (*N=41)* reported wellbeing as negatively impacted when being prevented from attending community events or involvement. Examples were being isolated from other ageing transgender people and transgender community or support groups only catering for younger generations (or being absent altogether). Other difficulties within transgender communities occurred due to a lack of agreement. Other issues raised were rejection from LGB people, families, and religious groups, and prolonged periods of encountering disrespectful behaviour from social groups (e.g., misgendering) (see Appendix V).

> (FG2) Amelia: *"I thought I had the support of my church, but when I transitioned, they didn't want to know – they weren't interested in having me. One of the members sent death threats to me."* And, *"I was involved in another sports club. Even after I'd been there twelve months, they were still misgendering me and still basically thought me as a male in a female outfit."*
>
> (FG3) Charlotte: *"For the majority of these* [older transgender people]*, they were struggling with being rejected by their families (because they were doing something about their gender identity).* [Additionally] *They were struggling to find a* [local] *medical provider who was going to assist with what they wanted done: and some of them weren't on the internet, so they were finding it very hard to make connections and find out more about their new community."*
>
> (MG1) Liam: *"I forget what the cut off age is at the* XXX [transgender support] *Centre… I'm too old to qualify, so I haven't been."*
>
> (MG2) Dylan: *"The trans community, I didn't have much to do with* [when I was affirming my gender]*. And, the gay community didn't have much to do with the trans community either back then."*
>
> (NBG1) Toni: *"It's* [support group] *supposed to be for gay women, and they are supposed to be welcoming of transgender people, but I have found that I am an imposter."*

2. *Misunderstandings within LGBTIQ groups and community health providers*

Some participants shared opinions on how broader community LGBTIQ groups, or individuals associated with those groups (including health providers), impacted their resilience in social situations. Often negative situations arose from a general lack of understanding or lack of interest in transgender issues. Such experiences reduced participants' resilience and means to cope by preventing them from addressing social, health, and gender affirmation issues. Moreover, one health professional had aggravated misunderstanding issues for all transgender people by misinterpreting and rejecting transgender patients' issues in published medical literature. Some participants further

reported that their transgender or race specific issues were misunderstood or misrepresented by other associated groups, such as LGB people or drag queens. Repercussions included discrimination, marginalisation, stigmatization, or bias (see Appendix V).

> (NBG2) Jo: *"I said* [to the doctor]*, 'I don't fit into this group of people and I don't want these things on my chest, and I think I've got gender dysphoria'… She would say, 'don't be ridiculous'…* "That doctor wrote a paper [which undermined my belief of being gender diverse and] *which profoundly affected, not only my well-being, but how other doctors saw me"*. And, "h*aving that past addiction. She* [doctor] *couldn't get beyond that."*

> (FG11) Ruby: *"They* [LGBTI specialised healthcare provider] *cannot understand the black person, if you like, who is also gay and transgender, or LGBTI."*

> (NBG1) Toni: *"I guess a lot of people are not ready and even some, in the division we conditionally call the gay community of lesbian women, have this bit of an attitude towards transgender that they do not understand."*

> (FG10) Penny: *"Drag Queens might be an issue because I think they are a demeaning parody of true feminine beauty."*

3. Being misunderstood or not fitting in to employment roles

Participants described difficulties associated with outward expressions and being visible in society. Negative impacts that have been detrimental to their social wellbeing arose from non-intentional and intentional discriminative practices. For example: experiencing the challenges of wearing ill-fitting uniforms; or alternatively, encountering hostility and rejection; or, being marginalised by colleagues and management staff to the point where employment has no longer been possible. Also described were the difficulties of gaining employment in the same industry following gender changes, such as obtaining referees (see Appendix V).

> (FG4) Ava: *"I had to wear the whole bizz uniform* [in my previous job]*. Now, I have to wear this, but I don't wear a bra. I probably should but I can't find one that is comfortable."*

> (FG8) Chloe: [Speaking of stigmatization within her workplace and colleagues thinking of transgender people as having a contagious disease] "*Quite a few of them don't want to get too close to you because they are worried about catching the disease. As far as they are concerned it's a disease.* [For example] a *lot of them also think it is some sort of sexualised fantasy we are going through."*

> (MG3) Oliver: *"I've cracked a job interview and excuse my French, but I am actually shitting myself. For the first time, I'm going to present for interview as a cis male in this new identity, back into my old professional field, and try not out myself. But then, trying to find referees! People who will support me, and who can stand up and say, 'HE….' – you know – use the correct pronouns that call me by correct name if I need referees."*

4. Family related community problems

Some participants had negative experiences with wider communities, such as education or family-related, or key individuals in family-related communities who might otherwise have assisted them to overcome any social obstacles involved in environments such as community events (see Appendix V).

(MG4) Dan*: "We (my son and I) had social problems with my transition because he was still trying to go to school. Like, there was no words for it. We would go to pick up … if you pick up a child from school, the other kids ask, 'Who is that?'. And, he can't say 'my dad' because he has already got another dad. And I said, 'Well, some kids have two dads these days,' and he said, 'Yes, but that makes my other dad gay and he's not, and I don't want to do that'."* And, "*So, it actually is very difficult for people with children to find a language that works. The minute he left school the problem was gone.*"

(FG9) Mila: *"I was always a laughing stock in terms of everyone that he* [my son] *was around. It was horrible because, then, I used to take him to soccer; I used to take him to cricket; I would take him to football. I ended up coaching his teams, which made it even harder."*

(MG3) Oliver: *"Well, when you started thinking about the bigger picture* [and gender affirmation], *like how would your family handle it, how would your work handle it, what sort of … because there was still a lot of discrimination (though mainly covertly) towards the lesbian and gay community."*

5. *Community information sharing difficulties*

Participants shared some important challenges encountered when gathering information about medical and social transitioning, and other transgender health matters, from community sources such as online forums. They reported difficulties in finding information from others, for example from secret Facebook groups, and distinguishing accurate from inaccurate information, or providing warnings regarding negative surgical outcomes (see Appendix V).

(FG5) Clara: *"There's always a lot of information there* [online]. *It's always difficult to sort through the facts and the fiction."*

(MG3) Oliver: *"*[Transgender] *people don't talk about their surgery when it goes wrong: and there is a lack of support, understanding, networking."*

(MG4) Dan: *"The internet is a great thing, but people do tend to need to be on Facebook… But then, because they are secret groups, they are not searchable on the internet. So, you go around-robin(ing)* [going in circles] *all over the place. Having to be open enough that people can find you, and closed enough that you are safe?"*

6. *Difficulties using public facilities*

This final topic reports a community that creates challenges for some participants and have difficulties overcoming stigma and prejudice in local public situations. Whilst there were only three comments, this point was important because it concerned not being able to use public facilities, such as changing rooms and toilets, and thus, impairs people's freedom to be out and comfortable in society (see Appendix V).

(FG5) Clara: *"They* [the gym] *need a change room, especially* [for] *pre-surgery* [transgender people]*, it's a bit of a worry."*

(FG9) Mila: *"I'm very sensitive of mums if they are in there* [toilets] *with their kids. Because I understand what they are going through, and I don't want to be called out by a little 3-year-old, who goes, 'Mummy, what's that man in a dress doing in the toilets?' Which is a perpetual fear of how you think you are going to pass or whatever. There is that horrid fear the whole time. So, that's a challenge from hell."*

ST3 (T3): Interpersonal Systems

In interpersonal systems participants reported both negative or positive impacts caused by informal and direct interactions within their families and elsewhere (*N=312)*. Commentary detailed how participants' interactions and relationships with those not associated with larger groups or organisations affects their determinants for health. Topics were grouped according to interactions with partners, family, close friends, close contact HPs (e.g., GPs). The only difference between positive and negative reporting was that friends helping participants received more commentary than partners. This contrasted with partners being more likely to create barriers for participants to overcome negative situations than friends. STs are presented accordingly to show reports below.

7.5   ST3 (T3): Interpersonal Systems: Resilience Enablers

Participants gave descriptions (*N=165)* of how close family, friends, partners or spouses, and close contact professionals, enabled resilience for them by assisting in matters related to capacity building and quality of life (e.g., good health and wellbeing). Categories belonging to this positive commentary section of the interpersonal systems sub-theme were the same as for what aggravates participants to overcome negative experiences. Participants' close families (excluding spouses or partners) received significantly more remarks than other categories. Commentary included the following:

1.   Families being accepting and supportive

FG participants gave the most information (*N=70)*, with almost double the remarks for all other topics. Information detailed how families gave assistance and support. This was particularly relevant to the Indigenous participant who explained her broad family and support systems as a resource. The Indigenous participant's family structure consisted of biological and non-biological family members having close connections within each others' lives.

A significant amount of commentary related to disclosure and individuals being able to share information about personal diversities, as well as being aware of family support. Examples of this are families: identifying their gender dysphoria; accepting participants' gender transitions; assisting with transition or presentation; respecting the need for appropriate language and pronoun use; and, guaranteeing participants' safe spaces. Participants also provided examples of parents contributing to the cost of their surgeries. Moreover, some felt they could get help in the future, if necessary, from close others if they become frail and/or experience independence difficulties, such as a place to live (see Appendix V).

> (FG6) Rose: *"If, you are courteous; you are information rich; you are personable; and they* [friends, families, other individuals] *appreciate that. They know your idea is different."*
>
> (FG11) Ruby: *"We as black fellas, we have a lot of affection from our family."*

(MG2) Dylan: *"I'm hoping that my sister will look after me* [if I get frail]. *If not, one of nephews."*

(NBG3) Charlie: *"My mother is okay, and* [since affirming my gender] *she tries to use they / them pronouns."*

(FG4) Ava: *"I remember one time both daughters, and my granddaughter* [supported me]. *For my birthday they said, 'Righto, we are taking you to Bras and Things to buy a new bra for you'."*

2. *Friends that accept, support, and assist with gender affirmation*

Good friendships included close relationships with other trans and cisgender people. Participants explained their importance in assisting them to be resilient by being accepting, supporting, and respecting participants' decisions to affirm their gender. In addition, participants reported how friends helped by researching literature to understand and strengthen friendships, as well as sharing information. For instance, one participant's friend helped them repair relationships with estranged families, by visiting the family home to explain transgender issues. Furthermore, some reported that friends who knew them at an earlier time, prior to affirming their gender, helped participants to recognise gender dysphoria or provide much needed companionship (see Appendix V).

(FG7) Abigail: *"I hadn't told them* [cisgender colleagues] *my history but when they found out from XXX that this was what was they decided, well, she's our friend, she's a girl, she's the same as us."*

(FG9) Mila: *"I, went with another trans friend to help her through her operation."*

(MG4) Dan: *"He* [gay friend], *was the first person I'd ever met that knew anything, or had seen anyone, or, could relate in any way. And, stayed with me to try and help me through* [affirming my gender] *... He is still with me."*

(FG6) Rose: *"She* [my friend] *said, 'Have you ever crossed dressed and gone out?' And, I said, 'No'. And she said, 'Well, it's about time you tried it. You'll never know unless you do'."*

3. *Partners and spouses being accepting and supportive*

Participants shared several ways in which their current partners or spouses helped them to overcome negative situations. Instances occurred where, at the time of coming out, partners were shocked but willing to work through issues together. Despite this, only one participant remained married to their spouse out of 11 participants previously married. Others found that challenges faced in relationships could not be overcome. Some partnerships adapted by taking on best friend support roles, particularly where partners' identities were LGBT. Not all participants were partnered at the time of interview, therefore it would be difficult to ascertain a relationship and behaviour pattern for the whole sample. Instead, there was a focus on the ways in which partners and spouses helped participants within their relationships. Examples were assistance with presentation, seeking services and professionals, support, and willingness to work through challenges (see Appendix V).

(NBG3) Charlie: *"I have an incredibly supportive partner who has always identified as a lesbian, but they say that it's me that they love, and they will support me in whatever decisions I make."*

133

(FG5) Clara: *"My ex-wife explained to the psychologist why I had breakdown".* And in current times, *"I've got a transgender partner."*

(FG3) Charlotte: *"We* [my wife and I] *have worked through my gender identity issues together. We've now being married* XXX *years* [more than four decades] *… We have separate bedrooms, but we are each other's best mates and we do a lot of things together, and we do some things separately. And, we are there emotionally for each other."*

7.6   ST3 (T3): Interpersonal Systems: Resilience Barriers

Participants commented (*N=147*) on ways in which their informal relationships with friends, family, partners and spouses, and close contact HPs created barriers for their capacities to overcome negative experiences. The knock-on effect was encountering negative impacts to health determinants. Participants were also indirectly prevented from addressing their needs when experiencing economic challenges and/or needing to care for others. The outcome was often delaying help-seeking for transitioning. Commentary included the following:

1. *Family struggles and/or rejection*

Commentary on family (*N=77*) was more than double that of the partner and spouse section. Seventeen of the 19 participants made remarks about the challenges encountered with family members. Largely these issues related to ageing and belonging to a generation that could not affirm their gender in earlier times because they feared discrimination. For some this meant they had not made a gender transition prior to having children. There were a few comments about friends and several encountered parenting issues. For instance, they may have not wanted to burden their children or upset the status quo in families. This led to delays in affirming gender or concealment. Other comments related to issues experienced when caring for others and having their gender transitions challenged with doubt, violence, or end-of-life funeral issues (see Appendix V).

> (FG3) Charlotte: *"It* [my transition] *was just such a troubling time. Not knowing how things would work at home. Not knowing how things would work with my mother (my father had died long before)."*
>
> (FG9) Mila: *"I just pretended to live. I did what I had to do to make everyone happy."* And, *"He* [my son] *was throwing things in the rubbish bin if I had anything feminine about me at all."*
>
> (MG1) Liam: *"I hadn't ever planned to look for birth parents and I don't now because, I reckon, I've got enough trouble, and it would be a double problem. So, that was a big part to not doing anything, and probably to not realizing. Because you think, 'ok, this is going to be really bad, can't I just manage?'."*
>
> (NBG3) Charlie: *"I wouldn't have done it whilst my father was alive."* Also, *"Because they are old, I would hate it if they* [my Catholic relatives] *disowned me."*
>
> (MG2) Dylan: *"I grew up in a very religious family, so it was not the norm and it wasn't even really talked about."*

2. *Partners and spouses: negative reactions*

Intimate relationships were a significant aspect of participants' wellbeing and capacity for resilience, because they made a significant impact on several participants and their ability to live in their authentic gender. There was a range of reports. Mostly participants' partners had negative reactions, such as giving ultimatums and refusing to discuss transitioning, or coercing a participant to conceal their true gender. The latter was described as being in the "box" or "closet". A few partners also attempted to change a participant's gender identity. Additionally, for some, wanting to transition did not mean an immediate separation but rather loving attempts to cope, which resulted in tension and stress for both parties. Whilst there were accounts of unfavourable or bitter endings to relationships, there were also reports of partnerships experiencing difficulties and impacts to health determinants that have not resulted in separation. Other comments regarding barriers to a participant's ability to overcome identity issues were partnering with a person in the past to conform to society's expectations or having to care for a gravely unwell partner (see Appendix V).

> (FG8) Chloe: *"After we got married it didn't take long until she started trying to change things. She was trying to stop me from dressing. Trying to get me to get help to, sort of, so that I would be a man, not a female."*
>
> (FG2) Amelia: *"My aim was to be female as soon as possible – post op. My fiancé told me that was not going to happen with her."*
>
> (FG10) Penny: *"A*fter ten years of living in hell she got pregnant, and so I put myself on the shelf and went back in the closet.*"*
>
> (MG2) Dylan: *"She* [my ex-girlfriend] *said to me that basically I was such a strong lesbian woman, why would I want to be a man?"*
>
> (NBG1) Toni: *"He* [the man I married] *was a friend of my brother… We all make mistakes. It was never a good mix, obviously, from the start."*

3. *Friendships: negative judgements and/or feeling distanced*

Most participants talked about relationships and how associated social determinants for health were impacted negatively prior to or during transition. In contrast to discussions about intimate relationships with partners or spouses, friends mostly did not impact participants by causing them to delay transition or conceal identity. Instead participants commented largely on being isolated from any friendships, even with other ageing transgender people, or, had received negative judgements from existing friends on religious or other grounds. Another reason for being isolated was that participants distanced themselves from others due to stigmatization fears when coming out to friends (see Appendix V).

> (FG4) Ava: *"I had no friendships really. It was always just work, and whatever."*
>
> (NBG3) Charlie: *"I told – apart from my family and my partner – a good friend: but I think, only after I'd started transitioning. Because, I didn't want to lose their friendship."*
>
> (MG3) Oliver: *"*[I am isolated from community because I live in a rural location]. *I reckon* [in my local area] *I could probably count the number of guys I know in this area on both hands."*

ST4 (T3): Individual Systems

Data concerning individual systems (*N=314)* showed a range of characteristics and traits or actions that enabled or created barriers to participants' capacities to be resilient and overcome negative issues. On an individual level people reported personal obstacles, such as life stage issues or self-stigmatization. Remarks belonging to the resilience sub-theme were more than double those reporting resilience barriers.

7.7   ST4 (T3): Individual Systems: Resilience Enablers

There were nine categories for this section. Participants had found resilience in a wide variety of ways as evidenced by the high quantity of remarks (*N=221)* in comparison to negative remarks. Discussions relating to how economic strengths boost resilience included 17 participants, which was the highest category of participation overall.

Common coping strategies and resilience were related to many determinants for overall good health and wellbeing. This indicated that the full range of topics discussed needed consideration to understand participants' lived experiences, regardless of the amount of comments reported. Commentary included the following:

1. *Empowerment: self-confidence, participation, self-efficacy, independence, and authenticity*
    Most, but not all, participants explained their personal ways of being resilient (*N=230)* to negative challenges and obstacles when moving around in public spaces. Generally, remarks showed that self-confidence helped with acceptance and creating normality. Some also explained their reactions when people were not accepting. Participants typically avoided any self-judgement by seeing an abuser as a person having problems of their own. Another example was knowing their rights when being discriminated against. Participants also mentioned maturity equipping them mentally, for instance when they perceived adversity as something that is part of life and needs to be overcome. Further, they described positive experiences that relied on an underlying factor of maintaining outward identity to achieve resilience. This included a feeling of wellbeing in terms of passing and being able to move freely in society without experiencing adversity. Some were fortunate in terms of having physical features that allowed them to pass. Others talked about helping themselves with clothing and gender affirming aids. Some explanations were linked to finding HPs online themselves and transitioning to avoid severe mental illness (SMI).

Integrity was another important health determinant factor. Most participants gave explanations about resilience in terms of self-understanding and affirming their gender in a way that was appropriate for them. Several described this as self-acceptance, liking oneself, and being true to a unique sense of gender. Participants explained how development in early years of life helped them to develop resilience and avoid adverse situations. Sometimes this was a result of having a nurturing

environment, or, from not having a nurturing environment. Some participants' parents may not have been fully aware of the depth of an individual's identity questioning. Regardless, what is clear is that no one size fits all and all participants' circumstances have been diverse.

Participants also explained their motivations for educating HPs, general society, and helping each other. Examples included how they have increased their capacities to be resilient by participating in educating others to improve societal knowledge shortfalls, to be better understood. Some participants' experiences related to educational environments, such as workshops on inclusivity and cultural competence. Their examples included explanations of how they: felt worthwhile when helping to create awareness of the issues transgender people face in local or large organisations; or, were ensuring that a contribution to transgender causes would ensure the safety of all Australian transgender people. Several participants also benefitted from personal involvement in encouraging Australian society and government to improve transgender people's lives. Examples given were lobbying in Parliament, taking on LGBTI advocacy and activism roles, and educating organisations with cultural competency.

Participants' financial situations and capacity to pay for services relied on personal strengths, such as managing savings, maintaining employment, and navigating payment schemes, including health insurance and credit systems. This benefitted participants by allowing them to remain independent (from others) and not always reliant on government programs. Participants also described how distance from others and independence allowed them to make choices and plan ways to overcome future adversities. This is particularly relevant to commentary in this and other sections asserting that taking their own lives is preferable to losing independence. Typical examples were planning funerals, choosing to transition without interference, and living a satisfying life without judgement from others. Participants further explained how resilience was developed and helped overcome negative situations of not knowing how and where to go to seek help for gender affirmation matters. Most gathered information by using technologies and/or communicated with others, either online or in person, or, by seeking ideas on YouTube, checking government websites, and investigating insurance policies by using comparison data (see Appendix V).

> (FG1) Ellen: *"I think you have to be confident – steely confident. I quickly learnt to actually enjoy the robustness of daring to stare back."*
>
> (NBG2) Jo: *"I've found over the years, just being myself, and straight out with it* [revealing my gender] *– with people that I've worked with – they've been very accepting."*
>
> (MG3) Oliver: *"I manage to pass out there. And, I think what that comes down to is it's about having that confidence in your gender, and that's a big issue too."*
>
> (FG11) Ruby: *"I stood out, and, I had this attitude that I was alright. No vanity. I was 'me'. I had nothing to feel afraid of, nothing to feel intimidated by. And, that's how I behaved."*
>
> (FG4) Ava: *"He* [boss] *said, 'Some of the older ladies may not accept you, and others might'. And I said, 'Well, I don't care. They can just take me out if they want. I don't care if I get called madam or mate'. And, that's basically the attitude I've had all the time."* Also, *"That's*

my life. I've had a fair few kicks in my tummy, but I've survived it. I've had some good times and bad times. I suppose it's the cycle of life isn't it."

(FG11) Ruby*: "If I no longer feel that I can look after myself, and there is nothing available for me out there, I will take my own life. I've got a will. I've done that specifically for that reason".*

(MG3) Oliver: *"I stood up to him* [psychologist] *and told him that he didn't know the WPATH standards."*

(NBG) Toni: *"My assertiveness* [helps me overcome difficult situations]. [For example] *some people, if the doctor says, 'No, you can't have this' or 'That won't happen,' they will just accept it, whereas I don't. If I don't like doctor saying, 'No, you can't have this,' I will just go somewhere else. There is no shortage of GPs."*

(FG7) Abigail: *"I really don't subscribe to any of that, how should a woman behave; how should a woman dress; how should a woman act; how should a man behave; how should a man… So now I'm totally – I call myself, 'post gender'."*

(MG1) Liam: *"I was pretty sure I wasn't crazy. I think about stuff for a long time before I do it, which I had done in this case."*

(NBG1) Toni: *"I don't intend to kid myself or society. I am what I am... I have no worries about if somebody doesn't approve of what I've done, then they can go and take a hike. My breasts were never an issue for me or my partner."*

(FG1) Ellen*: "I think it's of interest and importance to say that I did not grow up with the stigmas and the fears, for instance that a gay man who was gay from puberty did, of my age group."*

(FG9) Mila: *"[I presented] fairly androgynous through that (my child's early life) whole period. So, I still had very long hair (that was always there), still with the jeans, and androgynous shirts."*

(FG5) Clara: *"I educate a lot of people: psychologists, psychiatrists, everyone."*

(FG1) Ellen: *"Living my life as a worthwhile person actually assisting in my job, going with another trans person to hospital etc., and supporting them and encouraging them."*

(NBG1) Toni: *"So, my goal is to graduate as a lawyer and become a practicing lawyer, helping older people. Elderly abuse is rampant in the general population, let alone the non-conforming population."*

(FG11) Ruby: *"As an Aboriginal Person is a cultural person, I believe that there comes a point in time in your life where you are able to become an educator and a teacher. Whether it is about Aboriginal history and culture, and tradition. I can do that too. But, like also, because I am 66 years of age, and I've been around over 50 years, I can talk about gay history. Gay and transgender history – sister girl. I can talk about the new gender identities of the last ten years, you know, and how life has impacted on them."*

(MG4) Dan: *"I'm shit scared of it* [aged care], *and that is one of the reasons, other than money, that I want to do the work and the training in that area."*

(FG3) Charlotte: *"I'm doing as much as I can to change Society's perception of trans and gender diverse people. Therefore, I turn my efforts into that, rather than responding to a negative situation."*

(FG7) Abigail: *"I will do a bit of advocacy work."* Also, *"A lot of what I do is geared towards education and visibility."*

(FG7) Abigail: *"It* [transitioning] *was easier for me because I did have some money."*

(MG2) Dylan: *"I've been contributing extra into my super for many years."*

(MG4) Dan: *"It's very, very, good to be employed and recognised for the skills you've got."*

(NBG2) Jo: *"I had to be really frugal, and I couldn't have a life. And, you know, all those little, little, little things. I'd just go home, go to the studio, do a little bit of work – go home. It was just same, same, same, same, for a few years. And, when I'd got that extra money, I coughed up the ten and half grand myself, and paid for it* [surgery]*, and it's good."*

(FG9) Mila: *"I just basically emailed every single one of them – all of the doctors. And, had a look at what they had. I had a look at the hospitals. I had a look at their websites. I had a look at their forums. I had a look at everything that was out there to see who was going where?"*

(FG2) Amelia: *"2013, I got onto YouTube and started to research transgender and transsexual."*

2. *Concealment from society*

The comments below provided evidence that, as well as concealing themselves in the past, participants continue to conceal their identity in current times to maintain resilience and avoid judgement or discrimination (see Appendix V).

(FG10) Penny: *"You learn to hide* [from Society] *very well."*

(NBG1) Toni: *"I didn't disclose* [my identity] *it to anybody."*

(FG11) Ruby: *"I've got my own funeral fund, so nobody has to pay for me to be buried."*

(NBG2) Jo: *"I keep pretty much to myself and do what I have to."*

7.8   ST4 (T3): Individual Systems: Resilience Barriers

Commentary *(N=93)* for this negative section of ST4 was less than half of the commentary for positive remarks. Moreover, the quantities of comments per person was similar for each topic. Commentary seemed to be related to other areas of the study. Nevertheless, there were fundamental differences in health determinants discussed in the following points:

1. *Gender dysphoria: impact and confusion*

Several participants described *(N=55)* how difficult their lives were during periods of unsupported gender dysphoria before affirming their gender. Confusion led to distancing themselves from others or being confused about how they related to others. Some mentioned that they had not understood themselves to be transgender at the time of experiencing difficulties (see Appendix V).

(NBG2) Jo: *"I don't think that* [my dysphoria] *was prominent. I think there were too many other problems. And, when you've got complex problems it's difficult to define."*

(FG) Rose: *"I think you might be kind of sitting on the fence and you haven't really looked at the other side.* [When I was questioning my gender] *There's greener pastures, but you are too scared to put your toe in there to see if it's your pasture or not."*

2. *Delaying transition*

Some participants were deterred from overcoming negative situations when they could not rely on their own motivations for action. Others delayed initiation of transition processes or health

maintenance due to their personal circumstances, not planning health or assisted care for later life, avoiding seeking healthcare due to the challenges of finding providers, and feeling like issues such as corrective surgeries were too challenging to address (see Appendix V).

> (MG4) Dan: *"Yes, work needs touch-ups, corrections* [to mastectomy surgery]. *No, I haven't allocated the money to it. I just – I'm too old, and I just don't care. It doesn't need to be perfect."*
>
> (FG1) Ellen: *"Experiences of screening? In relation to government incentives, such as standard age cancer screening, has not been done. I have been neglectful."*
>
> (FG3) Charlotte: *"I, in fact, got a script from him* [my doctor], *and I delayed* [GAHT] *probably at about three, four, maybe, five months before I, actually, took it to the chemist because I saw that as being such a major big step in terms of the process; and, barely at the point where it was all systems go."*

3. Personal vulnerabilities and resilience issues

Participants' comments provided evidence that people may not necessarily overcome their personal vulnerabilities and resilience issues after transitioning. Barriers were reported as past traumas, physical changes, or being geographically located in under-served areas (see Appendix V).

> (FG2) Amelia: *"I had experienced so much hurt and harm – all my social skills and boundaries had been brought down by males."*
>
> (FG9) Mila: *"*[Since being physically weakened by gender affirming hormones] *I struggle a little bit now to pick things up, and do some of the things I used to do… I'm always having to ask other people to help with my equipment because I can't do it."*
>
> (NBG2) Jo: *"It seems like we've got so much … it's like we haven't got enough to worry about, that we start worrying about little things that mean nothing – you know?"*

7.9   Chapter Summary

Chapter 7 provided evidence that participants' capacities for entering healthcare systems and accessing appropriate HPs are impacted by multiple factors. Participants' reasons for being resilient were interrelated with all the systems described in this chapter. Moreover, all 19 participants reported personal issues and experiences in relation to the full range of topics. Overarching issues mainly related to being prevented from, or enabled to, affirming their gender by way of health system issues (such as funding schemes) and/or interactions with groups or individuals (communities, HPs, families, partners, friends) that have influence on participants' lives. Moreover, empowerment was critical to all participants as a way of overcoming any obstacles that created barriers to living in their authentic gender. Several participants also commented on these issues on behalf of other ageing transgender people.

The participants' collective issues showed how important efficient and inclusive health-related legislation and healthcare (including associated support or funding organisations) and strong relationships with others (community groups, HPs, close others), and self-empowerment is in their capacities for resilience. It should be noted that all participants reported some correlation between

these resilience enablers, their access to HPs, and their considerations for others. These points are described in more detail in the oncoming Chapter 8.

Chapter 8.   Discussion

8.1   Summary of Chapter

This chapter begins with a summary of the research project and methodology (see section 8.2, 8.3) to remind the reader of the study's purpose and process for exploring ageing transgender people's experiences of health and healthcare provision matters. The key findings (see section 8.4) summarise any prominent issues arising from Themes One (T1), Two (T2), and Three (T3), as they relate to literature specific to the commentary. The theme overview (see section 8.5) follows by providing detailed information about the participant commentary as specific to each theme. Included is some reference to literature (where necessary) to provide context to the reporting. A comparative discussion in relation to the literature (see section 8.6) considers how prominent concerns (for transgender health matters) arising from the literature review relate to any overarching issues found across the three themes. The outcomes of these sections are related to future ageing transgender health-related needs, as outlined by the participants in their commentary, in five recommendations for policy and practice (see section 8.7). Information drawn from the literature and data analysis explains any implications for future use of theory (see section 8.8) in ageing transgender people's health-related research and includes details of an adapted model used for analysis in this current study. Limitations (see section 8.9) of the current study are explained in the context of how the research outcomes were impacted; however, also explained is how the research can be effectively used by stakeholders, as well as suggestions for improved data gathering. Recommendations for further research (see section 8.10) are then made. These are based on information arising from the previous sections. The chapter will then finish with a conclusion (see section 8.11) outlining the most important aspects and outcomes of the current study.

8.2   Summary of Research

This study aimed to explore trans people's experiences of healthcare, and any factors enabling or hindering health and access to healthcare, as well as factors that enable or undermine their resilience. This study was undertaken because, as shown in the review of the literature (Chapter 2), it was evident that ageing transgender people often suffer poorer health than other population sub-groups, including ageing cisgender LGB sub-populations. This indicates that ageing transgender people are experiencing more health inequities than others within the LGBT and general populations. However, there is little understanding about how these inequities occur in relation to the intersection of ageing, and issues associated with gender transitioning. Whist there has been a general improvement in health-related data collection across the globe (Corscadden et al., 2017), there has been comparably less information gathering within Australia and across health sectors. Lacking

information regarding Australian ageing transgender health matters and needs is a concern because there has been insufficient research to inform much needed health policy reforms.

The literature review suggested that information regarding ageing transgender people is lacking because large-scale investigations, aimed at uncovering information in regard to the health determinants of Australia's ageing populations, have rarely revealed the specific components and range of their health and healthcare matters (past and present) in relation to their unique broad health issues. Significant gaps include the reporting of transgender patients' perspectives on why they encounter discrimination, marginalisation, or bias in healthcare situations (Teunissen et al., 2016). Information from international sources, which specifically targets the negative impacts on older transgender adults, showed that health and health determinants were exacerbated by victimization, internalised stigma (Fredriksen-Goldsen et al., 2014), and age-related co-existing conditions arising from a variety of side-effects from gender affirming hormonal therapy (GAHT) or gender affirming surgeries (GAS), or high health-related risks associated with other secondary conditions (Gooren & T'Sjoen, 2018).

Australian reports on ageing transgender people, however, have not focused on broad health issues or provided evidence of what can strengthen or weaken ageing participants' related health determinants (physical, mental, economic and social resilience, environmental factors). Moreover, some prominent Australian authors have demonstrated how filling related gaps requires gender identity specific reports (male, female, non-binary [NB]).

Riggs, Coleman, and Due (2014) outlined how indirect or direct discriminative practices in healthcare services and environments varied according to trans people's identity (trans feminine or masculine). Therefore, the impetus for questioning participants about their experiences was to contribute valuable information needed to fill existing gaps found in broad aged, transgender, or LGBTI literature. As such, this current study's themes present the sample's experiences, good health and wellbeing enablers and barriers, and health determinants, as a means of overcoming these issues. Moreover, the voices of multiple participants, detailing similar issues and experiences, further provides some indication of what future areas of ageing transgender people's health should be explored with more specific research tools.

8.3   Summary of Methodology

A qualitative phenomenological approach was used to explore and give contextual accounts, detailing a broad range of determinants for health and wellbeing, accessing healthcare, and any age-related intersectionality issues. Data collection involved a flexible, semi-structured, interview method which prompted participants to share their viewpoints for all health and health determinant matters. Giving life to participants' voices and lived experiences by documenting their commentary was

important to this inductive analysis. Their words determined how the data should be analysed, and written, to best convey their experiences, opinions, and needs.

The data was managed with NVivo software and analysed using the six-stage thematic analysis methodology designed by Braun and Clarke (2006). Data included in NVivo from the transcriptions was categorised according to the comments given. Overarching patterns emerged from the data. These were transformed into three themes (as shown in the oncoming sections). Within each theme, there were prominent sub-themes, which, in turn, had their own categorised topics of discussion.

Findings from the themes and sub-themes (STs) include references to related information from the literature review (Chapter 2), enabling a comparative discussion to reveal some important research gaps. Further, they provide reinforcement for any corresponding or existing evidence and provide the basis for recommendations for future research to inform policy and practice. These outcomes are used in the formation of any implications for future use of theory, as well as showing what limitations have occurred.

8.4   Key Findings: Summary and Reference to Literature

There were 17 key findings, as summarised below. For each finding, explanations include related participant commentary and how their experiences and opinions correspond with literature specific to the finding.

1. The first finding is that the NBG and MG groups reported predominantly negative healthcare experiences (see sections 5.1, 5.2, 5.3, 5.4). In contrast the FG did report negative experiences, but predominantly reported good experiences (see sections 5.5, 5.6). Negative commentary included poor experiences with healthcare systems as well as with a wide range of health providers (HPs). Theme One (T1) revealed many participants encountered multiple experiences of negative attitudes from HPs and were misunderstood in a variety of healthcare situations. Interestingly, NBG and MG groups (persons who were assigned female at birth [AFAB]) had undergone, or were undertaking, similar GAHT or GAS treatments, and made similar reports. Whilst Australian research reporting the experiences of ageing trans males and non-binary people's health and healthcare is scarce, there is some useful information from general ageing investigations. Health Talk Australia (2018) gathered information from a diverse range of ageing respondents and provided evidence that ageing people want to be treated as people first in healthcare situations. More information is needed to understand how HP approaches can accommodate the specific needs of ageing trans women, trans men, and non-binary people.

2. The second finding is that several participants from the NBG, MG, and FG spoke of their experiences of previous (pre-gender transition) serious (or severe) mental illness (SMI), such as depression, anxiety, or suicide ideation. Whilst this information mostly arose in T1 (see sections 5.2, 5.3, 5.4), SMI was also discussed as creating barriers to good health and resilience in the other themes (see sections 6.4, 7.6). SMI was often regarded as an integral part of gender dysphoria. Moreover, other longstanding mental health issues, such as post-traumatic stress disorder (PTSD) and genetic or chronic conditions were linked, by some participants, to increased social isolation.

The compounded impact of these mental health issues was reported of conditions worsening as the participants aged, particularly if appropriate healthcare could not be accessed. In contrast, information regarding participants' having strong mental wellbeing was associated with making gender transitions, achieving their desired outward expressions, and being visible in society. Mostly, participants from all three groups reported better wellbeing after their gender transitions if they attended a range of HPs (see section 6.1). Post-transition improvements in mental wellbeing align with the Houssayni and Nilsen (2018) gender dysphoria findings and explanation that an individual will experience distress due to gender incongruence, and therefore will benefit mentally from gender affirmation. However, improvements in mental wellbeing after a gender transition did not always alleviate the need for regular mental health monitoring.

3. The third finding concerns participants (all groups) encountering negative experiences, such as discrimination, marginalisation, and prejudice from HPs, in relation to accessing gender affirming healthcare (see sections 5.1, 5.3, 5.5, 6.4). Reports relating to gaining referrals and/or general healthcare were particularly significant. In this respect it is interesting to note that, despite the common experiences of the three groups, the FG had mostly positive experiences of healthcare whist the NBG and MG had mostly negative experiences. In this regard, MG and NBG participants often stated that their dysphoria and associated stresses were aggravated and exacerbated by interactions with HPs. For example, several participants conveyed their confusion to doctors in earlier life but found their gender dysphoria was often misinterpreted and dismissed (see sections 5.1, 5.3).

In more recent times, distress was also experienced when having to explain gender diversity to health system workers and organisations, such as hospital administration staff and insurance companies (see sections 6.3, 7.2). Refusal of care and prejudice had been experienced by several participants from the three groups in general healthcare settings (see section 6.4). Although there is a lack of literature available, particularly about trans men and non-binary people who were AFAB, this information corresponds with evidence that transgender people's healthcare and system discriminations are often

based on misconceptions and misunderstandings of their needs and are thus related to HPs' lack of knowledge (Hughes, 2017).

4. The fourth finding is that several MG and FG participants felt the gatekeeping approach (undertaken for gaining a mandatory diagnosis to commence medically-guided gender affirmation processes) is an unjust reason for having to undertake a six-month assessment or having to raise funds for further healthcare processes (see sections 5.3, 5.5, 5.6, 6.4). As is consistent with the American Psychiatric Association (2013a) guidelines, many participants needed multiple (costly) assessments over six months to demonstrate their need for a medically assisted gender transition and to proceed with GAS or GAHT. Evidence in general transgender research has shown transgender people will often prioritise gender affirmation processes wherever possible (Gooren & T'Sjoen, 2018, p. 8). This evidence clearly indicates that gender affirmation has been at the core of many transgender people's wellbeing.

5. The fifth finding is that both the NBG and MG had certain surgical needs and had been able to undergo reconstruction chest surgery to reduce breast tissue (see sections 5.1, 5.3). This type of surgery is mostly only available in private healthcare within Australia. This means surgeries and hospital expenses have often been paid for with assistance from superannuation (retirement) funds and health insurance. Whilst most procedures had been successful, three participants reported needing corrective surgery; however, all three felt that further surgery had been unavailable to them because they are unwilling to return to their original surgeon and/or because of the high costs involved in any corrective surgery that cannot be covered by subsidies (Medicare, health fund) (see sections 6.4, 7.2). Beyond chest surgery the NBG did not state a desire to have other surgeries, whereas some MG participants desired gender affirming surgeries to form male genitalia. However, most reported any hopes as unrealistic because genital surgery for trans men (in Australia) is either unavailable due to a lack of surgeons able to do such procedures or unaffordable because of the high costs involved in undertaking genital surgeries overseas. Mostly these factors were related to having to travel overseas to undertake such surgery. In comparison, not every FG participant required GAS (particularly if there had been adequate breast growth with GAHT) (see section 5.5). Several FG participants had multiple GAS (chest and genital) but were often impacted in Australia by high costs and limited availability (see sections 6.4, 7.2). They avoided any high costs by having GAS in Thailand (see sections 6.2). However, they also needed to be willing to cope with risk factors associated with travelling overseas, such as developing infections and finding an HP in Australia for any post-surgical care.

6. The sixth finding is that the NBG and MG concepts of good healthcare experiences mostly differed from the FG. Several NBG and MG participants did not always relate a good experience to any interaction with an HP, but rather to any positive outcomes from attending HPs (see sections 5.1, 5.3). An example is having satisfactory outcomes from GAS or GAHT or having local GPs who could provide a range of services. In contrast, the FG participants mostly related good experiences with health and healthcare, and healthcare access enablers, to good relationships with primary health carers (see sections 5.5, 7.3). However, their satisfaction with HPs and services may not necessarily be associated with gender identity. In comparison with the FG (*mean age=59*), the MG (*mean age=53*) participants' mean age was markedly less. Related research found that a general population cohort's expectations of healthcare altered as they aged, and aligned with any life changes and, thus, reports of patient experiences (satisfaction, cost barriers, interactions with HPs, appointment issues and knowledge) varied along timeframes (Bowling et al., 2013; Hargreaves et al., 2015).

7. The seventh finding was that much positive commentary concerning health matters (for all groups) was related to gender affirming hormonal therapy (GAHT) (see section 6.1). Positive reports mostly referred to HPs competently treating participants' health matters (see sections 5.1, 5.3, 5.5). These included uncovering any side effects of GAHT or GAS and/or prescribing, modifying, or administering medications in accordance with any physical changes related to ageing. These findings can be compared with a recent international study detailing a range of post-transition patient issues, which showed that transgender populations can be regulated by non-specialist HPs for appropriate hormone dosages by using standard clinical tests such as bone density, weight, blood, and other checks (Gooren & T'Sjoen, 2018). However, this contrasts with some important recommendations stating that specialist care is the safest pathway for administering GAHT and avoiding any side effects (Endocrine Society of Australia, 2017; Hembree et al., 2017). This contradiction warrants further exploration as to why specialist services, in relation to authorizing and administering GAHT, should be continued after ageing transgender people commence GAHT.

8. The eighth finding was that most participants (from all three groups) had undergone both GAHT and GAS, and, further, reported co-existing and/or age-related chronic or degenerative (physical and mental) health conditions for which they needed additional care from health providers (see sections 6.3). Houssayni and Nilsen (2018) found that, in both their investigations, male and female identifying participants required a full range of gender affirming treatments, as well as needing aged-related general healthcare.

Houssayni and Nilsen further emphasised the need for additional post-surgical care and protection of their rights for accessing services in general healthcare settings (2018).

9. The ninth finding relates to the two previous findings, in that participants (from all groups) who reported good experiences when accessing services described the willingness or competency of their HPs. Further, primary health professionals, such as GPs, were particularly valued when they gave holistic care to patients (see sections 6.2, 7.3). In other words, such GPs monitored participants' broad health and preventive health measures. For instance, a good GP will: undertake and prescribe GAHT; make referrals where necessary; undertake regular screening for a patient (blood tests); provide recommendations for exercise and nutrition, and counselling for patient's psychosocial issues (mental health screening).

Additionally, many conditions that can be screened are the same for all ageing people and are undertaken in general healthcare environments. There was a mix of positive and negative (see sections 5.2, 5.4, 5.6, 7.1, 7.2) reports from all groups relating to being screened in government services. Positive commentary mostly related to administrative and health staff using the correct patient details (labels, names, pronouns), being non-judgemental, or participants enjoying the ease of postal screening (bowel screening kits). In contrast, negative commentary often spoke of HP and service discrimination (stigmatization, prejudice, exclusion). This information relates to studies concerning transgender people. It is suggested that being excluded from healthcare, for example, when refused or deterred from cancer screening or health insurance, increases related health risks in transgender people (Auldridge et al., 2012; Markwick, 2016).

10. The tenth finding is that the internet was often crucial for assisting participants to communicate with others (community, HPs, information sites), learning how to affirm their gender; and, obtaining recommendations for specialist care (see sections 6.1, 6.2, 7.3). Multiple organisations provide online information as well as communication platforms to transgender people in Australia. There were many comments concerning highly experienced Thai specialist services, particularly in relation to gaining information via community and HP websites. These have been highly valued, particularly by participants who are isolated from trans communities. It should be noted that the literature corresponds with participants' commentary that fewer organisations specifically support ageing transgender populations than those supporting young generations. Several participants who are involved with these organisations stated that some funding from the Australian Government helps to support their workers. However, as discussed in T3 findings, contributions are often limited or not guaranteed. Given that some participants had explained the importance of gaining information and communication on these

platforms, more information to support the need for government support would be highly valued by ageing transgender communities.

11. The eleventh finding is that many participants related important resilience and health enablers to age-degeneration and: avoiding any side-effects from GAHT; undertaking health prevention measures (exercise, weight management, good nutrition); maintaining good social health, and even caring for others (see sections 6.2, 7.1, 7.3, 7.5). Throughout themes One, Two, and Three, it was apparent that a participant's ability to achieve good overall health and wellbeing was ultimately reliant on being empowered and having good personal health behaviours that coincided with their ability to access appropriate care. This information is consistent with WHO's (2016) assertions that people develop strong resilience with good mental and physical health, and often measure their capacities by assisting with the care of others.

12. The twelfth finding is that health determinants such as economic, social, and environmental factors are important for accessing healthcare and enabling resilience (see sections 6.2, 7.1, 7.3, 7.5, 7.7). Participants found these factors assisted them to feel empowered, self-confident, and independent. Whilst independence was often bolstered by savings, superannuation, and employment, there were often additional factors enabling them to be financially and socially resilient; for example, participants receiving assistance from others within their interpersonal systems (see section 7.5). Others in this instance included primary HPs, for instance when GPs provided participants with information and counselled them when making health gender affirmation decisions. Financial assistance from close others (family, partners, friends) included navigating any funding options (insurance) or contributing sizable funds to pay for the high costs involved in private healthcare, and to pay gaps in funding. Travel often caused economic barriers when costs for transport were high; for example, when participants live in rural or regional areas where there is a lack of specialist HP availability. Other barriers to gender transitions were not having enough funds for medically assisted gender affirmation (GAS, GAHT), or because they were caring for others, or they feared a gender transition would be damaging to family relationships and situations.

   Related information from previous non-Australian literature found that the sample's "visibly resourced" (p.22) sub-group experienced better overall health than less advantaged sub-groups (Fredriksen-Goldsen et al., 2017a). Visibly resourced, in this instance, referred to individuals having the support of good economic situations, family, and empowerment. However, in the current study, wealth was not necessarily an indicator of good health.

13. The thirteenth finding is that participants reported feeling more societal acceptance after affirming their gender with outward presentations and/or legal documentation (see section 7.1). Participants also referred to the helpfulness of matching legal identity documentation when attending any social or healthcare services. Moreover, matching identity documentation was also often related to gaining support in the workplace. Conversely, participants reported being more vulnerable to discrimination (misgendering, misidentification) in general healthcare or social situations when their identity was not protected, for example with matching legal documentation.

Fear of such discrimination caused participants to avoid public places (particularly if not accompanied by a close other) and accessing general healthcare (see section 6.4). Accident and emergency (A&E) departments were particularly feared. In relation to emergency care there is mounting research in Australia that reveals the difficulties transgender people encounter in hospitals and, further, why transgender people avoid HPs until their conditions and illnesses become too serious to attend primary health care (Jaffee, et al., 2016; Taylor, 2016). However, research also shows that progress can be made by training medical providers to understand transgender bodies after GAS and GAHT, and, when education programs include flexible approaches that engage with transgender people's mix of psychosocial and biological issues (Rotondi et al., 2013).

14. The fourteenth finding is that some participants struggled to find culturally competent HPs who will bulk bill. This created difficulties if they were on incomes too low to fund unsubsidised gender affirming healthcare (see sections 6.3, 7.2). The MG and NBG participants appeared to have more negative issues of this kind per person than the FG. A lack of bulk billing HPs was related to medical authority misunderstandings of transgender health needs and marginalisation from appropriate healthcare in certain regions. Some experiences of discrimination were compared to experiences of the Australian health system in previous times (more than two decades ago) when discrimination was more widespread or when legal gender transitions were not permitted. In other words, participants felt that not all healthcare service availability had improved over time. This means some participants continue to experience the compounded effects of discrimination. Such negative experiences are consistent with a large scale (US) broad age survey of trans male respondents who reported persistent challenges of finding culturally competent and willing HPs, as well as being able to finance such care (Shires & Jaffee, 2015).

15. The fifteenth finding is that transgender communities, advocacy groups, advocates, and support workers have been able to identify many resilience enablers or barriers encountered by transgender people who conceal themselves from society (see sections

7.3, 7.4). This is particularly important for future reporting, for those who may be suffering abuses or prejudice but are reluctant to report their issues to authorities. Fear of reporting to authorities was found in multiple sources in the literature review where respondents had often feared increased visibility or fear that authorities would not support them (Auldridge et al., 2012; Porter et al., 2016; Xavier & Simmons, 2000).

16. The sixteenth finding was that, in the context of community systems (LGBT, workplace, medical centres, family related, religious), feelings of companionship and involvement were important for building resilience, and there were markedly more positive than negative comments (see section 7.3). Positively, local (physical) communities offered significant feelings of safety and protection from abuse or discrimination; for example, in welcoming workplace environments. Being able to share feelings with others often assisted participants to understand themselves. Several participants suggested that aged-care environments would benefit from LGBTI-managed care staff for these reasons. Negative issues related to any deterrents or barriers to community involvement, such as marginalisation by HPs or in the workplace, or participants having concerns about outing themselves when searching the internet for closed groups and forums (attempting to find others), or, in local public places. This had knock-on impacts to health and wellbeing, such as social isolation and preventing participants from exercising.

17. The seventeenth finding is that in interpersonal systems family was the most commented on topic in relation to both enablers and barriers to resilience factors (see sections 7.5, 7.6). Moreover, friends were given significantly more positive commentary than spouses. Although no participant's situation was identical to another's, many mentioned that, as they aged, their family structures and relationships changed. Often this was due to their gender transition. An example of this was participants affirming their gender despite knowing a transition would cause friction between family members; and, that they would encounter rejection or separation from their families and/or relationships. Changing circumstances throughout life related to the WHO assertion that no ageing person's situation is typical (2018a) and demonstrated the importance of gauging people's health determinants by considering their key life stages and major health stressors. These particularly related to participants' close family, partners and spouses, friends, and even some close contact HPs. This assertion has been reinforced and expanded on by other research findings. One of the biggest risk factors known for LGBT populations has been coming out between the ages of 40 to 50, and after a past marriage and having children (Fredriksen-Goldsen et al., 2017b).

8.5   Theme Overview

This section provides a more detailed overview of any additional information gained within the themes that is relevant to the research outcomes. Some reference to the literature is provided (where necessary) to give context and/or meaning to any issues arising from the themes.

The analysis uncovered a broad range of determinants that can directly impacting health, wellbeing, and healthcare matters; or alternatively, indirectly impact health, wellbeing, and healthcare matters. A combination of directly and non-directly impacting issues were revealed; for example, when a participant reported that their physical and mental health relied on involvement in community activities and companionship, as well as having an income to pay for gym fees and health insurance. Alternatively, a participant may have the benefit of living in an area that supports them with well-serviced health systems. Their attendance in services may not have required high costs for travel or leave from employment.

All three themes – *Experiences of health and healthcare provision* (T1); *Factors enabling or hindering good health and wellbeing and access to healthcare* (T2); and, *Resilience enablers or barriers* (T3) – relate participants' experiences and opinions to health, wellbeing, and healthcare matters. However, there were marked differences between each theme. Separating them using the following theme topics gave clarity to the reporting: the first theme (T1) reports participants' direct experiences of health and healthcare; the second theme (T2) involves a wide range of issues directly impacting participants' capacities for good health and wellbeing and healthcare (including aged and assisted care) access; and, the final theme (T3) details a broad range of direct and indirect health determinants that may impact participants' broad health and/or access to a full range of services relating to health, aged and assisted care. Further categorisation within the sub-themes highlights any difference in reporting within themes. Theme three (T3), *Resilience enablers or barriers*, required use of a model for analysis and clarity in reporting, and was guided by an adaptation of Davidson et al.'s (2018) model of eight concentric circles, as outlined in Chapter 2. The sub-themes aligned with four key categories. These were needed to provide balance to the information by ensuring that each component of the participants' health reporting would be covered.

T1: Health and healthcare experiences

T1's *Experiences of health and healthcare provision* uncovered ageing transgender participants' broad health and healthcare provision issues.

Non-binary group (NBG) participants

NBG participants (aged 59-62) made up the smallest portion *(Number [N]=3)* of the study sample in comparison to the MG *(Number [N=5])* and the FG (*Number [N=11]*) participants.

Nevertheless, their reports were particularly valuable for this theme because two of the NBG lived in rural locations at the time of interview.

Overall, NBG participants' comments about health and healthcare experiences showed more negative than positive experiences. All NBG participants had negative mental or physical health issues from pre-transition times to report. However, they did not respond with much detail to health or healthcare questions concerning their post-transition general health issues.

Chest reconstructive surgery (GAS) was reported to be necessary for all NBG participants. One participant was awaiting their procedure at the time of interview. Additionally, only one NBG participant commented (positively) on their breast screening experience prior to GAS. Other positive health remarks concerned GAHT and associated physical (not psychological) post-surgical issues, such as repair and recovery, bodily comfort, and muscle building.

All NBG participants suggested they would have transitioned at a younger age but were deterred by poor interactions with HPs in earlier life stages. More recent negative issues related to interactions with surgeons; high financial and time costs associated with travel and GAS; ineffective hormones dosages; being misunderstood or being refused treatment. One participant felt completely misunderstood when refused care in an A&E department. The knock-on impacts to health were healthcare and social exclusion arising from lack of trust within the medical community, and rejection from local LGBT groups. These attitudes are related to general population ageing investigations where reports reveal that traditional mindsets of HPs have caused respondents to feel misunderstood and marginalised in early life (Bowling et al., 2013; Hargreaves et al., 2015). However, Hargreaves et al. (2015) also found that in later life, as participants aged, they felt their expectations of HPs were lower and they experienced more satisfaction. In this study, NBG participants' perceptions of their experiences were comparable with these findings, because any reports of positive experiences related to HPs and good professional practices (timekeeping, referrals, availability), rather than any personal interactions.

Male identifying group (MG) participants

This study's MG participants' (aged 51-56) health and healthcare reports had more similarities to NBG participants than the FG. Most services sought were for GAHT. Their gender dysphoria diagnosis was related to overcoming their mental health problems, not because of the diagnosis, but because they gained access to healthcare and found culturally competent HPs. Despite mostly negative reports overall (for gender affirming healthcare) they did report good HP experiences for GAS. However, some MG participants encountered negative experiences during their surgical procedures with professionals or other health staff. MG participants' commentary concerning HPs

mostly related to specific gender affirmation post-transition care needs, such as quality health-related treatments resulting in positive psychological outcomes.

MG participants also reported experiences of discrimination and concerns, such as safety risks in care situations, due to HP inappropriateness or insensitivity. Discrimination even occurred when attended to by well-trained HPs. Some commentary explains how participants were on the receiving end of demeaning comments, being misgendered, and feeling disempowered in care situations as a result. Poor experiences were encountered regardless of whether MG participants attended a private or public facility.

MG participants all reported co-existing general health (mental and physical) conditions, which they managed with help from HPs, and particularly GPs. Each participant's issues differed. Examples were depression, osteophytes, mobility issues, diabetes and strokes. Targeted research involving larger samples would likely provide evidence of a fuller range of healthcare needs in this population and how to protect them from discriminative practices.

Female identifying group (FG) participants

FG participants' positive experiences of health and healthcare commentary mostly described the mental and physical effects of GAHT. What differed from the MG was that not all FG participants associated their wellbeing with their need for any GAHT or GAS. Mostly FG participants' good health experiences related to their own perceptions of how they wanted to present themselves with outward expressions. For instance, one participant described her experience as spiritual, and others felt losing part of their anatomy might have altered important relationships or interactions with others.

FG participants' good experiences with HPs and healthcare were often associated with building trusting and strong relationships, particularly with GPs. These GPs had sometimes assisted them by overcoming long waiting times, referrals and assessment periods, and by authorising GAHT. Positive experiences with Thai surgeons and health staff were compared with less favourable contacts with Australian surgeons. Easy communication, feeling welcomed, and not being judged was a key factor for travelling overseas. Reduced GAS costs and reports of superior clinical standards of care were also an important aspect of Thai HPs.

Most FG participants also had existing physical or mental health conditions that were being managed by general HPs. These needs are consistent with information provided in a study by Houssayni and Nilsen (2018) who associated their participants' range of gender affirming treatments to their needs for specific aged-related general healthcare needs. Positive reports from this study's participants related to care practices, particularly standardised government program screening (postal screening, breast scans). Participants reported that changing documentation, to provide evidence of their gender identity, assisted them to have better experiences and reduced fears when entering

healthcare environments. Negatively, entering care situations led to experiences of being discriminated against and/or marginalised by misgendering, HPs not wanting to engage with individuals in clinical situations, confidentiality breaches, and HPs being unwilling to treat ageing transgender patients.

Most FG participants experienced serious (or severe) mental illness (SMI) throughout their lifetime. A variety of SMIs or chronic mental health issues experienced by the FG included: depressive disorders (including suicide ideation); genetic conditions (Asperger's syndrome, autism, Bi-polar disorder); and PTSD caused by early life traumas (sexual abuse). Depressive disorders were described as an integral part of gender dysphoria by some participants. One participant explained that her autism (from birth) is socially isolating, and another as experiencing Asperger's syndrome more severely after being sexually abused as a child in young life. This is concerning for ageing transgender people because general population literature has suggested that the complexities of managing SMI or mental health conditions together with other health conditions increases care needs (Fortuna et al., 2017; Martino et al., 2016).

The overarching issues for the entire participant sample were revealed in the third ST (ST3) of T1, when they expressed their opinions about transgender related needs, improvements to healthcare, and suggestions for progress. These have been detailed in the Recommendations for Policy and Practice sections (8.7).

T2: Factors enabling or hindering good health and wellbeing or access to healthcare

Theme Two (T2), *Factors enabling or hindering good health and wellbeing or healthcare access*, sub-themes (STs) described how participants have been enabled to, or hindered from, having good broad health or access to healthcare provision. Mostly the theme demonstrates participants' deep desires for gender affirmation. This is evident by their attendance to specialist or culturally competent HPs for treatments and associated health monitoring, as well as support services needed for good general and broad health. The evidence provided suggests that the intersection of participants' general and transgender-related health matters, and ageing health issues, needed to be explored with broad health questioning within the same study.

Sub-theme one (ST1): Enables good health and wellbeing

ST1 showed that most post-transition participants continued to rely heavily and holistically on HPs, and particularly GPs, for all their health concerns (counselling, health monitoring, medication administration) . Holistic care is important because ST1 also revealed that a prominent health enabler (for most participants) is being able to align an internal sense of gender with outward expression. Participants reported they were able to avoid compounded health issues (mental health, side effects of

GAHT, chronic conditions) with holistic care. These issues are detailed in findings from Gooren and T'Sjoen (2018), who also found that affirming gender and outward expressions meant participants could reduce their gender identity related anxieties. In the current study, participants reported that gender affirmation and holistic care from HPs helps to create a cycle of positive effects on their physical (fitness, weight, nutrition), mental, and social health. All these components also relate to their perceptions of good preparation for age degeneration factors. Social health, such as strong relationships with community and close others, and which also included care of others (partners, parents, family), is linked to mental strength, self-motivation, and resilience.

Sub-theme two (ST2): Enables access to healthcare

In ST2 all participants reported that finding uncomplicated and validated information (online, word-of-mouth) was necessary for gaining easier pathways to recommended healthcare, specialist HPs and gatekeepers. The outcome of these recommendations was often finding an HP who would proceed with their gender affirmation needs, such as GAHT or referrals (to specialists), earlier than the six-month assessment period recommended to HPs by the American Psychiatric Association (2013a). Often participants overcame these waiting periods by having trusting relationships with HPs (usually GPs). HPs helped by either providing them with known evidenced-based information, by exploring medical information on behalf of participants, or supporting them by accepting information provided by participants. They also helped to motivate participants by providing safe healthcare environments, unproblematic referrals, and time saving assessment periods.

Good financial situations helped participants with affordability issues such as pricey gender affirmation related needs (including clothes, wigs, cosmetic treatments, GAS, GAHT, and other costs associated with gender affirmation). Funding was often gained from Medicare rebates or superannuation, or from their own financial capacities (savings, income, saleable assets, family). Participants' own finances were often used to fund expensive insurance premiums. Moreover, several participants had used all their resources to pay for GAS and had no remaining savings.

It is also apparent that perceptions of good health enablers were associated with good healthcare access enablers. For instance, being well-connected with knowledgeable others (e.g., online or physical communities) or the medical community, and having HPs available and well-located, was associated with good health. This reinforces a future need to uncover how and where deficits occur. This can be achieved by matching ageing transgender people's primary needs for good health and healthcare outcomes against general populations. This is particularly important for ageing transgender people as their healthcare needs change after gender affirming treatments and procedures.

Sub-theme three (ST3): Barriers to good health and wellbeing

In ST3 FG participants most reports appeared to concern hindrances to poor health. Most had experienced physical and mental health problems throughout their lifetime. Gender questioning and dysphoria in earlier life was highly prevalent and often resulted in participants experiencing SMI, caused by suppression or denial of their feelings. Some participants' descriptions of coping, by way of confusion, suicide ideation, and isolation, were comparable to participant issues in the Cannon et al. (2017) study, in the US. Their study provided information regarding the causes of poor mental health in trans people to educational material for training health workers.

Most participants also experienced suicide ideation or attempted suicide at some point prior to affirming their gender. Sometimes chronic physical and mental health conditions were related to developing other health problems (e.g., side-effects of GAHT) or difficulties gaining access to appropriate services (e.g., problems with travel due to disability). Physical health problems (past and present) were prevalent across all groups, and involved strokes, deep vein thrombosis (DVT), diabetes, heart conditions, depressive disorders, mental health conditions, and past addictions. Good health often relied on GPs treating participants holistically, such as monitoring age as well as gender-related issues.

HP awareness of age-related health matters, such as those causing "frailty" and associated negative pathways (economic, mental, and physical resilience), is recognised by the medical community as crucial for people entering the transitioning years (WHO, 2018; Beard et al., 2016). However, this has been a general global message for ageing and vulnerable people, and not specifically for older transgender generations. Several participants stated that they had encountered HPs that were either not knowledgeable or willing enough to provide broad-ranging assistance. This is particularly concerning when considering that ageing transgender people may need to undertake preventive health activities outside of clinical health checks. For example, in this study participants often reported a reliance on being either educated in good health behaviours by practitioners or having self-awareness of their need for exercise and good nutrition.

Sub-theme four (ST4): Barriers to accessing healthcare

ST4 commentary showed some participants' hindrances to accessing healthcare were associated with HPs refusing treatments or because of participants' own reluctance to seek care. Complex or costly pathways, and fear of HPs, prevented some participants from having GAHT or GAS. Some FG participants had self-administered hormones in the past. A recent Canadian research project targeted transgender people, who were administering non-prescription hormones, to uncover and understand why avoiding healthcare might have happened. Common reasons for self-medicating were associated with poor historical experiences with HPs (Rotondi et al., 2013). In this current study,

one participant had self-administered in early life when she felt few HPs understood transgender processes, and another participant feared co-existing health conditions would prevent any approval for GAHT. Also, this study did show some similarities with the Rotondi et al. (2013) study when participants attended unwilling HPs and were delayed in receiving GAHT or GAS. However, at the time of interview, all participants receiving GAHT were being guided by HPs, and no participant was prevented from GAS or GAHT if they had the resources to fund the processes. Nevertheless, waiting for approval and relying on HPs for prescriptions caused considerable stress or anxiety. This led some participants to avoid healthcare directed monitoring or to self-medicate.

Some participants, or transgender people known to them, had been deterred from general healthcare situations. Lack of matching documentation was a reported deterrent and known cause for being mis-identified and misgendered in public healthcare environments. Negative social engagement led to further fears of discrimination and stigmatization from cisgender people. Fear of not passing, and having their authenticity respected, was an associated deterrent for accessing care. The absence of knowledgeable carers and mistrust of providers in general healthcare environments, particularly in A&E or aged or assisted care institutions, exacerbated participants' fears.

Some participants were assisted holistically because of their well-formed relationships with HPs, and particularly with GPs. However, all participants were aware of how funding or geographical location could impact their experiences and choice of provider. Funds for healthcare had been prioritised elsewhere for several participants when they needed to care for others (family and partners). MG participants had experienced additional issues; the most prominent example related to past obstacles for a clinical diagnosis and pathological pathways to GAS, GAHT, and legal documentation changes. One participant referred to his knowledge of past (more than two decades) negative attitudes and medical authority misunderstandings. He reported that male identifying transgender people had been denied diagnosis and therefore a pathway for referrals and assessment.

T3: Resilience enablers or barriers

Large volumes of health determinant data were allocated to Theme Three. The four STs, comprising health determinants taken from Davidson et al. (2018), (see 8.5 Theme Overview introduction). The first, macro-environmental systems (ST1), described participants' formal interactions with organisations, institutions, and government departments. These were either direct, such as telephoning insurers, accessing Medicare or entering hospitals; or, indirect, such as with health systems in general or scanning community websites for information. There was less positive than negative commentary, however any imbalances cannot be considered a measure for efficient and effective macro-environmental systems. For instance, more positive information could not assist with gauging whether the Australian Government and health systems have progressed in compliance with

previously mentioned human rights obligations towards the SOGII community (Cabral Grinspan et al., 2017; Yogyakarta Principles, 2007).

The nature and approach of this study has been important for understanding the variety of participants' accounts of what helps or creates barriers to building and maintaining resilience in negative situations. The review of the literature did give some good insights into what impacts ageing people encounter. These were strengthened by comparing the data with participants' reports. Particular attention was paid to what contextual factors needed to be considered. One example would be when participants make both good and poor reports concerning faith-based hospital systems. In this instance, descriptions of participants' contextual experiences were more important than how many incidences were reported.

Sub-theme one (ST1): Macro-environmental systems

Many participants had acquired legal documentation (passports, birth certificates, driving license) with few challenges other than having to repeat application processes with multiple organisations, including public services (e.g., health insurance, banks). However, according to where they lived, some participants were more advantaged than others in having access to health and support systems. For example, WA has a well-funded Indigenous health system based in Perth.

Most participants felt that affirming their gender and being able to move around freely and un-judged in public helped their wellbeing, by feeling social acceptance. Moreover, they felt that their visibility helps to raise awareness for the entire transgender community. Emphasis was placed on the advantages of organisational support in the workplace. Several participants had been socially, mentally, or economically supported with their gender affirmation processes. For example, there were two instances of organizations employing specialist psychologists to counsel all parties in the workplace or to assist with diversity policies. Other workplaces defended participants when encountering abusive interactions with customers.

Participants reporting on any barriers to building resilience to negative situations detailed their problems and challenges, particularly in regard to funding needs (for GAS), with health insurance organisations, lack of Medicare funding or bulk-billing doctors, workplace bias and marginalisation, and institutional discrimination in health and support situations. For instance, there were no possibilities for MG participants to receive genital (lower) surgeries, either with health insurance or Medicare subsidy assistance, because of the shortage of surgeons in Australia willing to perform the procedure.

Some participants acted as advocates or activists and were representing ageing populations in their regions. These participants confirmed they were in direct contact with others who feared reporting their issues would result in unwanted visibility and increased prejudice. One activist related

how these fears of prejudice arise when she described a first-hand experience of overt discrimination from politicians when raising awareness of aged care and general transgender discrimination issues. She witnessed government authorities likening transgender people to paedophiles wanting an excuse to prey on young people in public facilities.

Sub-theme two (ST2): Community systems

ST2 was loaded with a variety of positive and negative commentary concerning wider communities. Reports related to formal and informal interactions with workplaces, local communities (LGBTI, online transgender, and towns), and healthcare settings such as medical clinics. Most assistance for developing resilience in negative situations (associated with gender affirmation) was gained from HPs, support workers, and other groups or individuals. Participants valued others showing respect, understanding, cultural competency, knowledge, and willingness, particularly when participants needed professionally validated information and help with understanding their own gender identity issues. Examples included establishing good networks and relationships with school counsellors; or, joining LGBTI groups to actively serve in the community with advocacy or activism.

Participants' negative commentary was less than half of the positive commentary for community systems. Negative experiences – such as mobility access barriers, age cut-offs, secrecy (online Facebook groups), rejection and hostility, and lack of rapport and community choice – reduced capacities to be resilient by excluding participants from companionship. Other issues, such as fear of discrimination or stigmatisation in local community places, for example when attending social events, were mentioned. Moreover, using toilets in places such as gyms or local public places was an issue that had prevented people maintaining their physical health (prevention from exercising) and wellbeing. Participants also reported that marginalisation in the workplace occurred during and after their gender transition.

Community HPs had further marginalised, and discriminated against, participants by delaying gender affirmation processes through refusing to give referrals to specialist HPs (gatekeepers). Jaffee et al. (2016) suggested that their trans male participants experienced increased discrimination due to less visibility (in society) and being less understood in healthcare situations. However, this information was uncovered in the US. Whilst this current study's participants have reported discriminative practices, there were also multiple reports where participants found inclusive and knowledgeable HPs.

Some participants also had negative experiences, such as stigmatization on religious grounds from local faith-based community HPs. Many participants associated these experiences with traditional mindsets (encountered in their early life stages) from past times when scepticism had caused them to fear arrest and/or corrective therapies, such as electric shock treatments. Such

associations suggest that these fears, from times when transgender people were thought to have abnormal tendencies and be mentally disturbed (Beemyn, 2013), have provided some explanation for the participants' current explanations of their fear of entering aged care or having assisted care. Fear of stigmatization also explains participants' needs for forward-planning and payments for their own funerals, as discussed in ST4, individual systems.

Sub-theme three (ST3): Interpersonal systems

In ST3, commentary on interpersonal systems provides evidence of how relationships with others have impacted participants' capacity for resilience. These all concern informal interactions with friends, parents, siblings, children, pets, partners, spouses, and some HPs, particularly GPs. There was relatively more positive commentary in this respect from the Indigenous participant than from other participants. She explained how the culture, structure, and size of her family had always given her multiple avenues for support and acceptance. Other participants discussed how their parents or children, and sometimes siblings, needed time to adapt and/or come to terms with their coming out. This often resulted in delays getting support from their loved ones for the challenges they faced when they came out. In later life, developing dementia was also shown to render transgender people vulnerable to family-based discrimination. Examples are concealment in care or rejection and people having to, unwillingly and outwardly, revert to their pre-transition identities (Latham & Barrett, 2015).

Supportive family members helped participants overcome negative situations by giving them safe spaces to share feelings and give support. Friends filled a similar role, as well as helping participants to understand themselves. Friends were also often respectful of participants and supported them to express themselves as they wanted to in public. Friends had also helped gather information about recommended HPs. Pets were great companions and helped with loneliness issues.

Interpersonal systems that created barriers to resilience for participants were mostly related to family, partners or spouses, particularly when close others could not come to terms with a participant coming out. Parents were often unaware of a participant's gender dysphoria until they revealed their gender issues. Several participants reported delaying coming out during their parents' lifetime because they feared rejection or damaging their parents' pride. Mostly, family members, and particularly parents, were reported to overcome their issues and gain acceptance of the situation. However, many partners or spouses could not, and participants often described their delays in affirming their gender as putting themselves back in the box.

Several participants reported separation from spouses or partners. Some participants and partners or spouses attempted to adapt their relationship to a new situation. Examples of unsuccessful adaptations were related to partners or spouses trying to change participants, or, when partners and

spouses did not want a participant's gender transition to alter their own sexual orientation. For instance, some heterosexual or LGB partners did not wish to become LGB or heterosexual after a participant had affirmed their gender. Friends were not reported to impact participants by causing delays in transitioning and/or affirming gender. However, there were negative accounts of friends rejecting participants, or participants themselves feeling they needed to isolate themselves from pre-transition relationships.

Sub-theme four (ST4): Individual systems

In ST4 the positive commentary was almost double that of negative responses. It may be that this imbalance suggested a recruitment bias in resilient participants (see Limitations). Their individual strengths for overcoming negative barriers have primarily been personal resilience, visibility, and economic wellbeing. Self-confidence was described in a variety of ways. Being confident to move around and interact with society in general, and/or non-reliance on others (such as maintaining independence) were key factors. Additionally, some participants reported being able to create normality and avoid self-judgement, and that they rarely experienced adverse situations.

There were several remarks saying that people who are derogatory towards transgender people have issues themselves it should not be taken personally by the receiver. Concepts and beliefs, such as those just mentioned, were said to be strengthened with assertiveness, self-understanding, maturity and knowledge. An example of this has been participants knowing their rights in abusive or adverse situations. Others also mentioned that negative experiences were dealt with as part of life, or as a challenge to be overcome by maintaining their unique outward expressions and blending in with society by "passing". Some felt that this strength, sometimes learned in childhood upbringing, was mentally rewarding.

In ST4 creating barriers for participants' resilience capacities to overcome negative situations were less varied. Each topic gained a similar amount of remarks from participants. Commentary mostly concerned their inner fears or issues with society and was often related to historical trauma. Many participants reported past experiences of being closeted by concealing their gender questioning, dysphoria, or identity. Typical negative remarks referred to fear of coming out and not being able to go back into the closet. This fear was linked to their interpersonal or community interactions. This finding supported the assertion of Riggs and Due (2013) that related societal conditioning and gender role expectations through early life increased transgender people's vulnerability to discrimination in public situations, particularly when isolated from community protections.

Many participants had also been reluctant to put their loved ones in difficult situations; for instance, when participants feared coming out would cause family and partners to be faced with rejection, stigmatization, or prejudice in social situations, such as sport, family, or work-related

events. Often this delayed exploration of a participant's issues and resulted in suppression, combined with social and mental isolation, and confusion. Some participants knew other transgender people who had withdrawn from society and were reluctant to leave their homes, even when they needed healthcare. This finding aligned with reports from prominent authors who had uncovered that prolonged and multi-faceted life challenges, such as stigmatization, have resulted in sickness (Winter et al., 2016a). In the current study, physical and mental health conditions arose from lack of exercise and failing to address existing health issues or risks. These situations were worsened if their economic health was poor, or they had mobility issues, or they were geographically located in an under-served healthcare region.

8.6   Comparative Discussion in Reference to Literature

This section compares and considers the information gained in the literature review, as it aligns with the overarching issues arising from the current study themes. The outcomes of such discussion are then related to some future areas of research that may benefit from a broader focus.

The overall outcome of participant commentary aligned with recent consensus from the Australian Research Centre in Sex Health and Society (2017) research outcomes that ageing transgender people in Australia continue to experience numerous forms of discrimination (marginalisation, stigmatization, prejudice, and bias) in health and wellbeing, and healthcare situations.

In this study, combined reports relating to health, resilience to overcome negative situations, and macro-environmental systems aligned with identified human rights issues in the review of the literature. Examples are: regional healthcare availability imbalances; organisational hindrances to affirming gender in later life; government and health system obstacles; employment discrimination (resulting in financial difficulties); broader community exclusion, and institutional attitudes (AHRC, 2015a).

As mentioned in the literature review, important additions to the Yogyakarta Principles aim to guide governments (including Australia) to improve the life quality of culturally diverse populations, by identifying issues that negatively impact their capacity to achieve good health and wellbeing (Cabral Grinspan et al., 2017; Yogyakarta Principles, 2007; 2017). In relation to these guidelines, it has been suggested that sources of discrimination will be better understood with more information that includes health determinant factors. This shows the importance of combining literature reviews and contextual health determinant data to broaden understandings of participants' viewpoints in relation to discrimination within healthcare systems and society.

For ageing transgender participants, health determinant factors were shown to include: where they live in relation to HPs; how historical experiences shape their perceptions of trust, safety, and

inclusivity, with HPs; and, how current social and health support systems may negatively impact their ability to achieve good health and to access services. The best example of exclusion from healthcare is the gatekeeping approach mentioned in the literature review and by many participants. The cost of undertaking multiple assessments over a six-month period delayed some participants from commencing the gender affirmation process until they found ways to ensure they had enough funds to complete the assessment process, which often involved an unknown quantity of attendances to HPs. Given the costs involved in much of their private healthcare, immediate access should be granted based on informed consent.

A related and important international general population study, which compared Australia's health performance indicators with those of other high-income countries, concluded that patients' perceptions of care are contextual and depend on their circumstances in relation to their primary needs, such as relying on self-identification, appropriate healthcare, and information leading to access, as well as being located near services (Corscadden et al., 2017). However, past reporting of these issues has been shown to be missing from general population literature and large-scale investigations. A possible reason for this was shown in the literature review, where it was revealed that a lack of knowledge within Australian primary healthcare (PHC) settings is particularly problematic for survey developers who aim to capture broad ranges of experiences.

Most existing standardized surveys conducted in PHC settings generally overlook some aspects of patient experiences and rarely engage with the health matters of non-reporting patients, or patients requiring trans specific care (Gardner, 2018). Often missed are health literacy, self-management, health improvements, and access to care (Gardner et al., 2016). As shown in the data collected in this current study, most participants have self-efficacy in health situations and participation in this study was important for having their voices heard. Less information from those not willing to participate indicated a lack of balance in the information gained, which warrants a more targeted approach in future research. Whilst recruiting less resilient, less visible participants poses challenges, it may be more effective to collect data via those trusted in the community. Therefore, a community, PHC, and research allegiance is a suggested approach to procure needed information for those with less visibility.

Past LGBTI research has shown low sample sizes have also resulted in under-reporting or misrepresentations of ageing transgender people's experiences. Accounts from this study's participants and the literature reviewed were comparable because both revealed that transgender people may avoid disclosing any issues if they feared their doctors would breach their confidentiality (Kattari & Hasche, 2016). This information is relevant to how participants have avoided reporting discriminations against them. It further relates to issues raised in the literature review, where the Kattari and Hasche (2016) study revealed their sample had sometimes not recognised more subtle forms of discrimination or did not know how to report their issues. Examples of subtle discrimination

164

arise when HPs or medical literature use old-fashioned, or demeaning, language when referring to trans and gender diverse people. In recent times, for instance, terms such as "transgendered", "transsexual", or "a transgender" (noun) are considered disrespectful. In this current study, however, some participants used these terms to describe events in times past and may not recognise their current use to be derogatory. Further research to reveal how subtle forms of discrimination in healthcare and society impact ageing transgender people's capacity to be resilient in negative situations is warranted.

A lack of reporting may also explain why, specifically, reporting on ageing transgender people's healthcare (both preferences and outcomes) is relatively scarce, particularly when aiming to compare their discrimination issues with any corresponding general population literature on ageing. Existing research can provide HPs with some understanding about ageing transgender people's health concerns in relation to ageing cisgender people's health concerns. In the current study, many participants did not necessarily relate a good experience to HPs' knowledge or training levels, but rather that HPs were willing to engage with participants' needs. Moreover, expectations that HPs would have some understanding of their issues was not related to the outcome of their experience.

HP satisfaction was associated with overcoming economic, waiting time, travel, and information issues, as well as with professional and respectful healthcare practices. This is consistent with general population findings in Hargreaves et al. (2015) and indicates that ageing transgender patient experiences warrant further comparisons, which may reveal relationships between their changing (age-related) needs and their expectations of HPs' role in providing appropriate care. The above findings further suggest a need for longitudinal investigations that repeatedly follow participants' health-related matters over period of time, particularly after a gender transition, to uncover what expectations and needs ageing transgender people commonly have as they get older.

Most participants experienced serious (or severe) mental illness (SMI) throughout their lifetime as an integral part of their gender dysphoria. In other words, they were impacted by bodily issues of having a mismatch between their anatomy and their identity, and/or by their fears of stigma and discrimination, and the way that people might perceive them. Other participants had chronic or genetic disorders or encountered SMI as a result of trauma in earlier life. For example, one participant explained that having autism (from birth) has been socially isolating, and another as experiencing Asperger's syndrome more severely after being sexually abused as a child. Long waiting periods and high expenses for gender affirming healthcare were shown to exacerbate symptoms of SMI, such as depression, anxiety, and suicide ideation, in several participants.

For ageing trans people, who may have suffered over long periods of time, any delays in affirming gender may increase their vulnerability to SMI. Regardless of these issues, in Australia, trans people do not have an alternative pathway to affirm their gender with GAS or GAHT unless they

can access educated and/or willing HPs who can authorize or refer patients for GAHT or GAS within the six-month period. Possibly there has been no change (yet) to the gatekeeping system because of a lack of evidence to demonstrate the impact of the assessment period on transgender sub-populations. This indicates a need for further research regarding the appropriateness of the gatekeeping approach for ageing transgender adults.

Adding to the need for more specific research concerning mental health issues and determinants for good health are age-related health issues (see Section 8.4: Findings 12, 13) that may increase the likelihood of encountering factors that cause mental health issues. Evidently, the information provided by the participants reinforces Reisner et al.'s (2016) findings that the negative effects of discrimination become compounded and impact people's health determinants over the course of their lifetime and can cause minority stress by increasing people's mental health challenges. Not many Australian investigations were found (at the time of writing) to demonstrate the links between the benefits of gaining a diagnosis for gender dysphoria in relation to managing co-existing mental health issues and improving ageing transgender people's wellbeing, particularly when they are impacted by the intersection of ageing.

Prolonged periods of discrimination and experiences of rejection and hostile social situations were previously mentioned as a common cause of minority stress in LGB populations (Meyer, 2003). In Theme Three of the current study, it has been clear that some participants' age-related and life-stage issues, such as having raised children and caring for elderly or frail parents, and invested partnerships, have been compounded with other, intersectional, community and macro-environmental discriminations. More research is warranted in this regard because little is known about which sub-groups (FG, MG, NBG) amongst ageing trans people most experience these types of life challenges.

More research on ageing trans people is also needed in this regard to formulate understandings of what psychosocial services could assist them to avoid minority stress. This is because HPs have often felt challenged to assist with participants' intersectional experiences and needs for care of aged-related issues, gender affirming health, and general health, as well as consideration of people's health determinants (e.g., family ties, travel). At the time of analysis, there had been little specific research to increase understanding of how to manage the intersection of transgender health matters and risks associated with becoming frail after 50 years. More understanding of what knowledge HPs perceive is needed to deliver adequate care to ageing transgender people would assist HP educators to design appropriate training programs. Information for HP educators is particularly needed in relation to ageing transgender people's bodies and the intersection of age-related health conditions.

Intersectionality, described by Burnes and Chen (2012) as an analysis tool to reveal how systems of power contribute to the repression of vulnerable minority groups, by causing individuals to

use multiple personalities to cope with social challenges, arises in all areas of life for ageing transgender people. From the evidence provided, interpersonal systems may also be referred to as systems of power because relationships can cause transgender people to conform to the identity expectations of close others (e.g., family, friends, partners). Specific investigations into ageing transgender people's minority stress outcomes would reveal key issues needing increased support for building resilience in social contexts from caregivers, community or close others.

Evidence shown in general population literature suggests that the complexities of managing SMI together with other health conditions significantly increases healthcare needs. Possibly investigations that can uncover how to build resilience in social contexts can reduce the likelihood of needing increased healthcare provision as transgender people grow older. There have been limited reports detailing differences between transgender people's compounded care needs, particularly if their SMI is impacted by the intersection of ageing (for example, where chronic conditions or terminal illness such as cancer or dementia are involved). In this regard, resilience building is important because non-management of SMI places people at risk of premature dependence on assisted living and care, because people's capacities for good health (undertaking preventive health measures, health literacy, information issues) can be negatively impacted (Fortuna et al., 2017; Martino et al., 2016).

End-of-life issues concerning ageing transgender people have been well researched by prominent international authors. Some have revealed the extent of the issues ageing transgender people face in late life stages when they must consider costly legal affairs, such as wills and power of attorney (Porter et al., 2016; Witten, 2009, 2015). Related Australian research has mostly reported on LGBT issues. Mostly these studies have comparatively small sub-groups of transgender participants in comparison to cisgender LGB sub-groups. Consequently, not much is known about how best to protect transgender people who lack the resources to independently cope with end-of-life matters. However, some participants in this study mentioned the involvement of some nationwide organisations that provide community assistance for transgender people in crisis. This warrants an enquiry to boost decision makers' awareness of how community involvement can boost resilience by alleviating fear and promoting wellbeing, for example with online information and representation support.

This is particularly relevant to the MG and NBG participants who all reported pre-transition mental or physical health issues, such as chronic disease and/or disability. Recent international studies have shown that male identifying transgender people have been typically less understood than female identifying transgender people. Additionally, researchers report that health determinants are typically less reported upon for trans men than trans women (Shires & Jaffee, 2015). In the current study, three of the participants (male identifying and non-binary) lived in rural areas. All three commented on the travelling, time, and financial challenges of being distanced from major cities,

where there are often a variety of specialist or culturally competent HPs. This created significant challenges during assessment periods.

Research to uncover why rural areas are under-served and how to overcome this issue, with evidence to support an abolishment to the gatekeeping approach, may be an effective support mechanism for ageing transgender people. Abolishment would overcome healthcare access and authorisation issues associated with gender affirming treatments, as well as reduce multiple journeys and expense fears. Further research outlining these benefits may prompt changes in health-related policies, which focus on appropriate continuing care for ageing transgender people after a gender transition has been made.

To some degree Australian ageing transgender people have been protected by their rights to continue with transgender-related healthcare provision after gender transitions have been made. However, as shown in the literature previously, the post-transition specifier in the DSM-5 (American Psychiatric Association, 2013a), applied to protect access rights to care, has not always been acknowledged or had its significance recognised by HPs. The review of the literature demonstrated that some regions in Australia are well served for specialised care whilst others are under-served (Alexander, 2012; Government of Victoria, 2014).

Reports detailing how people have overcome a paucity of specialist HPs are quite limited, particularly those that include information concerning HP knowledge or expertise deficits. However, the information gained in this current study indicates how a greater gathering of such information, particularly from culturally competent HPs, could assist with understanding the specific regional concerns ageing transgender people have about being distanced from specialist HPs and having to travel to services. Moreover, ageing transgender people's viewpoints would increase understanding about why there may be lack of willing HPs in any given region. A US example in the literature review, where HPs were (geographically) disproportionately spread amongst the study cohort, argued that there were not enough healthcare programs initiated to attract HPs to particular regions (Fortuna et al., 2017). The deficits were associated with a lack of HP incentives, and were therefore acting as deterrents for any potentially larger and more appropriate transgender healthcare workforces; for instance, with specialist nurses and injection programs at hospitals (Fortuna et al., 2017).

Whilst there is some information in this study regarding primary HPs' willingness to support participants, there has not been further information that explains any healthcare experiences outside of clinical environments. For instance, neither the review of the literature, nor the participants' commentary, revealed any specific details relating to the care needs of those who avoid healthcare environments. Moreover, there was no information to show how they might benefit from home visits; for example, for health monitoring or for assistance in undertaking preventive health measures such as confidence building through safe exercise programs. Evidencing the Department of Health's ([DOH]

2016) approach of delivering culturally competent healthcare in safe and appropriate places has yet to be investigated in Australia, alongside any more detailed information of care.

Participants with the most gender affirming procedures were typically those who were most resourced (with finances). Despite Health Direct (n.d.) giving advice that GAS costing up to $30,000 can be subsidised with Medicare if referrals are gained, there is not much likelihood of being conveniently located to access HPs (who bulk bill under the Australian health scheme) for patients living outside of Australia's major cities. More research is needed to uncover how those who are less resourced can be supported by health schemes to fund their gender affirmation needs. This is particularly needed when considering the existing and limited options for GAS; and further, that some GAS post-operative individuals reported developing infections or needed corrective surgery. This factor also warrants future health and wellbeing research that considers wealth, such as that gained by employment, and/or qualification for social (Medicare) support for those on low incomes.

Australian researchers have shown a growing interest in employment discrimination and there has been some focus on reviewing discrimination legislation across all Australian states (Barrett et al., 2014; Morgan, Reavley, Jorm, & Beatson, 2016). Outcomes of employment data have yet to be compared in a large-scale study with ageing transgender people's health outcomes and health determinants. However, in a study by Fredriksen-Goldsen et al. (2017a), which included economic data in a health and social resilience analysis, the findings were that their sample's "visibly resourced" (p.22) sub-group experienced better overall health than less advantaged sub-groups (Fredriksen-Goldsen, Kim, et al., 2017a).

In contrast, this study revealed that wealth was not necessarily an indicator of good health. There were several fit and well participants who had used all their resources to transition and had no remaining savings. This information relates to evidence concerning the significance of employment discrimination to overall wellbeing in the long term for ageing transgender people. Further research and evidence of post-transition hardship, and any negative impacts such as suicide and suicide ideation, would undoubtedly contribute to any political weight needed to align anti-discrimination legislation with ageing transgender people's current situations.

Health spending was also shown in the literature review to be associated with economic advantage or disadvantage for those seeking and accessing care (Andritsos & Tang, 2014). What is also missing from Australian literature is a specific interest in uncovering ways in which close contact professionals (doctors and nurses) could further assist health systems (and ageing transgender people) by reducing costly services. Fortuna et al. (2017) gave an example of HPs reducing healthcare costs with patient-centred care and taking shared-decision approaches with patients. This is consistent with the current study, where the participants commonly regarded themselves as fortunate when they

experienced trusting and inclusive interactions with culturally competent professionals or GPs, with whom they had developed strong relationships.

Health spending is only one influence on healthcare seeking behaviour. Several participants mentioned that without identity documentation matching their outward expressions they would be challenged to enter healthcare administration systems, and/or would possibly be misgendered or refused care. Participants from all groups suggested that discrimination linked to societal prejudice, misunderstanding, and misconceptions, is still prevalent in current times. These issues need closer investigation into existing relationships between health determinants (environmental, economic, and social wellbeing) and patient-experiences, such as whether opportunities exist for quality patient-centred care.

This study has included a full range of determinants of good health for ageing transgender people, including some employment information. The information given is consistent with significant reports detailing the importance of undertaking health and healthcare research that includes consideration for ageing transgender people's determinants for good health. These reports were in the form of recommendations by the Institute of Medicine [IOM] (Scott & Jha, 2014) and WHO (2017), asserting that health investigations should aim to reveal all needs relative to health determinants by conducting broad investigations about people's lives. Most Australian reporting has targeted health outcomes and healthcare services, rather than gaining broad knowledge about the context of ageing transgender people's lives. This means there has been little understanding of how ageing transgender generations address life transitions and prioritise other life components over their wellbeing or accessing care.

8.7   Recommendations for Policy and Practice

This section provides an overview of any recommendations for policy and practice in relation to the participants' reported experiences, opinions, and concerns regarding their health, healthcare, and residential care and/or assisted living related issues. The ageing transgender populations of Australia will benefit from the recommendations being addressed as a matter of urgency; in other words, to align with any emerging and related Australian health reforms.

The current study investigated ageing transgender people's experiences of health and healthcare provision in the context of their broad health and capacity to enter healthcare provision and systems. There was a gender specific focus on their experiences of health and healthcare provision (Theme One [T1]). However, without including the study sample's underlying factors for good health and access to suitable healthcare provision (Theme Two [T2] and Three [T3]), the findings would not provide enough detail for health policy and legislative writers to use any information that may assist with formulating balanced and inclusive broad health programs or reforms. The following

recommendations for policy and practice are therefore based on the broad range of findings and evidence revealed throughout the research.

1. *Federal government census, which includes data collection on gender diversity to improve the accuracy of information with the following:*

   - ascertain any difficulties relating to data collection and use of appropriate and inclusive language;
   - ascertain the size of trans populations by using the "two-step" approach on ABS and national census surveys;
   - ascertain how many ageing members exist within that population;
   - identify service needs by gathering information from HPs caring for ageing transgender people in preparation for oncoming health reforms; and,
   - implementation of appropriate privacy measures to protect potentially harmful sharing of medical information without consent.

New survey measures may be the answer for the Australian Government and ABS for gaining more accurate population statistics. Underlying issues needing to be addressed largely depend on data gatherers in healthcare environments being educated and culturally competent in the use of appropriate language to communicate with trans people. Researchers from the Williams Institute designed the "two-step" approach for a more standardised approach to gather information on gender identity, for the purpose of ascertaining any discrepancies between a person's sex assigned at birth and any change of gender identity (Greytak et al., 2014).

These discrepancies have the benefit of indicating trans people who identify in the binary (male/man, female/woman) and would therefore overcome any statistical deficits in quantifying population sub-groups by gender. Moreover, these measures would protect transgender people from marginalisation and discrimination in healthcare policies and reforms. Additionally, they may have a positive effect of justifying the need for more emphasis on anti-discrimination laws in healthcare environments that can protect transgender people from being misgendered by HPs.

There are multiple state and federal health reforms due in Australia within the near future. An example relevant to the outcomes of this study is the widely broadcasted private health insurance reform, to be released in 2020, which relates to participants' reported challenges of paying for costly premiums and penalties. Data accuracy will assist with overcoming any knowledge deficits, research bias, or misinformed policy and legislative writing issues in Australia. This is particularly relevant to contextual health determinant data, which could be collected in primary healthcare situations, that may reveal how intersectionality and/or discrimination, such as employment, impact ageing transgender people's ability to access appropriate services. The data suggests that gathering accurate information is most likely achievable by gaining broad information relating to ageing transgender

people's overarching issues. This is achievable by way of multi-sectoral and community collaborations. These should include community members and others involved in the health and wellbeing of ageing transgender people (primary health carers), in the planning of data collection approaches and gathering of information.

It is suggested that collaborative approaches to data collection will help gain a deeper understanding of a full range of issues, as well as of healthcare issues alone. This range should include: issues concerning Australia's health and social system (Medicare, Centrelink, health insurers, assisted living and residential care); health program concerns (screening, mental health); socio-economic or demographic differences within the sub-population; and, the underlying psychosocial factors impacting ageing transgender people's capacity to maintain good overall health.

Several participants maintained that, if their issues improved relating to HP and health systems and identities, such as being respected in their authentic gender expressions, having appropriate and inclusive forms, and being addressed with appropriate pronouns, their experiences in and with services would be greatly improved. This indicates that government spending associated with research and data collection, health services, and programs for education and corresponding health system changes may be better allocated and will address the many risk factors associated with being an ageing transgender person, such as damaging and life-threatening mental health conditions.

Transgender leadership, by way of community and organisation involvement, can assist policy writers to understand how protections for ageing trans people can be promoted and increased in the long term. Their involvement should include all phases of research planning, data collection, analysis, and publication.

The *Australian Privacy Act 1988*, which promotes the privacy of individuals, regarding exchange of information (health, tax, research, consumer credit) between government agencies and large organisations, is a key regulation in this regard. However, there has been some misinterpretation of its content and how it can (or should) be implemented, which has led to some significant revisions. Whilst interpretation of the Act's legislation has led to the privacy of LGBTI people's information sharing being jeopardized, there have also been significant attempts to assist government departments' and workers', and information gatherers' (HPs, researchers, health insurers) understanding of appropriacy and respectfulness in relation to identity and sexuality privacy and documentation issues (Australian Government, 2013).

The *Australian Government Guidelines on the Recognition of Sex and Gender* (2013 [updated 2015]) addresses several privacy concerns by emphasising how and what principles were subject review in relation to gender identity and sexual orientation. Of relevance is that the behaviour of government agencies and other organisations should be respectful by treating all LGBTI people with dignity in compliance with anti-discrimination legislation.

Transgender community and organisation involvement should be involved in any progressive alignment (legislative, education, and training) and management of the legislation to government and organisation practices, as set out in the *Australian Government Guidelines on the Recognition of Sex and Gender* (2013 [updated 2015]). Involvement particularly relates to documentation Privacy Principles (6, 7, 8, 9): only one "personal record should be made or maintained for an individual, regardless of a change in gender or other change in personal identity" (Australian Government, 2013 [updated 2015], point 37); appropriate gender markers must be made available in documentation; and, a gender marker, not a sex (assigned at birth or other) marker, is required on documentation. Moreover, Principle 11 stipulates that information held that has no further use should have any identities removed or be destroyed.

2. *Training health providers and support workers (including psychosocial and assisted living services), by involving LGBT education organisations, to provide cultural and clinical competency should include:*

- sensitivity to the unique experiences of each ageing transgender person;
- sensitivity to their physical (ageing, trans-related, physical health), and socio-emotional needs (stigma, isolation); and,
- identifying unique service needs (e.g., preventive health, health screening) of ageing transgender people.

All participants called for upskilling programs for the full range of Australian HPs, including clinical staff, assisted living carers, and agency workers. In Theme One, Needs and Suggestions (ST3), participants also called for attitudes in general to be more inclusive. For example, several participants struggled with health screening (breast, prostate, and cervical cancer). Policies relating to improving inclusivity require considerations for appropriate service provision, as well as education and training programs that include universally inclusive identity terms to standardize care practices and help health insurers, HPs and care providers understand patients' needs.

Participants provided information about specific issues associated with ageing, as well as being transgender, that need to be addressed within health provider and support worker education events, online learning materials, and programs. Examples of these are provided by AusPATH. They currently refer to WPATH's, *SOC7* (Coleman et al.,2012), which has no specific categories dedicated to ageing transgender people. In relation to the findings, a revised edition (*SOC8*) will need to provide HPs with information to enhance understanding of the following issues: (1) that they have lived through times where people, including healthcare providers and specialists, were more hostile and less inclusive and/or accepting of gender and cultural diversity (meaning living in society caused them to experience stigma and isolation); (2) several participants had lost their sources of support (families, employment, friends and communities); and, (3) the price of gender affirmation and medical gender

transitions is highly expensive and the cost can severely limit services available to ageing transgender people entering or already in retirement.

The participants' voices were strengthened in T1's *Needs and suggestions for progress* (see ST3), where their viewpoints and ideas arose from experiences described in T1's former sub-themes (ST1 & ST2). They called for HP training to give them cultural competency when assisting with ageing transgender people's physical needs, such as age-related health issues, specifically GAHT, GAS, and other therapies (e.g., hair removal, speech), and general healthcare needs (degenerative disease and disability, health monitoring for side-effects, prostate screening). Other requested competencies related to being sensitive to their socio-emotional needs. These were associated with a lifetime of discrimination (or concealment to avoid stigma) and other social challenges (family, friends, employment).

3. *Department of Health to fund specialist training programmes (STPs) with a focus on increasing the capacities of primary healthcare providers (i.e., GPs, and aged care workers) to provide a broader range of services, particularly in regional areas for the purpose of:*

- assisting with recognition of the special role they play in the lives of trans people;
- paying attention to ageing trans people who lack mobility and/or resources for travelling to specialists or culturally competent service providers;
- focusing on provision of 'holistic' care (focusing on all needs [e.g., trans sensitive screening and psychosocial related counselling] related to achieving health) and,
- establishing community connections and collaborations for health-related data collection.

The Department of Health (DOH) does make special provisions for extending education for specialist providers to broaden services outside of the metropolitan areas by way of a Commonwealth grant system (2019). This is needed to bolster the capacity of health providers across Australia. Evidence of this need is found throughout the literature review and findings of this current study.

Several participants suggested that transgender community organisations and members can strengthen health providers capabilities to specialise in transgender health with training and data collection. Participants justified their suggestions by affirming that healthcare provision gaps, filled with standardized, culturally competent, and holistic services, would ensure consistency and awareness about transgender peoples' backgrounds, and community safety. Safety for ageing transgender people also extends to their privacy needs.

The range of collected data can contribute to existing literature and education material by adding the following: (a) detail describing how intersectionality and associated discriminations relate to general later-life wellbeing matters associated with capacities for self-efficacy and maintaining resilience, and (2) detail of any correlations found between health determinants and ageing

174

transgender peoples' specific range of needs for gender affirming, general, health, and age-related healthcare provision (and services).

4. *Initiatives to replace gatekeeping approach with appropriate consent and specialised support systems for gender transitions as follows:*

- implementation of standardised informed consent models to align with the Australian Commission on Safety and Quality in Health Care's (NSQHS), healthcare rights and informed consent standards (2019);

- community support organisations to provide programs to raise awareness and cultural competence among healthcare providers, aged care providers, and other support workers; and,

- community participation in the planning and delivery of healthcare services, aged care services, and support workers.

As mentioned in previous sections, the gatekeeping approach was usually stressful and added obstacles to participants' gender transition. For example, the six-month assessment duration and multiple attendances to private healthcare practices is costly and (often) unnecessary. Moreover, it should be acknowledged that ageing transgender people often pay for gender affirming care by drawing on their life savings and superannuation. A possible solution to this problem is to replace the gatekeeping approach with a standardised informed consent model, and to educate and train primary health carers to fulfil transgender people's range of health needs.

The NSQHS is a service that supports nationwide consistency in healthcare settings with eight standards to improve the quality and level of care (2019). They can be utilised across Australia to coordinate practices between the full range of HPs and to ensure the safety and quality of care for patients. This is done by ensuring that HPs' informed consent processes complies with co-ordinating legislation (2019). Additionally, increased opportunities for trans specific training will assist HPs to provide any necessary healthcare and understand what special roles specialists, health carers and support workers (including community support people) play in the lives of trans people.

5. *Community participation initiatives, in recognition of the body of knowledge these people have as elders in the trans community, and paid employment to community members, which will also provide the following:*

- assist with communications and social interaction to reduce isolation between ageing trans people;

- build mutual support and resilience by providing appropriate education and services for aged care facilities in which there are trans or LGBTI community workers;

- participation in planning and delivery of healthcare services, aged care services, and other support services; and

- employment support via improved legislation aimed at protecting trans people from workplace discrimination.

Such initiatives are important for capacity building for the ageing trans community, particularly those who are retired or long-term unemployed. There are some organisations, as mentioned in the literature review (e.g., GRAI, TGV), across Australia who specifically support ageing LGBTI or specifically trans community members. These have been highly successful in connecting individuals with care providers and creating safe social events for community groups. Members should be funded to run training programs in aged-related transgender issues (including other LGBTI people, HPs and related service providers). Programs should include training to: (a) assist with data collection; (b) be involved in trans-related advocacy, (c) provide counselling; and, (d) be culturally competent with hands-on care provision in health, aged-care, or assisted care settings.

Additionally, most participants expressed concerns or fears about entering aged care and assisted care, particularly if they anticipated stigmatization; for example, when entering an aged care environment without having genitalia matching their outward gender expressions. A solution to these is found in the Australian Government's (2017) strategy for addressing equal access to care for all older/ageing Australian people. The *Aged Care Diversity Strategy's* primary aim is to improve quality of care by meeting the needs of diverse and minority older adults (Australian Government, 2017). A most important concern and recommendation in this regard is for quality care and supervision to be provided by wage-earning leadership and community workers; and further, for effective health and aged-related care programs to be facilitated by transgender community educators. This combination may have the additional benefit of bolstering ageing transgender people's capacities for resilience and overcoming negative situations.

Legislation should include and support ageing transgender people's employment rights and protection policies. Participants commented on the injustice of penalties imposed on insurance premiums after a period of unemployment period and/or being on a government-funded pension. Not many ageing transgender participants maintained their employment during or after transition, therefore they would not have been able to keep up hefty premiums after penalty loadings.

8.8   Implications for Theory

This section addresses any findings within the literature review and participant commentary that suggested the need for a standardised approach to data analysis and use of theory for identifying health and healthcare issues relating to ageing transgender people.

Contemporary calls for more research on the ageing issues of trans people are significant in light of the world's rapidly ageing populations. Australia's ageing population, including those aged 50 and above, is predicted to almost double and make up more than one-third of Australia's total

population by 2050 (PopulationPyramid.net, 2019). This indicates that health systems and health policy must adapt to accommodate the rising demand for age-related healthcare.

Edgar et al. (2017), of the National Ageing Research Institute (NARI), associated rising population issues with the political weight of Australia's ageing population. That is, elderly or frail people are anticipated to make up as much as one-third of Australian society within two decades, which indicates a marked increase in healthcare needs and spending. The authors' recommendations for lessening the impact were to broaden decision and policy makers' viewpoints about solutions (for ageing and health issues) with wider-ranging research (Edgar et al., 2017). Based on these recommendations, it is important for ageing studies to place emphasis on a target population's mid-life years and what strategies are needed for maintaining good health and wellbeing. However, this is problematic because data collection issues, such as non-reporting, for ageing transgender people has not been overcome.

Whilst much is known about the statistics regarding ageing in populations in general, comparatively little is known regarding ageing transgender people. A lack of statistical information is a concern because, as discussed in Chapter One (section 1.4), lacking population information leads to inaccuracies in determining how many ageing transgender people are suffering with poor health and wellbeing-related issues (Olyslager & Conway, 2007). Regardless, transgender people over the age of 50 are a portion of the ageing Australian population and prevalence data shows there are, similarly, a growing number of ageing transgender people. The Australian Institute of Health and Welfare's ([AIHW] 2018) recent inclusion of population statistics detailed transgender people in the broader LGBTI group. Statistics published in the 2016 Australian Bureau of Statistics online census could not accurately convey how many transgender respondents there were, over the age of 50 years, due to non-reporting or non-disclosure of status. Despite providing multiple options for transgender identities the ABS survey could not identify trans people who simply identify as "male" or "female". However, the investigation did report that populations of ageing transgender people are likely to be higher than is currently estimated (Australian Institute of Health and Welfare, 2018).

What is not known is whether the growing number of ageing transgender people will continue to have lifespans that match cisgender people. Whilst they similarly have their own healthcare and aged care needs, many are without social support systems. If their population growth does not meet what is anticipated, it is highly likely they will have been impacted by exclusion and discrimination from healthcare. Discrimination and marginalisation are key concerns requiring policy reforms that give them the same opportunities for good health and wellbeing, and access to healthcare, as general ageing populations.

No universal pathway has, as yet, established a method for capturing a wide range of information concerning the full range of mid-life issues – even in general population data collection

(Beard et al., 2016). One barrier has been the difficulty of defining a typical middle-aged or ageing person (World Health Organization [WHO], 2018a). Instead of conducting single condition studies there has been some evidence to suggest that matching ageing-related life stages against health stressors (such as negative impacts on health determinants) could be a more effective way of showing shared issues and needs of ageing populations (Elliott et al., 2016).

In this study, Davidson et al.'s previously mentioned framework, comprising concentric circles (2018), allowed a range of life stage issues to be extracted for both general populations and minority sub-populations, including all age ranges of transgender people. T3's *Resilience enablers or barriers* content was comparable with a range of health determinant factors included within Davidson et al.'s (2018) model of eight concentric circles, as outlined in Chapter Two. Davidson et al. (2018) emphasised the importance of utilizing this type of model to reveal the complexities of ageing and their intersections with health-related matters. In this current study, most of the factors have been retained to create an adaptation of their model. However, to simplify analysis and highlight the key determinant factors, the data in this theme was analysed by using an adapted version of the model. The adapted version was reduced into four concentric circles to show any important influences and impacts to people's personal health, and gender affirmation goals. This adaptation helped to determine what underlying factors have negatively or positively impacted people's lived experiences and potential for achieving overall wellbeing via their determinants for good health.

The advantage of taking the Davidson et al. (2018) broad viewpoint is that it enabled participants' reports to span their lifetime within a single interview. Collecting data by using this approach and framework was at the core of the current study design. In future, the design could be developed, for example by adding a longitudinal element and multiple interviews over a given time period, thus providing a standardized way of gathering participant-driven information. Moreover, the Davidson et al. (2018) framework provided a way to determine and develop a theory to determine how and why gaps in ageing related research and healthcare occur; and also, to provide evidence for which key measures will most likely improve ageing transgender people's health and wellbeing. Zeeb et al. (2018) also outlined related gaps which could be added on to these questions. Zeeb et al. queries how and when ageing carries the most burden, and also how social gradients across age-ranges impact people's (transgender and cisgender) health determinants (2018).

8.9   Limitations

This section explains how this research project was limited and what aspects of the limitations impacted the study outcomes. It also provides suggestions that may assist future research to avoid such limitations.

Research comparing general populations with transgender populations has provided evidence that anti-discrimination legislation has not necessarily protected every transgender person from further systemic discrimination (Bockting et al., 2013; Grant et al., 2011). However, this information has provided little insight into any compounded impacts of discrimination that ageing transgender people may have encountered due to their increased need for healthcare. Many older transgender people have experienced a variety of psychosocial and/or physical issues throughout their lifetimes (e.g., generational and social circumstances into which they were born) that may have impacted their ability to openly convey their desired gender identity (Jablonski, Vance, & Beattie, 2013).

The study limitations were found in the participant sample itself. Whilst all efforts were made and recruitment was widespread, many participants volunteered for the study after attending an HP, or by snowball sampling. In other words, recruitment relied on assistance from community leaders and members, or HPs, to encourage others to participate in the research project. In this regard it is relevant to highlight the associated difficulties of reaching out to trans people who have little or no connections with these sources. This is particularly relevant to those living in Indigenous communities, sex industry workers, institutions, or being cared for by assisted living organisations, without undergoing a more rigorous ethical clearance process. A higher-level ethical clearance is beyond the scope of this study. In relation to this limitation, it was challenging to find LGBTI organisational representatives (community leaders, members) that could otherwise assist with recruitment. It was also difficult to reach out to ageing transgender people who are, for example, not accessing healthcare and are currently isolated or choose to be separated from others (HPs or community). Additionally, most participants volunteering for the study are persons who were assigned male at birth and are identifying as female, women, and/or trans women. All participants who were assigned female at birth identify as both male and/trans men, and non-binary. Moreover, all the non-binary participants were presenting with male outward expressions. Therefore, the study did not achieve a balance of gender identities because there were no non-binary participants who were assigned male at birth.

Whilst this current study provided some evidence to justify key areas in need of attention from HP policy and decision makers, there was only one interview per participant. This meant only capturing a relatively small amount of information about their past challenges and experiences. Moreover, most of the current study participants were not concealing their identity in any area of their lives, meaning there was no information gathered from transgender people who may be living in their authentic gender part-time. In addition, imbalances were found regarding participants' ages.

One of the most important deficits in this study related to the age of the participants and difficulty in recruiting ageing transgender (trans elders) people living in assisted or care institutions. Most participants' ages were under the Australian retirement age of 65. This meant very little information was gathered to represent elderly populations or frail populations. This means that some

important information may have been missed, such as those trans people who do not reveal their identity; and, other trans people who may have never undergone medical transition procedures, but nevertheless, identify as male/man or female/woman, and not as a trans man or trans woman. A suggested method for overcoming this issue would be to adopt a respondent-driven sampling method.

The weight of commentary related to MG and NBG showed them to be more likely to encounter more positive than negative experiences when in healthcare environments. Quantifying this issue however, in this study, is likely to be superficial and not a particularly valid way of analysing these data sets, because some utterances may have an overarching issue even if details belonged to more than one theme. This meant reporting some participant quotes in relation to just one ST even though they also fit within other STs. Moreover, it cannot be assumed that the broader transgender communities experienced less hindrances than enablers because, from the evidence presented, participants appeared to be quite resilient and confident. Less confident individuals may have experienced more issues and thus avoided healthcare environments altogether. As a result, the current study sample cannot be regarded as a representative sample.

Although the study could not give a complete picture of ageing transgender people's health determinants and healthcare provision issues, the findings and conclusion revealed important information. However, the information overall was limited by the broad topic range. This was due to the research design aiming to explore ageing transgender people's experiences and needs, and not an in-depth or specific report on any particular topic of health or healthcare provision. In this regard, there were no balancing viewpoints because no information was collected from HPs or other related organisations or agencies. Moreover, there was no information from participants in care institutions (prison, mental health, hospital, aged care).

It is important to point out that all efforts were made to gain an extensive and diverse sample group; for example, which included those in institutional care. However, the result was not wide reaching for a variety of reasons. Little is known in relation to the whereabouts of many ageing transgender people in Australia, particularly those outside of urban areas. They may be visible on online platforms, however, have no social relationships with other community members in their geographical locations. This meant it was very difficult to connect with individuals in the Australian context without assistance from HPs and community leaders and members (e.g., online coordinators). Moreover, there were limitations relating to the scope of the study, such as time challenges. Recruitment continued throughout much of 2017, however it needed to be closed after that year. This exploratory Master of Philosophy in Public Health study was restricted to a duration of two years after candidacy had been completed. These issues relate to the need for longitudinal studies, which can overcome such time restrictions issues. Additionally, the study was reliant on participants' goodwill to volunteer. Incentives to participate were restricted to travel expenses and having the opportunity to share their viewpoints and experiences.

Despite any limiting factors, this study has informed related and future research to pay attention to how data is collected. For instance, accessing quality information about a sub-group of the ageing trans population, or a particular healthcare provision issue that will benefit ageing trans people more than others, requires collaboration. Future collaborations will likely be broader reaching if they are community driven. In other words, community driven by engaging transgender communities and leaders, and trans advocates, in partnership operations with trans scholars, trans specialised HPs, primary healthcare HPs, health system authorities, and related government agents.

8.10   Recommendations for Further Research

This section details several key areas in which further research will benefit ageing transgender populations.

Prominent authors have long called for data gathering to provide information that addresses any disproportionate balances of physical (ageing, gender affirming, mental) and health determinants (socioeconomic, environmental, geographic) encountered by transgender and LGBTI communities (Hyde & Brown, 2011; Witten, 2009). In view of these, recommendations for future research are presented as follows:

1. *Improved reporting quality by making longitudinal investigations*
Longitudinal studies have the potential to overcome issues highlighted by the Australian Bureau of Statistics (ABS) that relate to discrimination or difficulties in healthcare provision. Most likely to be reported have been issues of fairness, cost, appropriate service provision, and un-partnered people being challenged to access care without assistance (Temple & Williams, 2018). These require consideration for people's changes in health determinants and health status. Significance has been placed on encouraging future investigations to cover any health and health determinant issues occurring throughout participants' lifespans.

Moreover, the Australian Government must be reminded that ageing transgender people need to maintain their outward and authentic expressions throughout later life. Given the increased health risks associated with ageing and GAS, and GAHT, access to quality and specialised healthcare is a medical necessity for many transgender and non-binary people. Additionally, these care needs are a clear indication that this sub-population will most likely continue to be significant health consumers across a range of services. Assessing ageing transgender people's health at only one period (for example, with just one survey or interview), and addressing only their most primary health needs, might overlook their additional health needs and any associated healthcare costs. Alternatives may include multiple data collection points over a period. An example might be when undertaking supervised exercise for a preventive health program, in which the participants complete a daily health and wellbeing diary (including activities and healthcare attendances), undertake health screening at set

points throughout the program, and complete a survey in relation to program outcomes and satisfaction.

2. *Australia-wide, larger scale quantitative data gathering, aimed at including less visible members of the community and geographical impacts related to healthcare access barriers*

Australia has been slower than other countries to provide large-scale reports detailing the scale of aged-related health inequalities for the entire ageing population. In Australia, general data gathering has excluded information from non-reporting people. Narayanan and Greco (2016) demonstrated that disproportionate data gathering has led to policy being guided by misleading information. Solutions for data collection are mentioned in the Recommendations for Policy and Practice section (see 8.7).

3. *Future data gathering to measure ageing transgender people's health and health determinants against mainstream ageing populations*

Comparing ageing transgender people's information with general population and heterosexual data collection might provide statistical evidence for which life stages most burden the cumulative impacts on health (Ettner & Wylie, 2013) and reveal the depth of each health component gap (e.g., chronic health conditions, socioeconomic status) experienced as an outcome of being transgender. Moreover, this type of data analysis would require multi-sectoral collaboration and involvement in data collection. This means including community members in consumer-directed information gathering in partnership with other related agencies, such as primary healthcare (PHC) settings.

4. *Program evaluation and data collection to provide valid scholarship: should include collaboration between transgender, relevant HPs (including health systems where necessary), and research leadership to provide inclusive and balanced decision making and execution*

An example would be research-based, transgender specific aged-care programs (see 8.7, point 5) and ageing health education programs, such as supervised preventive health and exercise programs. These would be particularly effective if the outcomes and benefits could be matched with community opinions and HP screenings, and care worker practices; for example, in relation to age-related health conditions and side-effects of GAHT and GAS. Undertaking investigations regarding the impacts of gender transition (psychosocial, GAHT, GAS), which allow collective, community and HP voices, would guide future data gathering, policy, and legislative practices.

Researchers have also called for research to provide outcomes that consider the benefit of disseminating targeted, quality, information to health and aged-care systems and PHC providers, as part of their upskilling programs to increase cultural and clinical competency (Persson, 2009; Zelle & Arms, 2015). Broader outlooks on health and aged-care system operations themselves would be recognised as pathways for nurturing good health and wellbeing capacities for all transgender people over their lifespans (Lindmeier, 2017; WHO, 2018a).

8.11   Conclusion

This study aimed to assist the ageing transgender population by capturing information which can be used by stakeholders, institutions, organisations, and policy makers, about participants' broad health and healthcare issues, including related assisted-living and aged-care concerns. It was anticipated that the information gained would reveal and link a range of health-related needs that ageing transgender participants have reported on to some Australian health system deficits and related healthcare access equity issues. Also, it aimed to uncover how their health determinants impacted their ability to have good health and wellbeing, and provide differentiations between transgender identities, as well as for cisgender LGB populations.

Aside from the sample limitations lacking some diversity, data collection from the participants met the study's purpose. The information gathered conveys multiple health and wellbeing, and healthcare (including aged-care and assisted living) concerns commonly experienced by ageing transgender people. Commentary revealed that many participants related their issues to the negative effect of experiencing compounded issues due to the intersection of ageing, being trans, and a having lifetimes of being challenged to maintain good health.

Participants mostly had negative experiences with health providers in the past, however this was avoided when participants had contacts with willing and/or knowledgeable, and culturally competent, practitioners and health workers. There were more positive experiences reported in current times, mostly because there are more specialised services and health providers available. Despite this, there were a range of problems and barriers to good health and wellbeing associated with:

(1) seeking competent and culturally sensitive providers outside of urban areas;

(2) coping (psychosocially, economically) with long waiting periods for services;

(3) documentation issues (health system and health insurance);

(4) having negative experiences (discrimination, marginalisation, stigmatisation, and prejudice) when accessing and attending mainstream services for general health issues;

(5) accessing appropriate and trans sensitive screening services;

(6) being identified under the LGBT umbrella and feeling misunderstood (needs related) when seeking services; and,

(7) fearing later life, losing the ability to live independently, and having to rely on institutional care providers and systems.

To justify and summarise any need for recommendations made for future research, much benefit has already been gained by allowing community leaders and trans experts, and professionals, to work alongside and provide leadership and/or guidance to decision makers in public policy and research. Pathways have been paved by transgender activists and advocates who, over time, have formed alliances to unite transgender leaders, experts, professionals, and communities across the

country, as well as forming tight bonds with significant HPs. Therefore, it is possible to create a multi-sectoral collaboration to assist with future research and data collection, for the purpose of gaining equal access to healthcare and overcoming discrimination and marginalisation issues. The inclusion of transgender leadership, experts, advocates, and HPs in collaborations will ensure efficient data gathering, and ensure that appropriate modifications of future policies will be practical, balanced, effective, and broad reaching (Ettner, 2013; Ettner & Wylie, 2013; Kattari & Hasche, 2016).

Since commencing this study, the Australian Government released the *Aged Care Diversity Framework Initiative* (2017). A collaborative approach, which included a diversity of sub-groups of the Aged Care Sector Committee, was adopted to address many of the concerns explained by participants in this study. The Australian Government asserts that every measure will be taken to align the framework with other policies (anti-discrimination, privacy). The aim is to improve and enhance diverse and minority ageing populations' lives by creating equal access to care and increasing opportunities for more choice, dignity, and respectful service provision. However, the literature also affirms that there are gaps in the related evidence needed to inform future policy design and provision of appropriate aged-care services (Australian Government, 2017). A solution to this issue is future research that involves the trans community as partners in research and policy design, which is an increasingly used strategy. This is described in the TRICON policy, which is advocated on the International Transgender Health Facebook site.

Broad and/or longitudinal studies would fill the data gaps that specifically relate to the Australian context. These would incorporate any preventive health and health determinant concepts, which are key factors to achieving good broad health and wellbeing, as outlined in earlier studies. These include a "what matters to you" (Akpan et al., 2018, p. 4) approach, which could support ageing transgender people's capacities to remain as functional, contributing citizens within Australian society. Examples of past success in general population research include improved health, literacy, social networking, and physical activity programs, as a pathway to healthy ageing and a reduction of costly HP attendances and promoted health measures, and resilience to social bias (Edgar et al., 2017). These outcomes are clear indications that there are positive pathways for ageing transgender people to achieve good wellbeing, and access to health and age-related care, when health policies and programs match those of general and cisgender ageing populations.

References

Adu, P. (2019). *A Step-By-Step Guide to Qualitative Data Coding*: Milton : Routledge.

AIDS Council of New South Wales. (2017). *Health Outcome Strategy 2017-2021*. Surrey Hills: ACON. Retrieved from https://www.acon.org.au/wp-content/uploads/2017/09/HOS-Ageing-2017_V6_web.pdf.

Akpan, A., Roberts, C., Bandeen-Roche, K., Batty, B., Bausewein, C., Bell, D., . . . Chen, L.-K. (2018). Standard set of health outcome measures for older persons. *BMC geriatrics, 18*(1), 36. http://dx.doi.org/10.1186/s12877-017-0701-3

Alexander, C. (2012, 17th August, 2018). *Medicare Coverage and Gender Reassignment Surgery Community, Health, Wellbeing, Life* [News]. Available from Out in Perth Retrieved from https://www.outinperth.com/medicare-coverage-and-gender-reassignment-surgery/

American Psychiatric Association. (2000a). *Diagnostic and statistical manual of mental disorders (IV: 4th ed., Text Revision)*. Washington, DC: (American Psychiatric Association).

American Psychiatric Association. (2000b). *Diagnostic and statistical manual of mental disorders. DSM IV-TR*. Washington, DC: (American Psychiatric Association).

American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders (DSM-5®)*: American Psychiatric Pub.

American Psychiatric Association. (2013b). Gender Dyphoria. In American Psychiatric Association (Ed.), In *Online* (Washington DC: American Psychiatric Association).

American Psychiatric Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *The American psychologist, 70*(9), 832.

Amnesty International. (2014). *The State decides who I am: lack of legal gender recognition for transgender people in Europe.* (EUR 01/001/2014). London: Amnesty International Ltd. Retrieved from https://www.es.amnesty.org/uploads/media/The_state_decide_who_I_am._Febrero_2014.pdf

Andritsos, D. A., & Tang, C. S. (2014). Introducing competition in healthcare services: The role of private care and increased patient mobility. *European Journal of Operational Research, 234*(3), 898-909. http://dx.doi.org/10.1016/j.ejor.2013.11.022

Asscheman, H. (2012, June 21 - 25, 2009). *Long term mortality in hormone-treated transsexuals* [Online Video]. Available from *A Global Challenge Göteborg* Retrieved from http://www.sexualhealthvisual.com.dbgw.lis.curtin.edu.au/Video_by_Henk_Asscheman_on_Long_term_mortality_in_hormone_treated_transsexuals.html

Auldridge, A., Tamar-Mattis, A., Kennedy, S., Ames, E., & Tobin, H. (2012). *Improving the Lives of Transgender Older Adults.* Retrieved from https://transequality.org/issues/resources/improving-lives-transgender-older-adults-full-report

Australian Bureau of Statistics. (2017). About the National Health Survey. 10 May 2017. *4364.0.55.001 - National Health Survey: First Results, 2014-15* Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2014-15~Main%20Features~About%20the%20National%20Health%20Survey~3

Australian Commission of Safety and Quality in Healthcare (2019). "*Partnering with patients in their own care: Action 2.4, Healthcare rights and informed consent.*" The NSQHS Standards. Retreived from https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard/partnering-patients-their-own-care/action-24.

Australian Government. (1988) Privacy Act 1988 (Cth). Retrieved from https://www.legislation.gov.au/Details/C2018C00292

Australian Government. (2013 [updated 2015]). *Australian Government Guidelines on the Recognition of Sex and Gender*. Retrieved from https://www.ag.gov.au/Publications/Documents/AustralianGovernmentGuidelinesontheRecognitionofSexandGender/AustralianGovernmentGuidelinesontheRecognitionofSexandGender.pdf

Australian Human Rights Commission. (2015a). The case for Australia's 'transgender awakening'. *The latest News* Retrieved from https://www.humanrights.gov.au/news/stories/case-australia-s-transgender-awakening#main-content

Australian Human Rights Commission. (2015b). Resilient Individuals: Sexual Orientation Gender Identity & Intersex Rights 2015. 1-100. Retrieved from https://www.humanrights.gov.au/our-work/sexual-orientation-sex-gender-identity/publications/resilient-individuals-sexual

Australian Institute of Health and Welfare. (2014). *An AIHW framework for assessing data sources for population health monitoring*. Canberra: AIHW.Retrieved from https://www.aihw.gov.au/getmedia/a754c39e-ec91-48a0-a9c5-cda828e0045b/18239.pdf.aspx?inline=true

Australian Institute of Health and Welfare. (2018). *Older Australia at a Glance* [Website]. Canberra: Retrieved from https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/diverse-groups-of-older-australians/older-australians-who-identify-as-lesbian-gay-bisexual-transgender-or-intersex

Australian Institute of Health Welfare. (2007). *Older Australia at a glance*. Canberra: Retrieved from http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442454209

Australian National Ageing Research Institute. (2016). *Strategic Plan 2016 - 2019*. Parkville: Retrieved from https://www.nari.net.au/files/files/documents/nari_mv036_strategic_plan-210x210_v4.pdf

Australian Research Centre in Sex Health and Society. (2017). *ARCSHS Annual Report 2017*. Melbourne: La Trobe University. Retrieved from https://www.latrobe.edu.au/__data/assets/pdf_file/0009/877113/ARCSHS-Annual-report-2017.pdf

Bariola, E., Lyons, A., Leonard, W., Pitts, M., Badcock, P., & Couch, M. (2015). Demographic and Psychosocial Factors Associated With Psychological Distress and Resilience Among Transgender Individuals. *American Journal of Public Health, 105*(10), 2108-2116. http://dx.doi.org/10.2105/AJPH. 2015.302763

Barrett, C., Crameri, P., Lambourne, S., Latham, J. R., & Whyte, C. (2015). Understanding the experiences and needs of lesbian, gay, bisexual and trans Australians living with dementia, and their partners. *Australasian Journal on Ageing, 34*, 34-38. http://dx.doi.org/10.1111/ajag.12271

Barrett, C., & Stephens, K. (2012). Beyond: 'we treat everyone the same'. A report on the 2010–2011 program: How to create a gay, lesbian, bisexual, transgender and intersex inclusive service. (Gay and Lesbian Health Victoria, Melbourne Australia).

Barrett, C., Whyte, C., Leonard, W., & Comfort, J. (2014). *No Need to Straighten Up: Discrimination, Depression, Anxiety and Older Lesbian, Gay, bisexual, Transgender and Intersex Australi* [Full Report](1921915323). Melbourne: Retrieved from http://grai.org.au/sites/default/files/NNTSU.pdf

Bates, D. (1998). Orlando's Sleep: An Autobiography of Gender. *The Lesbian Review of Books, 4*(2), 3.

Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). "I Don't Think This Is Theoretical; This Is Our Lives": How Erasure Impacts Health Care for

Transgender People. *Journal of the Association of Nurses in AIDS Care, 20*(5), 348-361. http://dx.doi.org/http://dx.doi.org/10.1016/j.jana.2009.07.004

Bauer, G. R., Scheim, A. I., Deutsch, M. B., & Massarella, C. (2014). Reported Emergency Department Avoidance, Use, and Experiences of Transgender Persons in Ontario, Canada: Results From a Respondent-Driven Sampling Survey. *Annals of Emergency Medicine, 63*(6), 713-720.e711. http://dx.doi.org/10.1016/j.annemergmed.2013.09.027

Beard, J. R., Officer, A., de Carvalho, I. A., Sadana, R., Pot, A. M., Michel, J.-P., . . . Chatterji, S. (2016). The World report on ageing and health: a policy framework for healthy ageing. *The Lancet, 387*(10033), 2145-2154. http://dx.doi.org/10.1016/S0140-6736(15)00516-4

Beemyn, G. (2013). A presence in the past: a transgender historiography. *Journal of Women's History, 25*(4), 113-121. Retrieved from https://www.researchgate.net/publication/265882812_A_Presence_in_the_Past_A_Transgender_Historiography

Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, Mental Health, and Resilience in an Online Sample of the US Transgender Population. *American Journal of Public Health, 103*(5), 943-951. http://dx.doi.org/10.2105/AJPH.2013.301241

Bound, M. (2011). Qualitative method of research: phenomenological. (Doctoral dissertation). Retrieved from http://www. academia. edu/1526812/Qualitative_Research_Phenomenological_ Method).

Bowling, A., Rowe, G., & McKee, M. (2013). Patients' experiences of their healthcare in relation to their expectations and satisfaction: a population survey. *Journal of the Royal Society of Medicine, 106*(4), 143-149. http://dx.doi.org/10.1258/jrsm.2012.120147

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101. http://dx.doi.org/10.1191/1478088706qp063oa

Brown, K. (2004). 'Sistergirls' - stories from Indigenous Australian transgender people. *Aboriginal and Islander Health Worker Journal, 28*(6), 25-26. Retrieved from https://search-informit-com-au.dbgw.lis.curtin.edu.au/search;res=IELAPA;search=FTI=yes%20AND%20IS=1037-3403%20AND%20VRF=28%20AND%20IRF=6%20AND%20PY=2004%20AND%20PG=25

Burnes, T. R., & Chen, M. M. (2012). The multiple identities of transgender individuals: Incorporating a Framework of Intersectionality to Gender Crossing. *Navigating multiple identities: Race, Gender, culture, nationality, and roles*, 113. Retrieved from https://www.researchgate.net/publication/286961040_The_Multiple_Identities_of_Transgender_Individuals_Incorporating_a_Framework_of_Intersectionality_to_Gender_Crossing

Butler, M. (2012). *National lesbian, gay, bisexual, transgender and intersex (LGBTI) ageing and aged care strategy*. (Publications approval number: D0981). Canberra: Australian Government.Retrieved from https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/08_2014/national_ageing_and_aged_care_strategy_lgbti_print_version.pdf

Cabral Grinspan, M., Carpenter, M., Ehrt, J., Kara, S., Narrain, A., . . . (2017) *The Yogyakarta Principles Plus 10*.[(accessed on 5 May 2019)]; 2017: 27." Retrieved from https://yogyakartaprinciples.org/principles-en/yp10/.

Cannon, S. M., Shukla, V., & Vanderbilt, A. A. (2017). Addressing the healthcare needs of older Lesbian, Gay, Bisexual, and Transgender patients in medical school curricula: a call to action. *Medical education online, 22*(1), 1320933. Retrieved from https://www.tandfonline.com/doi/abs/10.1080/10872981.2017.1320933

Cleasby, J., and Tilley, M. (2015, July 25-28). *Biopsychosocial changes to sexuality for transgender individuals undergoing hormone therapy in Western Australia* [Video Lecture]. Available from Sexual Health Visual Retrieved from http://www.sexualhealthvisual.com.dbgw.lis.curtin.edu.au/Video_by_Jessica_Cleasby_on_Biopsychosocial_changes_to_sexuality_for_transgender_individuals_undergoing_hormone_therapy_in_Western_Australia.html

Cohen, D., & Crabtree, B. (2006). Qualitative research guidelines project. Retrieved from http://www.qualres.org/HomeSemi-3629.html

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., Decuypere, G., Feldman, J., . . . Zucker, K. (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. *International Journal of Transgenderism, 13*(4), 165-232. http://dx.doi.org/10.1080/15532739.2011.700873

Comfort, J. (2010). LGBTI Health Research: Challenges and Ways Forward. *Gay and Lesbian Issues and Psychology Review, 6*(3), 132. Retrieved from http://lgbtihealth.org.au/sites/default/files/GLIP-Review-Vol-6-No-3-3.pdf#page=23

Corscadden, L., Levesque, J.-F., Lewis, V., Breton, M., Sutherland, K., Weenink, J.-W., . . . Russell, G. (2017). Barriers to accessing primary health care: comparing Australian experiences internationally. *Australian journal of primary health, 23*(3), 223-228. Retrieved from http://www.publish.csiro.au/PY/PY16093

Costa, L. M. and A. J. Matzner (2013). "*Male bodies, women's souls: Personal narratives of Thailand's transgendered youth*." Male Bodies, Women's Souls: Personal Narratives of Thailand's Transgendered Youth: 1-182.

Couch, M., Pitts, M., Mulcare, H., Croy, S., Mitchell, A., & Patel, S. (2007). *Tranznation: a report on the health and wellbeing of transgendered people in Australia and New Zealand*. Melbourne: Retrieved from http://apo.org.au/resource/tranznation-report-health-and-wellbeing-transgendered-people-australia-and-new-zealand

Crameri, P., Barrett, C., Latham, J., & Whyte, C. (2015). It is more than sex and clothes: Culturally safe services for older lesbian, gay, bisexual, transgender and intersex people. *Australasian journal on ageing, 34*(S2), 21-25. Retrieved from http://onlinelibrary.wiley.com.dbgw.lis.curtin.edu.au/doi/10.1111/ajag.12270/full

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*: Vol. 1989 , Article 8. Retrieved from https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Creswell, J. W. (2007). *Qualitative inquiry & research design : choosing among five approaches / John W. Creswell* (2nd ed.. ed.). Thousand Oaks: Thousand Oaks : Sage Publications.

Davidson, P., Rushton, C. H., Kurtz, M., Wise, B., Jackson, D., Beaman, A., & Broome, M. (2018). A social-ecological framework: A model for addressing ethical practice in nursing. *Journal of clinical nursing, 27*(5-6), e1233. http://dx.doi.org/10.1111/jocn.14158

Department of Health (DOH) (2016). *Primary Health Networks: Grant Programme Guidelines* Australian Government.Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/content/F4F85B97E22A94CACA257F86007C7D1F/$File/Primary%20Health%20Network%20Grant%20Programme%20Guidelines%20-%20V1.2%20February%202016.pdf

DOH (2019). *"Specialist Training Program."* Retrieved 31 August 2019, 2019, from https://www1.health.gov.au/internet/main/publishing.nsf/Content/work-spec.

Devor, H. (1993). Sexual orientation identities, attractions, and practices of female-to-male transsexuals. *The Journal of Sex Research, 30*(4), 303-315. http://dx.doi.org/10.1080/00224499309551717

DiNapoli, J. M., Garcia-Dia, M. J., Garcia-Ona, L., O'Flaherty, D., & Siller, J. (2014). A theory-based computer mediated communication intervention to promote mental health and reduce high-risk behaviors in the LGBT population. *Applied Nursing Research, 27*(1), 91-93. http://dx.doi.org/http://dx.doi.org/10.1016/j.apnr.2013.10.003

Drescher, J., Cohen-Kettenis, P., & Winter, S. (2012). Minding the body: Situating gender identity diagnoses in the ICD-11. *International Review of Psychiatry, 24*(6), 568-577. http://dx.doi.org/10.3109/09540261.2012.741575

Edgar, D., Edgar, P., Birrell, B., Betts, K., Dow, B., & Lovell, C. (2017). *The New Middle Age: Ways to thrive in the longevity economy* (978-0-6481689-0-4). Melbourne: Retrieved from https://www.nari.net.au/files/files/documents/the_new_middle_age_.pdf

Elliott, J., McNeil, H., Ashbourne, J., Huson, K., Boscart, V., & Stolee, P. (2016). Engaging older adults in health care decision-making: a realist synthesis. *The Patient-Patient-Centered Outcomes Research, 9*(5), 383-393. http://dx.doi.org/10.1007/s40271-016-0168-x

Endocrine Society of Australia. (2017, 13 August 2018). *Statement from the Endocrine Society of Australia regarding marriage equality and gender issues.* Available from Endocrine Society of Australia Retrieved from https://www.endocrinesociety.org.au/documents/StatementfromtheEndocrineSocietyofAustraliaregardingmarriageequalityandgenderissues.June2017.pdf

Ettner, R. (2013). Care of the elderly transgender patient. *Current Opinion in Endocrinology, Diabetes and Obesity, 20*(6), 580-584. http://dx.doi.org/http://dx.doi.org/10.1016/j.maturitas.2012.11.011

Ettner, R., & Wylie, K. (2013). Psychological and social adjustment in older transsexual people. *Maturitas, 74*(3), 226-229. http://dx.doi.org/http://dx.doi.org/10.1016/j.maturitas.2012.11.011

Fortuna, K. L., Lohman, M. C., Batsis, J. A., DiNapoli, E. A., DiMilia, P. R., Bruce, M. L., & Bartels, S. J. (2017). Patient experience with healthcare services among older adults with serious mental illness compared to the general older population. *The International Journal of Psychiatry in Medicine, 52*(4-6), 381-398. http://dx.doi.org/10.1177/0091217417738936

Fisk, N.M. (1974). Editorial: Gender dysphoria syndrome-the conceptualization that liberalizes indication for total gender reorientation and implies a broadly based multi-dimensional rehavilitative regimen. *Western Journal of Medicine, 120(5), 386-391.*

Fredriksen-Goldsen, K. I., Cook-Daniels, L., Kim, H. J., Erosheva, E. A., Emlet, C. A., Hoy-Ellis, C. P., . . . Muraco, A. (2014). Physical and Mental Health of Transgender Older Adults: An At-Risk and Underserved Population. *The Gerontologist, 54*(3), 488-500. http://dx.doi.org/10.1093/geront/gnt021

Fredriksen-Goldsen, K. I., Kim, H.-J., Bryan, A. E. B., Shiu, C., & Emlet, C. A. (2017a). The Cascading Effects of Marginalization and Pathways of Resilience in Attaining Good Health Among LGBT Older Adults. *The Gerontologist, 57.* http://dx.doi.org/10.1093/geront/gnw170

Fredriksen-Goldsen, K. I., Bryan, A. E. B., Jen , S., Goldsen, J. B. S., Kim, H.-J., & Muraco, A. (2017b). The Unfolding of LGBT Lives: Key Events Associated With Health and Well-being in Later Life. *The Gerontologist, 57.* http://dx.doi.org/10.1093/geront/gnw185

Gahagan, J., & Colpitts, E. (2016). Understanding and Measuring LGBTQ Pathways to Health: A Scoping Review of Strengths-Based Health Promotion Approaches in LGBTQ Health Research. *Journal of Homosexuality*, 1-27. http://dx.doi.org/10.1080/00918369.2016.1172893

Gardner, D. (2018). Patient Medical Compliance. *Northeast Pennsylvania Business Journal, 33*(1), 5-5. Retrieved from https://search-proquest-com.dbgw.lis.curtin.edu.au/docview/1988889548?accountid=10382

Gardner, K., Parkinson, A., Banfield, M., Sargent, G. M., Desborough, J., & Hehir, K. K. (2016). Usability of patient experience surveys in Australian primary health care: A scoping review. *Australian Journal of Primary Health, 22*(2), 93-99. http://dx.doi.org/10.1071/PY14179

Gleeson, H., Calderon, A., Swami, V., Deighton, J., Wolpert, M., & Edbrooke-Childs, J. (2016). Systematic review of approaches to using patient experience data for quality improvement in healthcare settings. *BMJ open, 6*(8), e011907. http://dx.doi.org/10.1136/ bmjopen-2016-011907

Gooren, L. J., & T'Sjoen, G. (2018). Endocrine treatment of aging transgender people. *Reviews in Endocrine and Metabolic Disorders*, 1-10. http://dx.doi.org/https://doi.org/10.1007/s11154-018-9449-0

Gottschalk, K. (2006). Abuse and Mistreatment in Western Australia: Blatant Discrimination against Pre-Operative Transexuals in the Public Hospital System. 2013. *Polare* Retrieved from http://www.gendercentre.org.au/resources/polare-archive/archived-articles/abuse-and-mistreatment-in-western-australia.htm

Government of Victoria. (2011). *Well proud: A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services* Melbourne: Department of Health. Retrieved from http://www.glhv.org.au/files/WellProud_updated2011.pdf

Government of Victoria. (2014). *Transgender and gender diverse health and wellbeing*. Victoria: State Government of Victoria. Retrieved from http://www.health.vic.gov.au/diversity/index.htm

Grant, J. M., Mottet, L., Tanis, J. E., Harrison, J., Herman, J., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey* (20373). Washington DC: The National Gay and Lesbian Task Force. Retrieved from http://ncfy.acf.hhs.gov/library/2011/injustice-every-turn-report-national-transgender-discrimination-survey

Green, J. (2017). Legal issues for transgender people: a review of persistent threats. *Sexual health, 14*(5), 431-435. http://dx.doi.org/10.1071/SH17104

Greytak, E., Gill, A.M., Conron, K.J., Herman, J.L. (2014). "*Best Practices for Asking Questions to Identify Transgender and Other Gender Minority Respondents on Population-Based Surveys*." https://williamsinstitute.law.ucla.edu/wp-content/uploads/geniuss-report-sep-2014.pdf

Groenewald, T. (2004). A phenomenological research design illustrated. *International journal of qualitative methods, 3*(1), 42-55. http://dx.doi.org/10.1177/160940690400300104

Hargreaves, D. S., Greaves, F., Levay, C., Mitchell, I., Koch, U., Esch, T., . . . Sheikh, A. (2015). Comparison of health care experience and access between young and older adults in 11 high-income countries. *Journal of Adolescent Health, 57*(4), 413-420. http://dx.doi.org/10.1016/j.jadohealth.2015.05.015

Health Direct. (n.d.). Gender confirmation surgery. *Health topics* Retrieved from https://www.healthdirect.gov.au/gender-confirmation-surgery

Health Talk Australia. (2018). People's Profiles: Health Services [Academic Information platform]. *The lived experience of ageing* Retrieved from http://research.healthtalkaustralia.org/experience-ageing/health-services

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., . . . T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons:

an endocrine society clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism, 102*(11), 3869-3903. http://dx.doi.org/10.1210/jc.2017-01658

Hollenbach, A. D., Eckstrand, K. L., & Dreger, A. D. (2014). *Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD: a resource for medical educators.* Association of American Medical Colleges. Retrieved from www.aamc.org/publications

Houssayni, S., & Nilsen, K. (2018). Transgender Competent Provider: Identifying Transgender Health Needs, Health Disparities, and Health Coverage. *Kansas Journal of Medicine, 11*(1), 15-19. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5834239/

Hughes, A., Luz, C., Hall, D., Gardner, P., Hennessey, C., & Lammers, L. (2016). Transformative Theatre: A Promising Educational Tool for Improving Health Encounters With LGBT Older Adults. *Gerontology & geriatrics education, 37*(3), 292-306. http://dx.doi.org/http://dx.doi.org/10.1080/02701960.2015.1127812

Hughes, M. (2017). Health and well being of lesbian, gay, bisexual, transgender and intersex people aged 50 years and over. *Australian health review : a publication of the Australian Hospital Association,* http://dx.doi.org/10.1071/AH16200

Hyde, Z., & Brown, G. (2011). *Health and well-being of transgender and transsexual Western Australians* (1743-6095). Victoria:

Hyde, Z., Doherty, M., Tilley, P., McCaul, K., Rooney, R., & Jancey, J. (2014). *The first Australian national trans mental health study: Summary of results* (0646923366). Bentley, Western Australia:

Jablonski, R. A., Vance, D. E., & Beattie, E. (2013). The Invisible Elderly: Lesbian, Gay, Bisexual, and Transgender Older Adults. *Journal of Gerontological Nursing, 39*(11), 46-52. http://dx.doi.org/10.3928/00989134-20130916-02

Jaffee, D. K., Shires, A. D., & Stroumsa, A. D. (2016). Discrimination and Delayed Health Care Among Transgender Women and Men: Implications for Improving Medical Education and Health Care Delivery. *Medical Care, 54*(11), 1010-1016. http://dx.doi.org/10.1097/MLR.0000000000000583

Joosten, M., Tinney, J., Barrett, C., Whyte, C., Dow, B., & Maud, P. (2015). *Improving mental health for older LGBTI Australians: A resource kit targeting depression and anxiety among older gay, lesbian, bisexual, transgender and intersex Australians. .* Melbourne: Beyond Blue. Retrieved from https://www.beyondblue.org.au/docs/default-source/research-project-files/improving-mental-health-for-older-lgbti-australians-research-report.pdf?sfvrsn=2

Kattari, S. K., & Hasche, L. (2016). Differences Across Age Groups in Transgender and Gender Non-Conforming People's Experiences of Health Care Discrimination, Harassment, and Victimization. *Journal of aging and health, 28*(2), 285-306. http://dx.doi.org/10.1177/0898264315590228

Katz, M. L. (2013). Provider competition and healthcare quality: More bang for the buck? *International Journal of Industrial Organization, 31*(5), 612-625. http://dx.doi.org/10.1016/j.ijindorg.2013.02.001

Kimmel, D. (2014). Lesbian, gay, bisexual, and transgender aging concerns. *Clinical Gerontologist, 37*(1), 49-63. http://dx.doi.org/10.1080/07317115.2014.847310

Kuper, A., Reeves, S., & Levinson, W. (2008). An introduction to reading and appraising qualitative research. *Bmj, 337*(7666), 404-407. http://dx.doi.org/10.1136/bmj.a288

Latham, J., & Barrett, C. (2015). *"We're people first": Trans Health and Ageing – An Evidence-Based Guide to Inclusive Services* (9781921915871). Melbourne: Australian Research Centre in Sex Health and Society at LaTrobe University.

Leonard, W., Pitts, M., Mitchell, A., Lyons, A., Smith, A., Patel, S., & Couch, M. (2012). *Private lives 2*. Melbourne: ARCSHS. Retrieved from http://www.healthycommunities.org.au/sites/default/files/PrivateLives2Report.pdf

Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International journal for equity in health, 12*, 18. http://dx.doi.org/10.1186/1475-9276-12-18

Lindmeier, C. (2017). Health Services Must Stop Leaving Older People Behind [Online]. 2018. *News* Retrieved from http://www.who.int/news-room/detail/29-09-2017-health-services-must-stop-leaving-older-people-behind

Loewy, K. (2017). Erasing LGBT People From Federal Data Collection: A Need for Vigilance. *American Journal of Public Health, 107*(8), 1217-1218. http://dx.doi.org/http://dx.doi.org/10.2105/AJPH.2017.303914

Markwick, L. (2016). Male, Female, Other: Transgender and the Impact in Primary Care. *The Journal for Nurse Practitioners, 12*(5), 330-338. http://dx.doi.org/http://dx.doi.org/10.1016/j.nurpra.2015.11.028

Martino, S. C., Elliott, M. N., Haviland, A. M., Saliba, D., Burkhart, Q., & Kanouse, D. E. (2016). Comparing the Health Care Experiences of Medicare Beneficiaries with and without Depressive Symptoms in Medicare Managed Care versus Fee-for-Service. *Health services research, 51*(3), 1002-1020. http://dx.doi.org/10.1111/1475-6773.12359

Mason, J. (2002). How many qualitative interviews is enough. *Expert voices and early career reflections on sampling and cases in qualitative research*, 29-30. Retrieved from http://eprints.ncrm.ac.uk/2273/4/how_many_interviews.pdf

May-Welby, N. (2015). Born Transsexual. *2018*(29th June), Retrieved from https://www.google.com.au/search?q=Born+Transsexual+norrie's+ever+evolving+understanding+of+hir+gender+identity&ie=&oe=

May-Welby, N. (n.d.). Norrie gets the X passport. Retrieved from http://sageaustralia.org/linked/norrie%20get%20the%20x%20passport%205-10-2011.pdf

Mayer, K. H., Bradford, J. B., Makadon, H. J., Stall, R., Goldhammer, H., & Landers, S. (2008). Sexual and gender minority health: what we know and what needs to be done. *American journal of public health, 98*(6), 989-995. Retrieved from http://ajph.aphapublications.org.dbgw.lis.curtin.edu.au/doi/pdf/10.2105/AJPH.2007.127811

McMillan, J., & Schumacher, S. (1993). Research in education: A conceptual understanding. *New York: Haprer Collins,*

McPhail, R., & Fulop, L. (2016). Champions' perspectives on implementing the National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing and Aged Care Strategy in Queensland. *Australian Health Review, 40*(6), 633-640. http://dx.doi.org/10.1071/AH15185

Meyer, I. H. (2003). Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychol Bull, 129*(5), 674-697. http://dx.doi.org/10.1037/0033-2909.129.5.674

Michael, J., Walsh, L., Goldner, S., Healy, T., Draper, R., Elder, K., & McLoed, K. (2018). Supporting Aged Care Workers to Understand and Respond to the Needs of Trans and Gender Diverse People: An Australian Co-designed Quality Improvement Initiative. *Diversity and Equality in Health and Care 15*(3), 5. Retrieved from http://diversityhealthcare.imedpub.com/supporting-aged-care-workers-to-understand-and-respond-to-the-needs-of-trans-and-gender-diverse-people-an-australian-codesigned-qu.pdf

Monash Health. (2014). Information for Potential Clients Retrieved from http://www.ftmaustralia.org/images/PDF/Melbourne-GD-Clinic-2014.pdf

Monash Health. (N.d.). Gender Clinic. Retrieved from
        http://www.monashhealth.org/page/gender_clinic

Monash Health Gender Clinic. (n.d.). Frequently Asked Questions. Retrieved from monashhealth.org

Morgan, A. J., Reavley, N. J., Jorm, A. F., & Beatson, R. (2016). Experiences of discrimination and positive treatment from health professionals: A national survey of adults with mental health problems. *The Australian and New Zealand journal of psychiatry, 50*(8), 754-762. http://dx.doi.org/http://dx.doi.org/10.1177/0004867416655605

Moss, S. (2015). *Research skills : analysing, researching and presenting* Prahran, Victoria: Tilde Publishing and Distribution.

Motmans, J., de Biolley, I., & Debunne, S. (2010). *Being transgender in Belgium: Mapping the social and legal situation of transgender people.* Brussels: Institute for the equality of woman and men. In M. Pasteel (Series Ed.) (pp. 205). Retrieved from https://www.researchgate.net/publication/276857643_Being_transgender_in_Belgium_Mapping_the_social_and_legal_situation_of_transgender_people

Moye, J. (2016). Their Time Has Come: Providing Culturally Competent Care to LGBT Older Adults. *Clinical Gerontologist, 39*(5), 363-365. http://dx.doi.org/http://dx.doi.org/10.1080/07317115.2016.1203584

Mulé, N. J. (2018). LGBTQI-identified human rights defenders: courage in the face of adversity at the United Nations AU *Gender & Development, 26*(1), 89-101. http://dx.doi.org/10.1080/13552074.2018.1429099

Nakata, Y. (2015). Insider–outsider perspective: revisiting the conceptual framework of research methodology in language teacher education. *International Journal of Research & Method in Education, 38*(2), 166-183.

Narayanan, A., & Greco, M. (2016). Patient Experience of Australian General Practices. *Big data., 4*(1), 31-46. http://dx.doi.org/10.1089/big.2016.0010

National Health and Medical Research Council. (2007a). National statement on ethical conduct in human research: National Health and Medical Research Council. Retrieved from https://www.nhmrc.gov.au/guidelines-publications/e72

National Health and Medical Research Council, Australian Research Council, & Australia Universities. (2007b). *Australian code for the responsible conduct of research*. MHMRC.Retrieved from http://www. nhmrc. gov. au/publications/synopses/r39syn. htm

New South Wales Health. (2017). Adult Population Health Survey. Retrieved from http://www.health.nsw.gov.au/surveys/adult/Pages/default.aspx

Office of the United Nations High Commissioner for Human Rights, & World Health Organization. (n.d.). *The Right To Health: Fact Sheet 31* Geneva, Switzerland: UN. Retrieved from http://www.ohchr.org/Documents/Publications/Factsheet31.pdf

Olyslager, F., & Conway, L. (2007). On the Calculation of the Prevalence of Transsexualism. *International Journal of Transgenderism (IJT)*, 10. Retrieved from https://www.researchgate.net/publication/237519830

Persson, D. I. (2009). Unique Challenges of Transgender Aging: Implications From the Literature. *Journal of Gerontological Social Work, 52*(6), 633-646. http://dx.doi.org/10.1080/01634370802609056

Pitts, M., Mitchell, A., Smith, A., & Patel, S. (2006). *Private Lives: A report on the health and wellbeing of GLBTI Australians*. Melbourne, Australia: Retrieved from http://hdl.handle.net/1959.9/459763

Polkinghorne, D. E. (1989). Phenomenological research methods *Existential-phenomenological perspectives in psychology* (pp. 41-60): Springer.

PopulationPyramid.net. (2019). Population Pyramids of the World from 1950 to 2100: Australia. Retrieved from https://www.populationpyramid.net/australia/2020/

Porter, K. E., Brennan-Ing, M., Chang, S. C., Dickey, L. M., Singh, A. A., Bower, K. L. M. A., & Witten, T. M. (2016). Providing Competent and Affirming Services for Transgender and Gender Nonconforming Older Adults. *Clinical Gerontologist, 39*(5), 366-388. http://dx.doi.org/10.1080/07317115.2016.1203383

Registry of Births Deaths & Marriages. (nd). Change of Sex. *Changes and Corrections* Retrieved from https://www.bdm.nsw.gov.au/Pages/changes-corrections/change-of-sex.aspx

Reisner, S., Poteat, T., Keatley, J., Cabral, M., Mothopeng, T., Dunham, E., . . . Baral, S. (2016). Global Health burden and needs of transgender populations: a review. *The Lancet, 388*(10042), 412-436. http://dx.doi.org/10.1016/S0140-6736(16)00684-X

Reisner, S., Radix, A., & Deutsch, M. (2016a). Integrated and Gender-Affirming Transgender Clinical Care and Research. *JAIDS Journal of Acquired Immune Deficiency Syndromes, 72*, S235-S242. http://dx.doi.org/10.1097/QAI.0000000000001088

Reisner, S., Radix, A., & Deutsch, M. B. (2016b). Transgender Health and Wellbeing: Gender-affirmative Healthcare for Transgender People Worldwide. *The Lancet*, 2. Retrieved from www.thelancet.com/series/transgender-health

Rhodes, C. (2017). 8 hard-won rights for LGBTI Australians. Retrieved from https://www.moadoph.gov.au/blog/8-hard-won-rights-for-lgbti-australians/

Riggs, D., & Due, C. (2013). *The Healthcare Experiences of people whose gender identity differs from that expected of their natally assigned sex*. Adelaide: F. University. Retrieved from http://www.genderidentityaustralia.com

Riggs, D. W., Coleman, K., & Due, C. (2014). Healthcare experiences of gender diverse Australians: a mixed-methods, self-report survey. *BMC Public Health, 14*(1), 230. http://dx.doi.org/10.1186/1471-2458-14-230

Rosenstreich, G., Comfort, J., & Martin, P. (2011). Primary health care and equity: the case of lesbian, gay, bisexual, trans and intersex Australians. *Australian journal of primary health, 17*(4), 302-308. http://dx.doi.org/10.1071/PY11036

Rosenstreich, G. (2013). *LGBTI People Mental Health and Suicide*. Revised 2nd Edition.Retrieved from https://www.beyondblue.org.au/docs/default-source/default-document-library/bw0258-lgbti-mental-health-and-suicide-2013-2nd-edition.pdf?sfvrsn=2

Rotondi, N. K., Bauer, G. R., Scanlon, K., Kaay, M., Travers, R., & Travers, A. (2013). Nonprescribed hormone use and self-performed surgeries: "do-it-yourself" transitions in transgender communities in Ontario, Canada. *Am J Public Health, 103* http://dx.doi.org/10.2105/ajph.2013.301348

Sanchez, N. F., Sanchez, J. P., & Danoff, A. (2009). Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City. *American Journal of Public Health, 99*(4), 713-719. http://dx.doi.org/10.2105/AJPH. 2007.132035

Saraswat, A., Weinand, J., & Safer, J. (2015). Evidence Supporting the Biologic Nature of Gender Identity. *Endocrine Practice, 21*(2), 199-204. http://dx.doi.org/10.4158/EP14351.RA

Sasaki, S. (2007, 6 May 2016). *Relationship between Gender Identity and Physical Treatment among Transgender People in Japan Sexual Health Visual*[Online Video]. Retrieved from http://www.sexualhealthvisual.com.dbgw.lis.curtin.edu.au/Video_by_Shoko_Sasaki_on_Relationship_Between_Gender_Identity_And_Physical_Treatment_Among_Transgender_People_In_Japan.html

Schilling, I., & Gerhardus, A. (2017). Methods for Involving Older People in Health Research—A Review of the Literature. *International journal of environmental research and public health, 14*(12), 1476. http://dx.doi.org/10.3390/ijerph14121476

Schwandt, T. A. (2001). *Dictionary of qualitative research*. Thousand Oaks, CA: Sage.

Scott, K. W., & Jha, A. K. (2014). Putting quality on the global health agenda. *New England Journal of Medicine, 371*(1), 3-5. http://dx.doi.org/10.1056/NEJMp1402157

Sharek, D. B., McCann, E., Sheerin, F., Glacken, M., & Higgins, A. (2015). Older LGBT people's experiences and concerns with healthcare professionals and services in Ireland. *International Journal of Older People Nursing, 10*(3), 230-240. http://dx.doi.org/http://dx.doi.org/10.1111/opn.12078

Shires, D. A., & Jaffee, K. (2015). Factors associated with health care discrimination experiences among a national sample of female-to-male transgender individuals. *Health & social work, 40*(2), 134-141. http://dx.doi.org/10.1093/hsw/hlv025

Siverskog, A. (2015). Ageing Bodies that Matter: Age, Gender and Embodiment in Older Transgender People's Life Stories. *NORA-Nordic Journal of Feminist and Gender Research, 23*(1), 4-19. http://dx.doi.org/10.1080/08038740.2014.979869

Skerrett, D. M., Kõlves, K., & De Leo, D. (2015). Are LGBT populations at a higher risk for suicidal behaviors in Australia? Research findings and implications. *Journal of homosexuality, 62*(7), 883-901. http://dx.doi.org/10.1080/00918369.2014.1003009

Smith, D. (2013). The perils of privatising health care US-style. *Queensland Nurse, The, 32*(4), 28. Retrieved from https://search.informit.com.au/documentSummary;dn=562736920983774;res=IELHEA

Smith, J. (2012). From Australia to England: the health care reform challenge [Website information page]. 2018. *News and comments* Retrieved from https://www.nuffieldtrust.org.uk/news-item/from-australia-to-england-the-health-care-reform-challenge

Smith, R. W., Altman, J. K., Meeks, S., & Hinrichs, K. L. M. (2018). Mental Health Care for LGBT Older Adults in Long-Term Care Settings: Competency, Training, and Barriers for Mental Health Providers. *Clinical Gerontologist*, null-null. http://dx.doi.org/10.1080/07317115.2018.1485197

Stryker, S. (2017). *Transgender History: The Roots of Today's Revolution*: Seal Press.

Sweeney, L. (2017). Legal recognition of gender identity in Australia: the role of complimentary laws, policies, cases and inquiries to progress reform. Canberra: AHRC.

Tashakkori, A., & Teddlie, C. (2010). Sage handbook of mixed methods in social & behavioral research. http://dx.doi.org/10.1177/0002764211433795

Taylor, M. (2016). Holistic Care of Older Lesbian, Gay, Bisexual, and Transgender Patients in the Emergency Department. *Journal of Emergency Nursing, 42*(2), 170-173. http://dx.doi.org/http://dx.doi.org/10.1016/j.jen.2016.02.007

Temple, J. B., & Williams, R. (2018). Multiple health conditions and barriers to healthcare among older Australians: prevalence, reasons and types of barriers. *Australian journal of primary health, 24*(1), 82-89. http://dx.doi.org/10.1071/PY17038

Tervalon, M., & Murray-García, J. (1998). Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117-125. http://dx.doi.org/10.1353/hpu.2010.0233

Teunissen, T., Rotink, M., & Lagro-Janssen, A. (2016). Gender differences in quality of care experiences during hospital stay: A contribution to patient-centered healthcare for both men

and women. *Patient education and counseling, 99*(4), 631-637. http://dx.doi.org/10.1016/j.pec.2015.10.033

The Council on the Ageing Victoria, & Transgender Victoria. (2017). The Future is now! Safeguarding end of life for older LGBTI Victorians..... Retrieved from https://lgbtihealth.org.au/future-now-safeguarding-end-life-older-lgbti-victorians/

Tufford, L., & Newman, P. (2012). Bracketing in Qualitative Research. *Qualitative Social Work, 11*(1), 80-96. http://dx.doi.org/10.1177/1473325010368316

United Nations. (1998). Universal declaration of human rights. *JAMA*.doi 10.1001/jama.280.5.469

Urquhart, G. J., & Saunders, P. (2016). Wider horizons, wiser choices: horizon scanning for public health protection and improvement. *Journal of Public Health, 39*(2), 248-253. http://dx.doi.org/10.1093/pubmed/fdw039

Van Wagenen, A., Driskell, J., & Bradford, J. (2013). "I'm still raring to go": Successful aging among lesbian, gay, bisexual, and transgender older adults. *Journal of Aging Studies, 27*(1), 1-14. http://dx.doi.org/http://dx.doi.org/10.1016/j.jaging.2012.09.001

Wachsmuth, L. (2015). Caitlyn Jenner, formerly Bruce, congratulated by Australia's first transexual. *News* Retrieved from https://www.theherald.com.au/story/3122170/transgender-pioneer-applauds-jenners-rebirth/

Whittle, S., Turner, L., Al-Alami, M., Rundall, E., & Thom, B. (2007). *Engendered penalties: Transgender and transsexual people's experiences of inequality and discrimination*: Communities and Local Government Publications Wetherby.

Winter, S., Settle, E., Wylie, K., Reisner, S., Cabral, M., Knudson, G., & Baral, S. (2016a). Synergies in health and human rights: a call to action to improve transgender health. *The Lancet, 388*(10042), 318-321. http://dx.doi.org/10.1016/S0140-6736(16)30653-5

Winter, S., Diamond, M., Green, J., Karasic, G., Reed, T., Whittle, S., & Wylie, K. (2016b). Transgender people: health at the margins of society. *The Lancet,*Retrieved from http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00683-8/fulltext

Winters, K. (2019). International Transgender Day of Remembrance 2019. *Trans Policy Reform Blog.* https://transpolicyreform.wordpress.com/

Witten, T. M. (2009). Graceful exits: Intersection of aging, transgender identities, and the family/community. *Journal of GLBT Family Studies, 5*(1-2), 35-61. http://dx.doi.org/10.1080/15504280802595378

Witten, T. M. (2015). Elder Transgender Lesbians: Exploring the Intersection of Age, Lesbian Sexual Identity, and Transgender Identity. *Journal of lesbian studies, 19*(1), 73-89. http://dx.doi.org/10.1080/10894160.2015.959876

Womens Health West. (2014). *Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Health and Wellbeing Plan 2014*. Footscray, Victoria: Retrieved from http://whwest.org.au/wp-content/uploads/2012/03/SUB_GLBTI-Health-Wellbeing-Plan-2014.pdf

World Health Organisation (WHO). (2013). *HIV, sexually transmitted infections and other health needs among transgender people in Asia and the Pacific: joint regional technical brief* [Joint Technical Brief](9290616075). Geneva, Switzerland: World Health Organization Regional Office for the Western Pacific. Retrieved from http://iris.wpro.who.int/bitstream/handle/10665.1/6773/9789290616078_eng.pdf

WHO. (2016). Determinants of Health. *Health Impact Assessment* Retrieved from http://www.who.int/hia/evidence/doh/en/#

WHO. (2017). Determinants of Health. *Health Impact Assessment (HIA)* Retrieved from https://www.who.int/hia/evidence/doh/en/

WHO. (2018a). Ageing and health [Website]. 5 February 2018. *News* Retrieved from http://www.who.int/news-room/fact-sheets/detail/ageing-and-health

WHO. (2018b). Ageing and Life-course: Frequently Asked Questions: Ageism. Geneva: (World Health Organisation, WHO). Retreived from https://www.who.int/ageing/features/faq-ageism/en/

WHO. (2018c). Seventy First World Health Assembly. 21-26 May 2018 Retrieved from http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_JOUR5-en.pdf

WHO. (2019). Primary health care in the Western Pacific. 2019. *Primary health care* Retrieved from https://www.who.int/westernpacific/health-topics/primary-health-care

WHO (19 June - 22 July 1946). Preamble to the Constitution of WHO as adopted by the International Health Conference, signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948. [Website]. New York.

WHO. (2019). International Statistical Classification of Diseases and Related Health Problems (11th Ed., ICD-11). Retrieved from https://icd.who.int/browse11/l-m/en#http%3a%2f%2fid.who.int%2ficd%2fentity%2f411470068

World Professional Association of Transgender Health. (2019). WPATH's Global Education Initiative (GEI). *WPATH Global Education Initiative* Retrieved from https://www.wpath.org/about-gei

Wylie et al., Winter et al., & Resiner et al. (2016). Transgender Health. *The Lancet Series* Retrieved from http://www.thelancet.com/series/transgender-health

Wylie, K., Knudson, G., Khan, S. I., Bonierbale, M., Watanyusakul, S., & Baral, S. (2016). Serving transgender people: clinical care considerations and service delivery models in transgender health. *The Lancet, 388*(10042), 401-411. http://dx.doi.org/10.1016/S0140-6736(16)00682-6

Xavier, J., Bradford, J., Hendricks, M., Safford, L., McKee, R., Martin, E., & Honnold, J. (2013). Transgender Health Care Access in Virginia: A Qualitative Study. *International Journal of Transgenderism, 14*(1), 3-17. http://dx.doi.org/10.1080/15532739.2013.689513

Xavier, J., & Simmons, R. (2000). *The Washington transgender needs assessment survey*. Washington DC,: US Helping Us – People Into Living Inc. Retrieved from https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fdctranscoalition.files.wordpress.com%2F2010%2F01%2Fdc.doc

Yogyakarta Principles. (2007). Yogyakarta Principles on the application of international human rights law in relation to sexual orientation and gender identity. Retrieved from http://www.yogyakartaprinciples.org/principles_en.htm

Zeeb, H., Rothgang, H., & Darmann-Finck, I. (2018). Ageing, Health and Equity—Broad Perspectives Are Needed to Understand and Tackle Health Challenges of Ageing Societies. *International Journal of Environmental Research and Public Health 15*(457) http://dx.doi.org/10.3390/ijerph15030457

Zelle, A., & Arms, T. (2015). Psychosocial Effects of Health Disparities of Lesbian, Gay, Bisexual, and Transgender Older Adults. *Journal of psychosocial nursing and mental health services, 53*(7), 25-30. http://dx.doi.org/DOI: 10.3928/02793695-20150623-04

Appendices

Appendix I

Literature review: Illustrative matter.

Figure 7: *Social ecological model influencing ethical practice*

Framework by Davidson et al. (2018a), (pg. e1233).
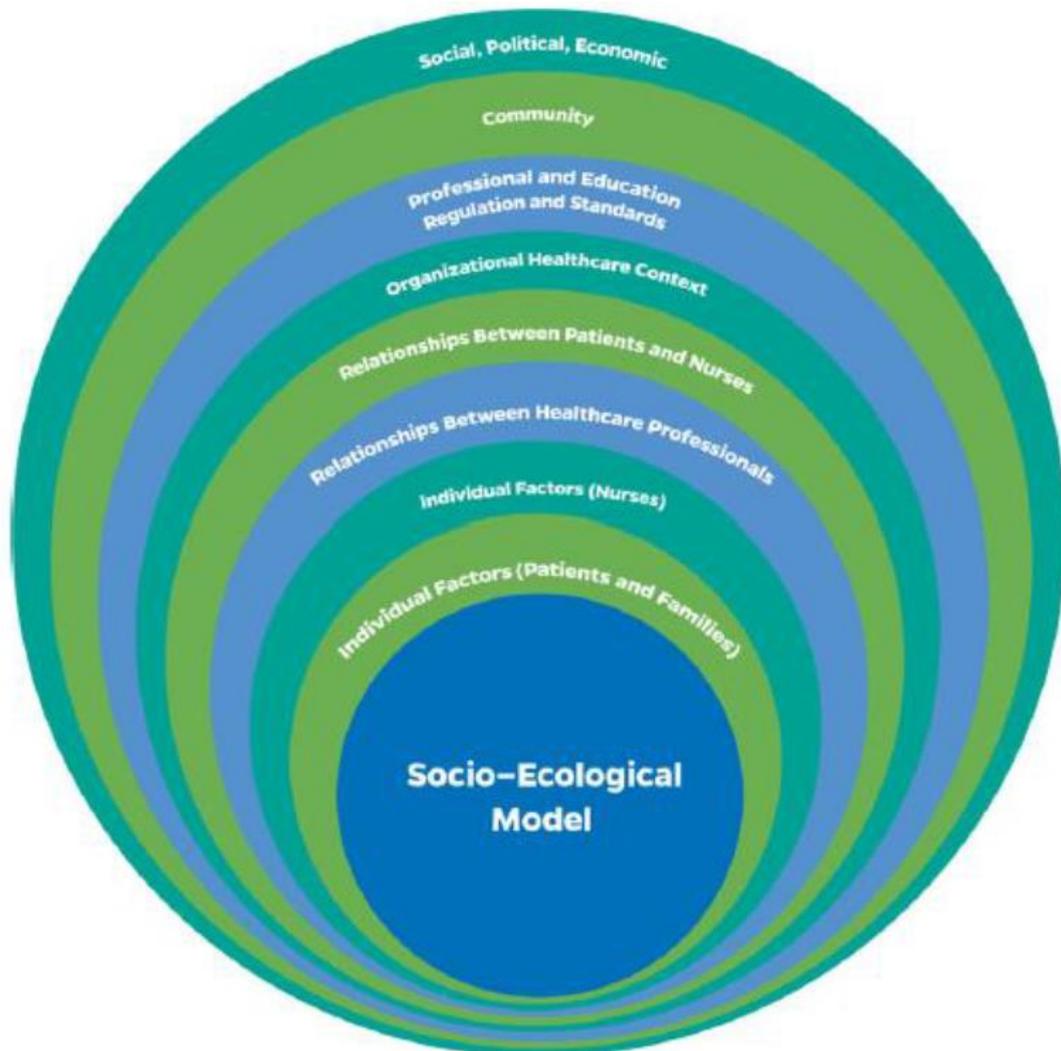
Figure 8: Context, Potential Mechanisms, and Outcomes (CMO)

CMO Structures: (a) developing meaningful relationships; (b) developing trust between patient and providers; (c) improving communication between patients and providers (Elliott et al., 2016, p. 3).
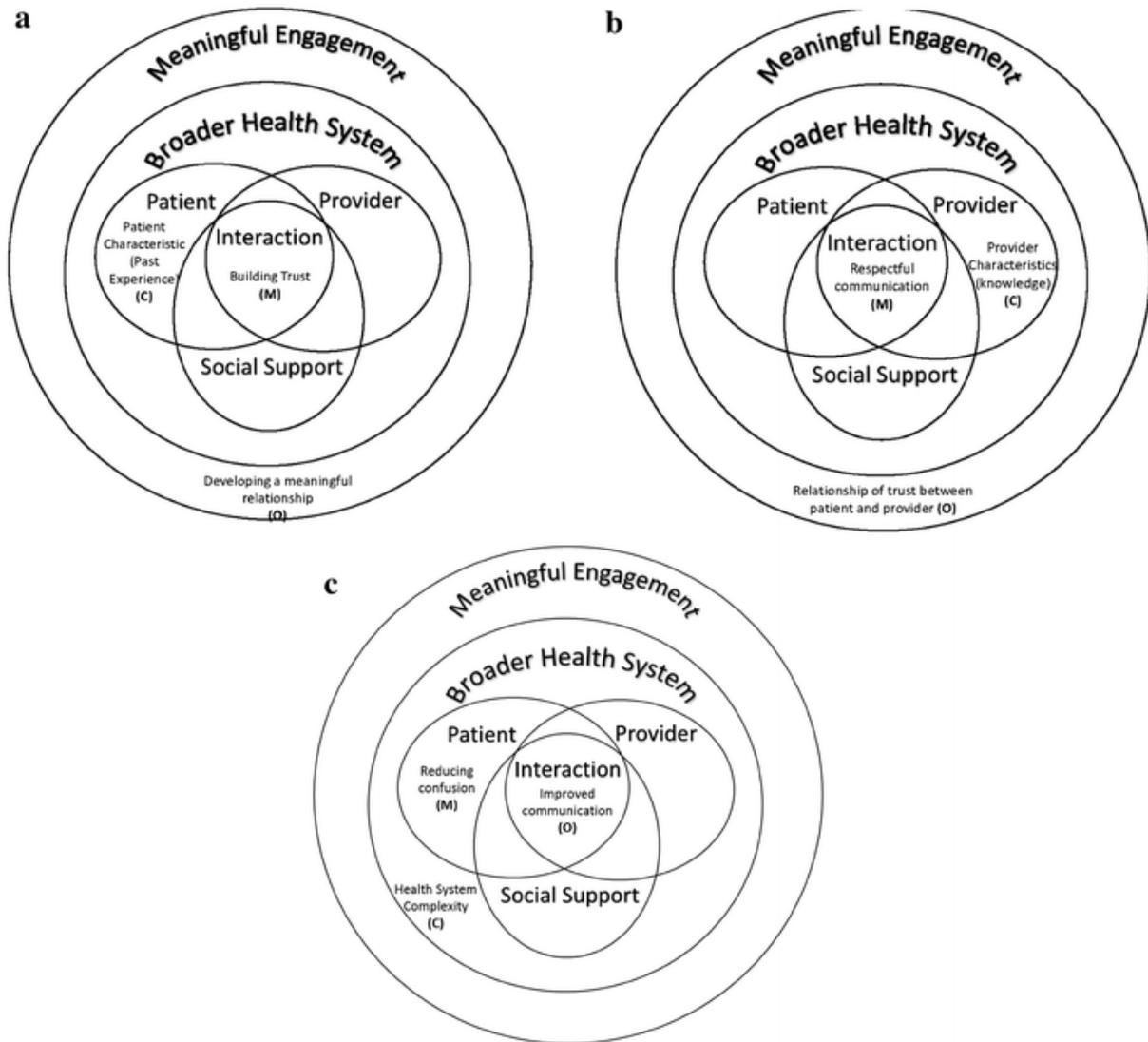
Figure 9: Barriers to accessing primary health care: comparing Australian experiences internationally
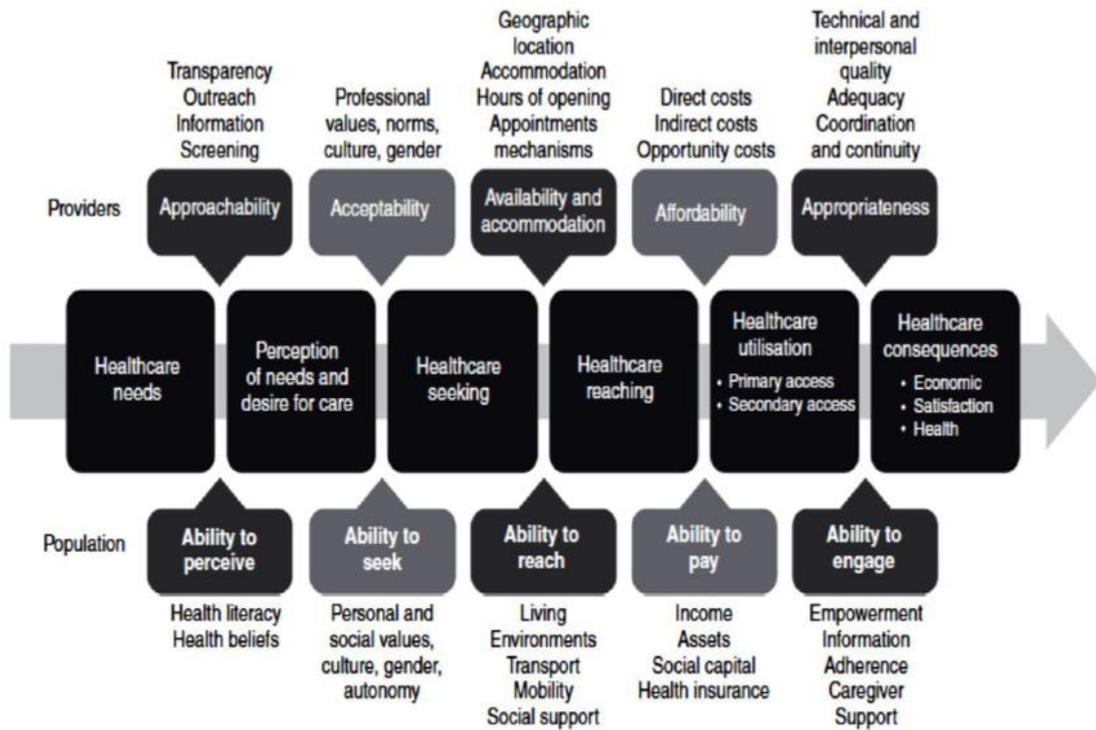
Fig. 1. Access to health care: a conceptual framework. Adapted from Levesque *et al.* (2013).

(Corscadden et al., 2017, p. 224).

Appendix II

Research protocol.

ATPEH Healthcare:
Short Script Advertising

Curtin University

Seeking Participants: study of **Ageing Transgender Peoples experiences of health and healthcare provision (ATPEH Healthcare).**

Transgender and post-transition people needed **over the age of 50 years** for a study through Curtin University in Western Australia. The project will explore peoples lived experiences of health and healthcare provision throughout Australia. The overall aim is to improve healthcare provider, healthcare legislators, and society's, understanding of transgender health and support needs. Disseminated research findings are anticipated to empower ageing transgender people by giving voice to the specific needs of older transgender generations.

The research process involves each participant engaging in an interview for approximately 1.5 – 2 hours. Interviews will be conducted either online, or in a convenient meeting place agreed by both participant and researcher. Participants will be compensated for travel or internet expenses up to the value of $15

Contact Kirilee Wood at 16918445@student.curtin.edu.au. For more information about the study contact the Chief Investigator at Sam.Winter@curtin.edu.au.

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number: HRE2017-0202).

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Page 1
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201

ATPEH Healthcare:

Email to support organisation script

Curtin University

Dear Organisation,

My name is Kirilee Wood. I am a Curtin Researcher by Higher Degree (Masters of Philosophy in Public Health) student at Curtin University in Western Australia. I am seeking male (pre- and post- transition transmen) and non-binary identifying research participants for a study of ageing transgender peoples' experiences of health and healthcare provision (ATPEH Healthcare).

The purpose of this communication is to request permission to advertise the coming ATPEH Healthcare project on your website. For this study transgender and post-transition people are needed **who are over the age of 50 years**. This qualitative study will explore peoples lived experiences of health and healthcare provision throughout Australia. The overall aim is to improve healthcare provider, healthcare legislators, and society's, understanding of transgender health and support needs. Moreover, the disseminated research findings will empower ageing transgender people by giving voice to the specific needs of older transgender generations.

To give more information about this study I have attached a short script advertisement, and copies of the project's Participant information form, and Consent Form.

I will be most grateful if you reply in the first instance by contacting myself, Kirilee Wood at Kirilee.wood@postgrad.curtin.edu.au to discuss permissions and formatting. If additional information is required about this study please contact the Chief Investigator of this study, Sam.Winter@curtin.edu.au.

Kind regards,

Kirilee Wood

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number: HRE2017-0202).
Human Ethics Coordinator: +61 8 9266 9223

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Page 1
CRICOS Provider Code 00301J (WA)

202

ATPEH Healthcare.

**A research project about ageing transgender peoples
health and healthcare provision in Australia**

Curtin University

A call for **Ageing Transgender People**:   Interview participants <u>over the age of 50 years</u> needed.

What have your experiences of health and Australian healthcare provision been?

Project details: ATPEH Healthcare is an exploratory research project to learn about ageing transgender and gender non-conforming (trans) peoples lived experiences of healthcare and healthcare provision across Australia.

Project Aims: ATPEH Healthcare aims to improve healthcare provider, healthcare legislators, and society's understanding of transgender health and support needs. Disseminated research findings are anticipated to empower people by giving voice to the specific needs of ageing transgender generations.

Participation involvement:

- Upon your expression of interest and communication (see details below), we will assess your suitability for the study based on the selection criteria (see below).
- Selected participants will be invited for interview. Also, the researcher will forward you a Participant Information sheet which includes a more detailed explanation of the research project and all confidentiality matters.
- At interview, you will be asked to sign an Informed Consent Form before being asked questions about your healthcare experiences.
- Interviews will last for approximately 1.5 hours. They will be conducted as per your preference; either (1) online (Skype); or, (2) in an appropriate meeting place (time and location chosen collaboratively by yourself and the researcher).
- The information you provide will only be used in this research project. Full confidentiality will be maintained by assigned codes to any data collected.
- Withdrawal from the study will be permitted if you feel uncomfortable. If this occurs your data will be destroyed.

Participant Selection Criteria

- Age 50 years and above.
- Currently identify as a gender which does not match the sex you were assigned at birth.
- Should have qualified for Medicare subsidies for a minimum of two years (from the date of interview).

Contact

- Email to Kirilee Wood: 16918445@student.curtin.edu.au
- Chief Investigator: Sam.Winter@curtin.edu.au

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number: HRE2017-0202).
Human Ethics Coordinator: +61 8 9266 9223

ATPEH Healthcare:

Short Script Advertising

Curtin University

Seeking Participants: study of Ageing Transgender Peoples experiences of health and healthcare provision (ATPEH Healthcare).

Needed for a study through Curtin University in Western Australia.:

- Male, transmen (pre- and post-transition procedures / therapies),
- non-binary identifying people (gender neutral, gender diverse, bi-gender)
- over the age of 50 years.

The project will explore peoples lived experiences of health and healthcare provision throughout Australia. The overall aim is to improve healthcare provider, healthcare legislators, and society's, understanding of transgender health and support needs. Disseminated research findings are anticipated to empower ageing transgender people by giving voice to the specific needs of older transgender generations.

The research process involves each participant engaging in an interview for approximately 1.5 – 2 hours. Interviews will be conducted either online, or in a convenient meeting place agreed by both participant and researcher. Participants can be compensated for travel or internet expenses up to the value of $15.

Contact Kirilee Wood at 16918445@student.curtin.edu.au. For more information about the study contact the Chief Investigator at Sam.Winter@curtin.edu.au.

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number: HRE2017-0202).

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Page 1
CRICOS Provider Code 00301J (WA)

Curtin University

Ageing Transgender People

PARTICIPANT INFORMATION

HREC Project Number:	HRE2017-0202.
Project Title:	*Ageing transgender people's experiences of health and health care provision*
Principal Investigator:	*Sam Winter* *Associate Professor (School of Public Health)*
Student researcher:	*Kirilee Wood*
Version Number:	*1*
Version Date:	*12/04/2017*

Purpose of Research

Thank you for your interest in this research.

Current research has shown that accessible and non-discriminate healthcare provision is directly related to peoples' good health and overall wellbeing, and avoidance of age related and chronic health conditions. To date, however, there are minimal studies reporting the related lived experiences of ageing transgender people over the age of 50 years. This exploratory study of what negatively and positively impacts health and health care access in Australia (in relation to ageing transgender people) aims to demonstrate that more in depth and specific research is needed. Data collection from transgender people over the age of 50 years will help and improve understanding societal, institutional, and governmental understandings about the broad health of ageing transgender people in relation to healthcare provision.

Background Information

To capture a range of lived experiences this study will include a participant sample of approximately 21 transgender-identifying persons. The gender spectrum will be reflected using three allotted sub-groups. These are:

1. Female identity: assigned male (sex) at birth.
2. Male identity: assigned female (sex) at birth.
3. Non-binary transgender identified.
   Defined as a person who does not identify as feminine or masculine, or who integrates both identities.

Eligibility

Are you?

- 50 years or older?
- An Australian resident?

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Page 1 of 6
CRICOS Provider Code 00301J (WA)

205

Curtin University

Ageing Transgender People

- Been eligible (or should have been eligible) for Medicare subsidies for a minimum of two years?
- Identify as belonging to one of the above listed study groups (see background information)?

Research Procedure and Details

The project is being conducted by Kirilee Wood, a student at Curtin University's School of Public Health. The results of this research project will be used by Kirilee to obtain a Masters of Philosophy at Curtin University and is funded by the University.

You have been selected by the research project because you have been identified as someone who has a great deal to share about your experiences of healthcare provision in Australia. If you chose to participate, you will be asked to attend a one on one interview with Kirilee for approximately 1 – 2 hours. There will be no cost to you for taking part in this research. In appreciation of your participation we will give you up to $15 to cover your car parking, transport, or internet fees while you attend an interview.

The study will take place at a mutually convenient location. As such, you have the option of being interviewed either electronically (e.g., Skype), or in an appropriate room at Curtin University; or, in a safe and discreet place (agreed by myself and you) which facilitates the comfort and freedom to share your experiences and knowledge (such as your home or meeting room in a known transgender social place). Please respond by email to 16918445@student.curtin.edu.au, or telephone 0420 757525, to discuss a convenient time and location for the interview to take place.

Interviews conducted will ask questions about experiences of health and healthcare provision in Australia. The interview process aims to be made as transparent and as comprehensive as possible throughout. I will make a digital audio recording so I can concentrate on what you have to say without being distracted with note taking. After the interview, I will make a full written copy of the recording. Your audio recording will be deleted immediately after verbatim transcription. The interview transcription will then be returned to you to check that the written details correctly reflect your thoughts and experiences. Your personal and consent details will be stored on a safe and secure electronically device, separately from the transcription. Once your data is returned to Kirilee it will be destroyed after it is scanned and added to Curtin University's data storage drive. The information will then be translated into codes and themes for analysis with assistance of the research team members (research team supervisors: Dr S Winter and Dr C Davis-McCabe).

Possible Benefits

Sometimes, people appreciate the opportunity to discuss their experiences, opinions and ideas. In this instance, the information you provide may benefit, empower, and support, ageing transgender people by giving voice to Australian health and healthcare issues - and evidence based inequalities. As such, we hope the results of this research will stimulate and contribute towards;

- Development of education programs;
- Preventative healthcare;
- Health promotion; and,
- Add to the knowledge we have about healthcare provision in relation to transgender people.

Results of the research

We will write to you at the end of the research (in about 6-8 months) and let you know the results. Results will not be individual but based on all the information collected and reviewed as part of the

Participant Information Form Version 1, 12/04/2017
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Page 2 of 6
CRICOS Provider Code 00301J (WA)

218

Ageing Transgender People

research. The results of this research may be presented at conferences or published in professional journals. You will not be identified in any results that are published or presented. The results may be made available online and in print in publications such as The Gerontologist, LGBT Health, and Transgender Studies Quarterly.

Possible Risks

Thinking about information you intend to provide may upset or worry you, if so here are some useful support services:

Beyond Blue – This organisation specialises in depression and anxiety issues, they have support available via website, webchat and phone.

Web: www.beyondblue.org.au/

Phone: 1300 22 46 36

Lifeline – 24/7 support via web, text or phone.

Web: www.lifeline.org.au

Phone: 13 11 14

Gender Centre: A website that provides information and support to transgender and gender diverse people.

Web: www.gendercentre.org.au

Who Will Have Access to my Information?

The information collected in this research will be re-identifiable (coded). This means we will remove identifying information on any data and replace it with a code. Any information we collect will be treated as confidential and used only in this project unless otherwise specified. Electronic data will be password-protected and hard copy data (including audio tapes) will be in locked storage until they are destroyed. The information we collect in this study will be kept electronically under secure conditions at Curtin University for 7 years after the research has ended and then it will be destroyed.

The research team will have access to the information collected in this research. The team comprises of Kirilee and her supervisors:

- Dr Sam Winter, Associate Professor (Curtin School of Public Health).
- Dr Catriona Davis-McCabe (Curtin School of Psychology and Speech Pathology).
- Kirilee Wood (Research Student).

In the event of an audit or investigation, staff from the Curtin University Office of Research and Development may also access your information.

FAQS

1. Do I have to take part in the research project?

Taking part in a research project is voluntary. It is your choice to take part or not. You do not have to agree if you do not want to. If you decide to take part and then change your mind, that is okay, you can withdraw from the project. You do not have to give us a reason; just tell us that you want to stop. Please let the research team know you want to stop so we can make sure you are aware of any thing that needs to be done so you can withdraw safely. If you choose not to take part or

Curtin University

Ageing Transgender People

start and then stop the study, it will not affect your relationship with the University, staff or colleagues. If you chose to leave the study, any information collected from you will be used unless you tell the research team not to. In that event any information collected from you can be destroyed up until the point of analysis.

2. *What happens next and who can I contact about the research?*

To obtain further information or to answer any questions Kirilee Wood will provide you with:

- Direct telephone numbers of the research team.
- Online contact details for the research team.

3. *How I will obtain your consent?*

If you decide to take part in this research I will ask you to sign the consent form. By signing it is telling me that you understand what you have read and what has been discussed. Signing the consent indicates that you agree to be in the research project and have your health information used as described. Please take your time and ask any questions you have before you decide what to do. You will be given a copy of this information and the consent form to keep.

Information Sheet Statement

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HRE2017-0202)

Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

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Page 4 of 6
CRICOS Provider Code 00301J (WA)

208

ATPEH Healthcare

🔲 **Curtin University**

CONSENT FORM

HREC Project Number:	HRE2017-0202.
Project Title:	*Ageing transgender peoples experiences of health and health provision*
Principal Investigator:	*Sam Winter: Associate Professor (School of Public Health)*
Student researcher:	*Kirilee Wood*
Version Number:	*1*
Version Date:	*12/04/2017*

- I have read (*or had read to me in my first language – delete if not appropriate*) the information statement version listed above and I understand its contents.
- I believe I understand the purpose, extent, and possible risks, of my involvement in this project.
- I voluntarily consent to take part in this research project.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I understand that this project has been approved by Curtin University Human Research Ethics Committee and will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007).
- I understand I will receive a copy of this Information Statement and Consent Form.
- I understand that a digital recording of my voice will be deleted after verbatim transcription.
- I understand that by permitting the researcher to proceed, after confirming I understand the content Participant Information sheet, Consent Form, and digital recording process, I will give my consent for data collection by Skype recording.

OPTIONAL CONSENT

🔲 I do	🔲 I do not	consent to being audio-recorded
🔲 I do	🔲 I do not	consent to be contacted about future research projects that are related to this project

Participant Name	
Participant Signature	
Date	

Declaration by researcher: I have supplied an Information Letter and Consent Form to the participant who has signed above, and believe that they understand the purpose, extent, and possible risks, of their involvement in this project.

Researcher Name	
Researcher Signature	
Date	

Note: All parties signing the Consent Form must date their own signature.

Participant Consent Form Version 1, 12/04/2017
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Page 1 of 1
CRICOS Provider Code 00301J (WA)

209

Kirilee Wood: 1691 8445
Ageing Transgender People's Experiences of Health and Healthcare Provision: Interview Guide

Section	Information required

Question Guide	**Initial Questions**
	
	• Basic background data: age, area / current region of residence,
	   o transition information (level of),
	   o transition level preference.
	   o accessibility of healthcare providers).
	• Rapor building questions/ major milestones from birth era
	   o culture of origins,
	   o social attitudes of birth era,& from young age to maturity
	   o cultural norms in areas of residence,
	
	Primary research question:
	What have your experiences of health and health provision been?
	Secondary research question:
	What has helped or hindered you from accessing appropriate healthcare?
	How are you planning for your future health and ageing care?

Domains (Probing & Permissable Prompts)	**Domains** 1) people's experiences; 2) people's views and opinions; 3) individual and community practices; 4) why people feel and behave in certain ways; 5) describing underlying issues behind their activities; 6) societal opinions and social norms; and, 7) contextual descriptions.
Permissable prompts	**Domain follow-up questions examples. (Naïve interest)** • *"Tell me (more) about.........?"* • *"What was that like for you..."* • *"What is it that you mean by ...."* • *"How do you feel about....."* • *"What do you do when....?"* • *"Please give me an example."* • *"Please help me understand."* • *"Can you expand on...."*

FIELDWORK PRELIMINARY RISK IDENTIFICATION:
This checklist gives a preliminary rating of whether the fieldwork is **LOW RISK**, or whether further assessment is required to determine the risk.
Fieldwork Coordinator, Supervisor or Student to complete

Fieldwork Coordinator:	Sam Winter
Curtin Supervisor: *(if different from above)*	
Name of Student/Staff:	Kirilee Wood
Unit of Study or Research Project:	Masters of Philosophy (Public Health)
Partner Organisation:	**Location:**
Reason for Fieldwork:	Exploratory qualitative investigation of Transgender experiences of healthcare provision
Fieldwork Participants:	Transgender people (50+yrs)	If a group, please attach a list of student and staff names
Fieldwork Dates/Date Range: *(if not concurrent)* Supervisor/Coordinator to contact Risk Management if Fieldwork travel exceeds 180 days (6months).	03/2016 - 09/2017

Fieldwork Description: *Please attach a brief fieldwork description including location, type of fieldwork, activity, equipment, partner organisation (or type of organisation if multiple organisations of a similar risk profile) and their contact details.*

STEP ONE: I verify and agree that:	Yes	No	
A risk assessment in relation to this (or an equivalent) activity has previously been prepared, and there have been no significant or material changes in the situation since that time. *(If yes, attach the previous risk assessment - no further assessment is required at this time. If No, go to Step Two)*	○	◉	

STEP TWO: I verify and agree that the fieldwork involves:	Yes	No	If Yes, complete relevant risk category
1. A high risk, experimental or other sensitive activity, or involves the tangible export or intangible supply of sensitive technologies under the Defence and Strategic Goods List	○	◉	Categories 1 & 3
2. A hazardous location or hazardous activity, working with hazardous materials, using a hazardous mode of transport or vehicle, or undertaking an activity which exceeds the applicable level of professional practice skills of the participants	○	◉	Categories 1 & 5
3. International travel to a country with known political or security issues, known highly contagious or serious health risks (eg Ebola, Zika Virus, Malaria, HIV), a country with significantly different cultural issues and laws, a DFAT 3 or 4 country, or a country subject to Australian Autonomous Sanctions, which may impact on the planned fieldwork	○	◉	Categories 1 & 5
4. Travelling to a remote location (domestic or international), or a destination with extreme weather or environmental conditions	○	◉	Categories 1 & 5
5. Working alone as defined in Working Alone or in Isolation Guidelines or driving to a fieldwork destination outside of the metropolitan area or on unsealed roads.	○	◉	Categories 1 & 5
6. Any activity which could have an impact or exceeds the amber shaded region of the Consequence Table in the Curtin Risk Reference Table	○	◉	Complete relevant sections of Risk Matrix

STEP THREE: I verify and agree that:	Yes - I agree	No	N/A	If No, complete relevant risk category
1. The fieldwork involves a partnership or collaboration with another party where there is a written agreement and the party agrees to adhere to the risk framework that will govern the fieldwork.	◉	○	○	Category 2
2. All the external permissions, permits and licenses required for the fieldwork are in place – if yes, copy attached.	◉	○	○	Category 3
3. The supervision and assessment structure for the fieldwork is adequate.	◉	○	○	Category 2
4. Reasonable adjustments are in place for participants with disclosed pre-existing medical or other conditions which may be affected by the fieldwork.	◉	○	○	Category 4
5. The fieldwork fits within Curtin's curriculum and course requirements or co-curricular standards, as relevant, and the participants have already received or will receive the advice and support necessary to demonstrate the required professional practice standards (if applicable).	◉	○	○	Category 2
6. All applicable Curtin policies, and all the required internal approvals, including current ethics approval, has been identified and addressed in planning the fieldwork. If relevant: Ethics Approval No: _pending approval_	◉	○	○	Categories 3 & 6

STEP FOUR:

If you answered **Yes** to any questions in Step Two or **No** to any questions in Step Three please complete the relevant categories of the Fieldwork Risk Matrix to determine if Risk is Medium, High or Extreme.

If you answered **No** to all questions in Step Two and **Yes** to all questions in Step Three, this Fieldwork activity is **LOW RISK**. Please sign the form and submit to your Fieldwork Coordinator or Supervisor for approval if relevant.

Once Fieldwork is approved, seek appropriate Travel Approval as per *Travel Procedures*, before commencing travel.

STEP FIVE: If applicable the following must be completed before the form can be signed off	Yes	N/A
1. There is an Emergency Plan in place for domestic fieldwork or international fieldwork	◉	○

Fieldwork Preliminary Risk Identification completed by

Name: Kirilee Wood **Position:** Research Student **Date:** 20 January 2017

Fieldwork Preliminary Risk Identification approved by *(Supervisor, Fieldwork Coordinator or Head of School):*

Name: Kirilee Wood **Position:** Research Student **Date:** 20 January 2017

Preliminary Risk Identification Tool v1.0   10/10/2016   Document is uncontrolled once printed

211

Curtin University

Curtin Emergency Notification Plan - Domestic

In a Life Threatening Emergency

↓

Dial 000

↓

Notify Curtin Manager or Supervisor

↓

Notify Next of Kin

↓

Notify Curtin Critical Incident Risk Management
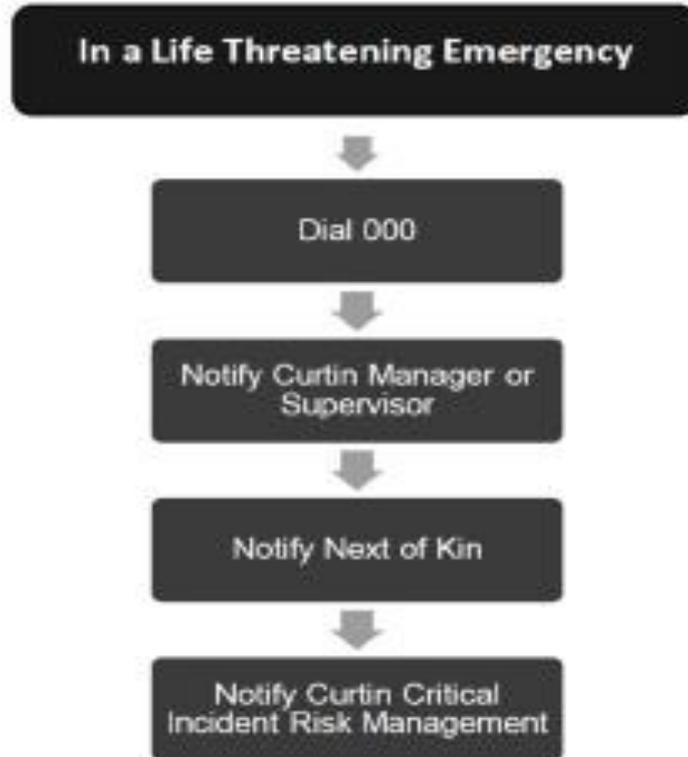
Note: Even if the event or incident has been resolved, you will still need to contact your Curtin Fieldwork Coordinator to keep him/her informed.

Please complete the incident/hazard/accident report form online as soon as possible via the Health, Safety and Emergency Management website.

EMERGENCY CONTACTS	
Curtin Manager or Supervisor INSERT NUMBER	
Curtin Critical Incident Risk Management	0401 103 483 (08 9266 3951 during office hours)
Curtin Counselling Services	08 9266 7850
Customer Care After Hours 24/7 Counselling Service	(02) 8907 5686

Research data management plan.

Curtin University
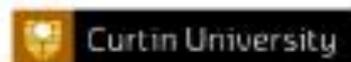
Research Data Management Plan

Ageing transgender people's experiences of health and healthcare provision

Supervisor	Sam Winter
Data Management Plan Edited by	Kirilee Wood
Modified Date	9/04/2017
Data Management Plan ID	WINTES-H802527
Faculty	Health Sciences

1 Research Project Details

1.1 Research project title

Ageing transgender people's experiences of health and healthcare provision

1.2 Research project summary

Within the field of gender studies knowledge of transgender people (people with a gender identity other than that matching their sex assigned at birth) is an emerging topic. In present times, most studies relating to sub-groups of ageing and older (50+ yrs)transgender people have been conducted overseas, particularly in the US. The literature commonly reports how compounded impacts of ageing cause older transgender people to experience elevated levels of institutional, organisation, and social discrimination. Stigmatisation directly and indirectly causes them to be excluded from public life and have a poorer standard of health than other members of society.

In Australia, most studies have focused on younger age groups or combined populations of diverse sexual orientation and gender identities (SOGI). Little is specifically known about how older transgender adults are disadvantaged in relation to health and attaining certain health services in comparison to these other sub-groups or the general population. This exploratory study seeks to expand the knowledge about health provision needs of ageing transgender populations in both national and international contexts. The study will pay particular attention to the institutional and social issues associated with being transgender, together with compounded impacts of ageing.

A qualitative phenomenological research design will be used to investigate and the lived experiences ageing transgender people living Australia wide. The study aims to explain common health and healthcare issues by using NVivo computer software to conduct thematic analysis upon data collected from in-depth semi-structured interviews. Initial non-probability samples will be sourced from key informants. Snow ball sampling will be used from thereon. Twenty one participants will be recruited.

1.3 Keywords
Transgender, Ageing, Older, Health, Healthcare, Public Health

2 Research Project Data Details

2.1 Research project data summary

2.1 Summary of the Research Project Data
This project involves the following data:

1. 21 digital recordings aprox 1-1.5 hours each
2. 21 transcripts from the interviews, transcribed verbatim

All interviews will be recorded using a digital voice recorder and will be transcribed verbatim. The digital voice recording will be deleted once the interview has been transcribed. The researcher will ensure that participants contact details will be stored electronically on a password protected computer and separately from physical paper work (transcriptions). A qualitative phenomenological research design will be used.

21 research participants will be recruited. Participants will be divided into three groups according to gender expressions

213

(male-to-female, female-to-male, non-binary). Semi-structured interviews will use the same main questions (open-ended). Additional questions will be guided by each participants responses.

The interviews will be transcribed verbatim and analysed thematically with NVivo computer software. The researcher will use Braun and Clarke(2006, p.98-99) guidelines to identify, analyse and report patterns(themes) within the data. Themes will be used to understand the phenomenon of being an ageing transgender person in healthcare contexts.

Transcripts will be read multiple times. The initial analysis will define any important participant responses relating to the research question. Notes will be made note in the left hand margin. This process will be repeated using the right hand margin.

Emergent themes (patterns) of significant participant responses will be checked against the transcript to ensure incidence is sufficient and justifiable. Themes and sub-themes will be clustered (grouped) and given appropriate codes. Correlations and marked commonalities will be derived from the entire data set to provide accurate and rich descriptions of the predominant themes. Data will then be compared and verified against the content of the primary source material.

Themes will be allocated names (appropriately describing sub-themes) and arranged in table format.

Each transcript will be systematically processed as above. Attention will be paid to both similarities and differences equally. Weak or less significant sub-themes will be eliminated. The remaining themes will be deemed superordinate and sufficient for a final analysis of all the transcripts. A definitive table of results will then be drawn. Transcripts will be back-checked once more to ensure the analysis and the data match eachother.

2.2 Summary of any Ethical, Confidentiality or Privacy Considerations

This project will gather information from human participants. Condifentiality will be prioritised because some of the information may include sensitive material, or disclosure of illegal activities to ensure no identifiable participant information could be accessed by a third party.

Measures to maintain confidentiality of research data and primary materials by protecting the data from unauthorised access and use. Ethical treatment of data will concern the collection, generation of data, storage, and dissemination. Methods used will comply with measured outlined by Curtin University and the Australian Code for the Responsible Conduct of Research.

Participants will be made anonymous by allotting a number to research data for identification purposes. Digitally recorded interviews will be deleted immediately after verbatim transcription has occurred. Research material will be stored in a locked filing cabinet at Curtin University. The research project supervisor will lock the key in a secure cabinet in his Curtin University office. Electronic data will be stored on a password protected computer until data analysis is completed. Curtin Universities R: Drive will provide archived backup on secure servers for a period of seven years. Archives will be deleted thereafter.

2.3 Description of Research Project Data Organisation and Structure

Physical data sheets will be sorted by group name and number. Each group will be held in a single folder.

2 Will the data be identifiable

- Re-identifiable — identifiers have been removed and replaced by a code, but it is possible to re-identify an individual

3 Will data, including biospecimens, be sent overseas?

No

4 Data organisation and structure

Each participant will be given a group name and number - all data colected will be stored under the participants group name and number. Each group will have a separate folder. Data forms will be scanned. Scans will be added to Curtin University's R: Drive before destroying the original.

Research Project Data Storage, Retention and Dissemination Details

1 Storage arrangements

Participants will only be identified by number allocation for the duration of the project. All physical paper work (transciptions) will be made anonymous and stored in a filing cabinet in the principal investigator's office. All electronic information will be held on a password protected computer at Curtin University. When in the field, data will be stored on the primary investigator's laptop and backed up to an external USB hard drive on a nightly basis. Upon return to Curtin University, all digital data will be scanned and transferred to Curtin's R Drive before destroying the original. Data will be backed up by Curtin University. After a period of 7 years data will be deleted from Curtin's R Drive servers. No information that could identify a particpant will be released to a third party or made public in any way.

3.2 Estimated data storage volume

100 MB

3.3 Safeguarding measures

Physical data will be kept in a locked filing cabinet. All other electronic data will initially be held on a password protected computer.

3.4 Retention requirements

7 years (All other research with outcomes that are classed as Minor)

3.5 Collaboration

N/A

3.6 Data dissemination

The researcher intends to publish in a gerontology journal relevant to research of ageing and older adults. This will be decided once the research is complete.

3.7 Embargo period

N/A

Thematic analysis.

Phases of thematic analysis.

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

(Braun & Clarke, 2006, p. 87)

216

Appendix III: Findings: (T1) Experiences of Health and Healthcare Provision

Corresponding with Chapter 5 of main body thesis

ST1/ST2 (T1): Non-Binary Identifying Group (NBG)

5.1   **ST1/ST2 (T1): NBG gender affirmation and gender affirming healthcare**

ST1 (T1): NBG Positive gender affirmation and gender affirming healthcare.

ST1 (T1): NBG positive gender affirming healthcare issues.

(NBG3) Charlie: "*I found an endocrinologist on the Gold Coast who is fantastic*".

(NBG3) Charlie: "*Well, I did actually tell the XXX doctor about my gender diversity about a year-and-a-half ago. He was very surprised. Well, he was shocked, but he then covered and wasn't judgemental". But he was concerned and offered endocrinologist support*".

(NB1) Toni: "*I went to the surgeon that Dr XXX* [the specialist psychiatrist] *had recommended initially, which was Dr XXX*".

(NB3) Charlie: "*I started testosterone 13 months ago… I had to get a psychiatrist or clinical psychologist referral before I could start that*".

(NB1) Toni: "*She* [the psychiatrist] *gave me a list of about six questions, and so I had to give a bit of a spiel; write an essay as to why and how much I had thought about it - you know, the good, the bad, the consequences before proceeding. That was first session,* [which] *was, 'here's your homework'. The second the session (after she had had a chance to read it) she said, 'yes, I think you are well, you are ok, and yes '*".

ST1 (T1): NBG negative gender affirmation and gender affirming healthcare issues.

ST1 (T1): NBG negative gender affirming healthcare issues.

(NBG1) Toni: "*Where I lived no-one* [health practitioners] *was experienced in gender affirming healthcare". And, "anything outside of the standard GP umbrella, they don't know how to cope". And, "I did actually go and see surgeon who practices in XXX* [my region]. *He does breast reduction. And I thought, oh, this is just radical breast reduction … Well, he just said, 'no. I won't go to that extremity, I will reduce the size of your breasts, but I won't do – not to the size of a man's*".

(NBG3) Charlie: "*The GPs knowledge was none, except that he gave those guys their shots of Reandron* [testosterone brand]".

(NBG1) Toni: "*The only reason I didn't* [go overseas] *was because I thought, 'well at least if it's done in Australia, it'll be to Australian standards and if anything goes wrong, it's easier to go back and get it fixed' (you know, if you have a bleed or a problem). Plus, I didn't have to worry about organizing a sitter for my cat and dog*"

(NBG1) Toni: "*Dr XXX* [surgeon] *attitude? To me, it's inexplicable. I was treated like a guinea pig. Does he not like me? Is he trying to get back at me for something?*"

(NBG1) Toni:" *Where I lived there was no-one* [HP] *experienced* [in gender affirming healthcare].

(NBG3) Charlie: "*I went to go back* [to the endocrinologist, wanting to get a prescription for hormones] *and he was gone. He had only been visiting apparently and was based down in Grafton or Coffs, or somewhere so... and on leave as well, so he wasn't available anymore*".

(NBG2) Jo: "*he'd* [psychiatrist] *said, "your life will be very hard – you will find life very hard". And he said, "I recommend you get to university and stay there": which, at that time, I'd come from poverty and if you are poor, and you go to university it's not exactly possible*".

(NBG3) Charlie: "*I tried finding another clinical psychologist at the university which is where my other had been based, and they told me that they weren't taking on any new patients; and I said, 'you know this is urgent, I've got to get this piece of paper for top surgery?' They said, 'we will, talk to so and so,' who I knew somebody else who was trans was seeing, 'and see if they will get you in, we will get in touch with you as soon as possible'. And, I never heard from them again. I never got any leads*".

5.2   ST2 (T1): NBG general health and healthcare.

ST2 (T1): NBG positive general health and healthcare.

(NBG3) Charlie: "*I had to have a mammogram, which I'd never had before (because I didn't like the idea of pain), but that will all be gone with the top surgery*".

(NGB3) Charlie: "*I took the drugs for a year and managed to clear it (Hepatitis C and Ross River virus). I had very good support in that time, both from my partner. And also, there was a counsellor facilitating, I can't remember, but anyway a support group with other "heppers*".

ST2 (T1): NBG negative personal general health and healthcare

(NBG3) Charlie: "*I live in a hilly area, so I find it challenging to walk*".

(NBG1) Toni: "*It bugs me that the whole health system has been allowed infiltrated on religious grounds. As in the Catholic – you know the way they now hey get a huge whack of taxpayers' funds to provide a health cherry pick what services they will and won't provide... Taxpayers' funds should not be paying for people to provide discriminatory services. And, if they do that to women in general, then there is no surprise, whatsoever, that they are not going to be supportive of non-gender conforming people who don't conform with their religious beliefs*".

ST1/ST2 (T1): Male-identifying group (MG)

5.3   ST1 (T1): MG gender affirmation and gender affirming healthcare issues.

ST1 (T1): MG positive personal gender affirmation issues.

N/A

ST1 (T1): MG positive gender affirming healthcare.

(MG1) Liam said, "*She* [my GP] *did know her stuff and she did know the information*".

(MG5) Ben: *He* [Professor] *was from the Netherlands. They have all got a very positive attitude, and they have done a lot of research and all the rest of it about transgender, and sexual health*".

(MG4) Dan: "[When I moved] *I, as fast as I could, learnt where the GPs were that knew what this was, and I moved all my health over to them. I didn't go back into mainstream*".

(MG2) Dylan: "*I went to see my doctor up here and spoke to him about it, and he was fine. I'd found out that he'd actually worked with a transgender client when he was in [overseas] so he was fine looking after my health and so on up here, which was a real 'thank goodness'! And, what he didn't know he actively sought out information for, and actually went and contacted the gender clinic in Brisbane to get any information that they can give him to help me - so he was really proactive*".

(MG3) Oliver: "*I've got a brilliant GP, I've got a brilliant endocrinologist, I've fantastic support services*".

(MG4) Dan: "*I was very lucky to be in a supportive clinic. They were working through the problem with me rather than, sort of, throwing up the reins and saying, 'no'*".

(MG5) Ben: "*The attitudes of the other hospital staff were good. Yes, they were brilliant. One guy, going through his final year, or internship or, something, I don't know how it works: but he, watched all the surgery*".

(MG1) Liam: "*Dr XXX checked with this doctor she knew at XXX. I think [she] thought it would be months before anything happened, but it was only a couple of weeks, so I was able to get the Reandron very fast*". Also, "*With the shots, which are Reandron (1000) – it is really good. It took a few days, and then it was full on*".

(MG4) Dan: "*He [GP] said, 'well there's a new testosterone out. Do you want to try it?'. I said, 'I will try it with the condition that I will go back to this one if it's not perfect'. And, we tried, and it's perfect for me!*".

(MG4) Dan: "*I've been getting [state] funded counselling by people through them who actually do understand trans, so it's a good service, and it isn't costing me*".

(MG5) Ben: "*It's just basically, what my GP knew. Right, and people over in Melbourne. Well, all their medical contacts and all the rest of it. Ok, this one will be appropriate, there is their address*".

ST1 (T1): MG negative gender affirmation and gender affirming healthcare issues.

ST1 (T1): MG negative gender affirmation issues.

(MG1) Liam: "*I know one of the councillors said, 'you know, wouldn't it be funny if you are depressed because you are trans and you get over it?' I don't think it's that easy. I think I've probably had it (depression) since I was a kid. I had a lot of anxiety problems*".

(MG4) Dan: "*I did try to get through the gender clinic early and was told that; 'you couldn't be a trans man – they don't exist. The trans-ness is on the Y-chromosome, so only men can have it. So, there's only male-to-female'. A woman who walks into the clinic, and says she thinks she feels like a man is just a confused lesbian. [The HPs would say] 'Off you go dear, you will be right'*".

ST1 (T1): MG negative gender affirming healthcare issues.

(MG1) Liam: "*The surgical vest was to help with pain and inflammation and swelling. Since I've heard of some pretty bad experiences of that, if people didn't have them. But, they are not fun, they are not comfortable*".

(MG5) Ben said, *"There is one [surgeon] in Sydney. He has a very bad reputation. He is known as the 'butcher of XXX'. Still, mind you, if you accuse them of that (being a butcher), he turns around and sues you…The only thing he is in it for is the money".*

(MG5) Ben: *"He [psychiatrist] wanders in and I sit down, and he goes, 'right I haven't received any referral letters, so why are you here?'. I said, 'well, I'm actually transsexual;' and he, 'right, well, you're not making that much of an effort'. I said, 'I'm not male to female, I'm female to male'".*

(MG1) Liam: *"Some of the guys say that there are some doctors that are not sympathetic. You do get people mentioning adverse experiences".*

(MG3) Oliver: *"where I was living down in Tasmania, I went and saw my GP, and I said to her, 'I think I'm transgender, and I'd like to explore this'. She said, 'I won't treat you because I don't believe in it'".*

(MG2) Dylan: *"Because I live in a small town, and I wasn't quite sure how my doctor would react to my questions about this [transition]".*

(MG1) Liam: *"Dr XXX talked about needing to do therapy to be sure that I wasn't crazy. Ok, that's my word. I don't believe she said that exactly, but it was kind of annoying. I'd gone therapists off my own back when I had some bad depression problems"* and *"I mean, I knew I was depressed, but I didn't think I needed that [psychiatry]".*

(MG4) Dan: *"I think the GPs and the trans clinic were lost as well. There was nowhere to send me. There weren't any support groups; there wasn't anywhere"*: And, *"there is not any support specifically for the over 50 years age trans group".*

(MG4) Dan: *"For psychs … I found the process a bit frustrating in that I paid $300 odd for a visit and there was no clear indication of when it would stop; how many visits you needed; how long did it take to have an assessment".*

(MG4) Dan: *"When I had the first shot of hormones I thought, oh, nothing's happened. You know, people say that something does; but, some people say it feels something like, I don't think I can tell anything at all. But, that's all right, I'm in it for the long haul, I don't mind how long it takes. Also, "We do have difficulties with the endocrinologists themselves. Interpreting the PBS rules. The rules say. I've looked into where they say, you only have to go the once. But, some endocrinologists are saying, 'oh no, but I need to see you again next year'. You think, 'no you don't, you are just money making – give yourself another patient'. There is nothing in the rules that say they need to review. [As if speaking to an endocrinologist] 'You just seeing whether I've grown any testicles last year'. Really – it's not going to change! Changing like that? We [the transgender male community] said, 'well, it doesn't'. So, yes, there's still arguments, I suppose, as to how to actually interpret the rules of government. So wisely being done!"*

(MG3) Oliver said, *"I remember saying to the sexual health professional one day – I make a comment to him – and he said, "I don't know about that," yet it was common information I'd got off the internet".*

(MG5) Ben: *"Going to all the trouble and supplying these doctors with these CD-ROM's [about transgender health concerns and needs]. Only, I don't think they will use it, because we hadn't put them to their checking up [administration]. So, all that time, money, effort, and a lot of them just … 'oh, okay, thanks'. He [the doctor] put them into the drawer and forgot about it. Would have been better to have got more of a positive response from them, instead of just [the doctor saying] 'ok, thanks' [then he] take[s] a look at it and [we hear] nothing!"*

(MG5) Ben: *"He [doctor] just walked in, took one look at me, then looked at me again and said, 'you are not what I was expecting'. [He] turned around and walked out, so of course no*

blood tests. They [the hospital staff] had to take me back down to my room and call up someone from pathology to take the blood".

(MG3) Oliver: *"In my case, when I'm saving on DSP – I'm on disability support pension – finding $300 to pay for a psychiatrist appointment, and then getting only $200 of it back … That's nearly 50 percent of your income for that fortnight. So, don't you pay your rent: don't you feed yourself? It's all of these issues around it".* And, *"I've talked to my GP about this problem under my arms. She has looked at it, and even she is grimaced, because I think she is worried like I am that I am going end with a skin integrity issues and ulcers before much longer. But the problem is, now accessing a plastic surgeon at a public hospital. Then, adding into the mix…. funding of what they will prioritise? So, rather than being a preventative thing that they look at it and say, "let's get something done about this (lumps under my arms) before it gets much worse, it's going to end up having to be that critical acute situation that then turns into a chronic problem. Then, I will end up with ulcers or whatever under my arms: that is going to be disgusting, but, I've got no choice about it".*

5.4   ST2 (T1): MG general health and healthcare

ST2 (T1): MG positive personal general health.

(MG3) Oliver: *"Essentially, the only one screening that I'm involved in is obviously the bowel screening – the compulsory bowel screening. That's the only one that I know of".*

ST2 (T1): MG positive general healthcare.

(MG1) Liam: *"[My GP does regular blood tests and other screening because] I think she wants to make sure I'm healthy. It's good, she's a doctor. That's what they are meant to do I think"*

(MG4) Dan: *"[When I had my shoulder surgery] I knew my surgeon knew my body, that I was in no danger from my point of view".*

(MG5) Ben: *"I only see the one doctor at the moment... She, sort of, takes care of everything".*

ST2 (T1): MG negative general health and healthcare provision.

ST2 (T1): MG personal negative general health problems.

(MG2) Dylan: *"I was going to transition (about 44) I had a minor TIA (a mini stroke). They weren't sure what caused it, but I get migraines, and after a year of going through all these tests and things they worked out that this mini stroke was actually directly related to my migraines. That really worried me, in that I thought that I may not be able to have the [gender affirming] surgery done".*

(MG3) Oliver: *"The day I can't look after myself I'm going to put myself down".* And, *"we have that laugh because, to trans guys, having to have pap smears is the equivalent of blokes having to have prostates. You know, it's like, [health providers and clinical staff thinking] 'urgh?'".*

ST2 (T1): MG negative general healthcare issues.

(MG4) Dan: *"The hospital staff think they have got everything under control. They think they know what confidentiality means. They think, oh, your records and that aren't going to get passed to anyone – we will keep it all secured, oh blah, blah. What they haven't got is confidentiality around anyone who can hear anything, or people standing around".* And,

"high dependency is like: there's no walls between the beds, there is just … this is when you need high levels of care. Yes, it's alright, but this way of treating everyone the same doesn't work because, if everyone is naked because they need to get tubes in and out quick, and you know, it's high level care, that's fine for the rest of the population because their bodies look how they are meant to look".

(MG4) Dan: *"I know, from the training programs that I teach and do, that the trans women who, even post-op, if there is any prostate left they have to have prostate checks. And, that can be confusing for doctors".*

(MG5) Ben: *"An example of a good health provider is one that doesn't freak out when you tell them that you transgendered – [but others will say] 'ahh, ok, that's it … bye bye' – in other words, 'get out, and don't come back'. He [the health provider I saw] had absolutely no consciousness of the ethical obligations".*

(MG4) Dan: *"Tor trans men who might have been not as lucky as myself, who haven't got the funds to get the chest [surgery] done, but are for intensives purposes the same as me because they have had testosterone for a number of years, trying to get those breast screens done in a safe environment (and a culturally safe environment) is nearly impossible".*

(MG3) Oliver: *"It [local health system] certainly needs better priority and something. The clinic I go to, they've four sites around XXX. They do a deal with a lot of patients, and she [my GP] said it's like a lot of things with the way that they deal with obesity, they deal with diabetes, they deal with a lot of other issues. It tends to be reactive or acute than preventative".*

ST1/ST2 (T1): Female-identifying Group (FG)

5.5   ST1 (T1): FG gender affirmation and gender affirming healthcare

ST1 (T1): FG positive personal gender affirmation

(FG1) Ellen: *"To some extent I have feminized. I started off with these [cheek bones], and I had a massive jaw, but the muscles have reduced massively".*

(FG3) Charlotte: *"Some people take two or three goes to find a hormone that suits them. I was fortunate that I haven't had any reactions to that. And, I'm effectively on the same medication today".*

(FG4) Ava: *"They [hormones] really get them [breasts] growing. They feel pretty good".*

(FG7) Abigail: *"My journey to being me started when I accepted that I was transgender".* And, *"I'm still affirming my gender in new and strange and wonderful ways as I progress".*

ST1 (T1): FG positive gender affirming healthcare

(FG1) Ellen: *"My main, absolutely my main guide, has been my psychiatrist. I am fortunate that he specialises in trans issues and he is very well known".* And, *"I have an arrangement with my local chemist, and I have quite a good one now".*

(FG4) Ava: *"He [my psychologist] used a lot of photos of how I felt as I was growing up, and which photos best fitted my feelings. And, all that came back that I was transgender and stuff. I was really pleased about that".*

(FG7) Abigail: *"They [clinic] had gay GP there who is great.".* And, *"I really enjoy those kind of holistic doctor types who are not just getting you in there, prescribing you a med, and*

get out, sort of thing". Also, *"I think he* [medical clinic director] *must have a really good business model and is obviously a good business man as well as a great doctor".*

(FG8) Chloe: *"You are frightened to tell her* [GP] *about your female side but she soon puts you at ease and in contact with the psychiatrist".*

(FG9) Mila: *"The local GP, Dr XXX, is a lovely person…. She was 100% supportive. She was beautiful. She just said, 'look, it's okay. You don't have to feel… we will fix this for you, it's okay. It's all going to be fine'".*

(FG10) Penny: *"They* [online nationwide support organisation] *have been totally supportive as far as gender is concerned".*

(FG11) Ruby: *"I've been looked after by health care professionals".* And, *"Well, they asked me about my life, and what it was like for me to be a person who identifies as being female, you know".*

(FG5) Clara: *"I saw* {the psychologist] *less and less. I just sort of started getting on with life and waited a year or so – eighteen months or something – and then I went to my doctor".*

(FG9) Mila: *"Gender affirmation support people? Just a psychologist. And, she was great. And, "I found a place called* [XXX with a psychologist], *who was a specialist with transgender. So, she was really understanding. Really good. She helped me through the early phase".*

(FG1) Ellen: *"Changes do happen. The facial feminisation of it sensibly requires you to be on hormones for a couple of years, so changes naturally on you, you know?"*

(FG3) Charlotte: *"The doctor I started with, I considered to be an expert in this area. He was the one that prescribed me hormones at the start and I was regularly monitored, in terms of hormones and other aspects, and I had confidence that he knew what he was doing".*

(FG7) Abigail: *"I'm on post-operatively … Climara patches. In fact, I'm thinking, after the stroke, I think that is why they switched me over to patches. Rather than taking the oral tablets which would then get processed by, I guess the liver and kidneys, they switched me over to the subcutaneous".*

(FG8) Chloe: *"You start on hormones. In the meantime, every couple of months, you are going back to see a psychiatrist. And the GP monitors your bloods and everything else".* And, *"I get help by seeing the GP for hormones or you could end up with osteoporosis".*

(FG2) Amelia: *"Post op* [genital surgery] *I just need oestrogen, and that's it".*

(FG9) Mila: *"I never found it* [hormone therapy] *affected me at all. It just did nothing. My levels were high already, so I think I was just, sort of, predisposed to having high oestrogen levels, so it made no difference to me".*

(FG10) Penny: *"He started with the Spironolactone, which is actually an anti-diuretic, but it goes over a long term has an anti-androgen effect. And, oestrogen on the same, that I was actually self-medicating anyway".*

(FG7) Abigail: *"I've only had one surgery, and that was the lower neo-vaginal surgery".*

(FG8) Chloe: *"The Thai hospitals are better than five-star. Absolutely spotless. It's just marble everywhere. Everything is just so shiny. Everywhere was clean, clean, clean".*

ST1 (T1): FG negative gender affirmation and gender affirming healthcare

ST1 (T1): FG negative personal gender affirmation issues

(FG10) Penny: *"I had an operation to have a double mastectomy because I thought it would fix me".'*

(FG2) Amelia: *"[completing my gender transition was unpleasant because] you can imagine what it's like [very difficult] going to find a Justice of the Peace [JP] who will be there when you are being examined by a GP to say that yes, you have a vagina".*

(FG) Clara: *"I couldn't really come to terms with it [my gender dysphoria or changing my gender]".*

(FG9) Mila: *"We went to my GP and explained to the GP what my issue was. And she just sat there, and went, "oh my God. How did you survive this long, and keep this under your hat without going mad?" I said, "I didn't! I went mad".*

ST1 (T1): FG negative gender affirming healthcare issues

(FG) Clara: *"She [my psychologist] didn't know much about gender at first. She didn't really understand a lot about it [gender dysphoria]".*

(FG4) Ava: *"With the psychologist, I didn't really feel as though she had helped at all through the transgender things".*

(FG3) Charlotte: *"Well I had spent all this time with the psychologist, so I found it (the XXX Clinic gatekeeper model) didn't add any value to me at all. And, I got frustrated because I saw the director of the clinic, and she was not a pleasant person. She was in her mid-seventies at that stage, and when I contacted her - and then had sessions with her - she saw that I was fairly articulate and wanted to use me to help further the cause of the clinic, which was struggling for funding at that stage – rather than to be adding any value to me".*

(FG1) Ellen: *"My psychiatrist, and my endocrinologist is very expensive. My first meeting with an endocrinologist was $500 - $600".*

(FG2) Amelia: *"When I had my breast augmentation, the only place that I was able to find that might have considered it was based in Sydney in the West in a plastic surgery place, and they said, 'you will have to have chest expanders and its multiple operations'. Their quote was $6,000 ended up being something like $15-20,000.*

(FG5) Clara: *"I went to an endocrinologist who would be able to prescribe them [hormones] to me. The appointments for the endocrinologist were like for seven weeks, and more than two months to see the one that could do that sort of thing".*

(FG2) Amelia: *"[After GAS] I had trouble going to the toilet for a little while. I had ultrasound for that".*

5.6   ST2 (T1): FG general health and healthcare

ST2 (T1): FG positive personal general healthcare

(FG2) Amelia: *"I had once to have spots checked for a melanoma. I had one removed. That's the only time I ever had to look for a doctor other than my normal doctor. He was ok, but I don't actively seek healthcare".*

(FG2) Amelia: *"I have a GP now. He's local. I often go to my GP that I was visiting when I first had transitioned. He's very helpful"*.

(FG4) Ava: *"Dr XXX is the most lovely person you could ever meet. I don't know if you've ever met her but she's so genuine and endearing, and you wonder why she is dealing with people like me. Dr XXX really tries to do her best by me"*.

(FG1) Ellen: *"Now they call out my name, because that is my name. I was sensitive, and they won't do that twice"*. And, *"I mean obviously when I'm on the ultrasound bench, you do have a conversation - typical young women's you know. And she'll tell me about her sisters. Just recently there was an occasion I could have talked for hours and hours, and I'm really conscious of doing, Because I'm used to doing it a lot. When we got into a trans conversation my wonderful new friend said, "Oh I'm really interested""*.

(FG4) Ava: *"I really should go back and talk about the early 2000s. I was in a really bad way. I was crying, I went to Dr XXX. I just didn't want to be around anyone. He was sending me to XXX to the psychiatric part there. And, then they referred me the XXX clinic in XXX. And, I saw a psychiatrist there. They were magic to me there"*.

(FG2) Amelia: *"Mostly labelling has been fine. My birth certificate, and everything has been changed"*.

ST2 (T1): FG negative general health and healthcare

ST2 (T1): FG negative general healthcare

(FG2) Amelia: *"When you there [ultrasound clinic], it's quite obvious that, people have said whom you and what you are, so to speak, what you are, because others will walk past while past while you are in the waiting area and look at you. You know they are looking at you"*.

(FG2) Amelia: *"Experience level of General Practitioner I would say no experience and didn't want to"*.

(FG3) Charlotte: *"Too many of our providers today are used to heterosexual bodies and minds, and they are not as accepting of difference as they should be"*.

(FG3) Charlotte: *"From the feedback I'm getting, the majority of A&E clinics are not coping well. I think that the majority haven't had training around trans bodies"*.

(FG4) Ava: *"The psychologist was all in for this mind stuff, and I found that bit ... it didn't sort of work"*.

(FG5) Clara: *"I started seeing her (my psychologist) about my depression. And another psychologist who I went to see, but they knew nothing about gender"*.

(FG8) Chloe: *"I stopped [another transgender woman] twice from suiciding. I got her to go, the first time, in, to get help in [the local hospital] ... They told her that she wasn't transsexual, and everything else – rah, rah, rah. They gave her a few pills and put her out into the street. A few days later, she was trying again. And, they really just didn't want to know. It was all just too hard as far as they were concerned"*.

(FG3) Charlotte: *"A number of people I know have had to go through accident and emergency in public hospitals. And, I think; that they [Accident and Emergency departments] are difficult places because people are dealing with emergencies often"*.

(FG2) Amelia: *"Fifty percent of the people that will go have been to psych nurses and doctors. 50% will say male, but not say they are female... I don't see any reason why they*

would change, because you can't prove that they are doing. When you can prove that they are doing, they say, 'well it's only the paperwork".

5.7   ST3 (T1): Healthcare needs and suggestions

1.   Australian government and health systems (including insurers)

(FG9) Mila: *"Having the system to want to help".*

(FG6) Rose: *"I mean, they are going to get it off Medicare anyway, their rebates, so why not do them a Medicare rebate for some of these individuals?"*

(NBG1) Toni: *"This business of a penalty being imposed on people after they have had a break from private insurance while on a healthcare card. That needs to change".*

2.   Transgender identity and inclusivity needs in institutions and organisations

(FG10) Penny: *I don't have to, or have any need to have, 'female'* [cisgender identity]'. *Transgender is fine. But, that would be fine if there was a definition raised of what transgender male and transgender female is".*

3.   Upskilling healthcare providers

(FG1) Ellen: *"Some people haven't quite got it yet because they just don't get it. They need to be educated (for goodness sake) if, as professionals, or in their workplace, they will come into contact with trans or any other minority group".*

(FG7) Abigail: *"Well, just trying to educate people that, you know, that trans people come in all shapes and sizes, and presentations, and things like that".*

(FG8) Chloe: *"Education will make things better. That's a big thing. A lot of the psychiatrists, who have been around for years, definitely want to know".*

4.   Recommendations for better practices and availability from all healthcare and related wellbeing providers

(FG6) Rose: *"I've done a Diploma of Counselling which I found was quite involved... Yet, there's no way I can do anything* [be a counsellor to other transgender people] *through Medicare because I'm not a* [health funded] *psychologist, or a psychiatrist, or a doctor... Yet, there are so many people out there screaming and in need".*

(FG9) Mila: *"I think a standardised situation of GP, psychologist, endocrinologist, psychiatrist, is very sensible to protect those that are going through it".* And, *"I guess, with the forms it would possibly be a really wonderful thing for them to give a patient another alternative than male or female, if they so choose that. You know, for those that are non-binary, or those that are maybe still living as a male, or whatever, that they had an option in hospitals to deal with that".*

(MG4) Dan: *"There is not one single-folded support organisation for trans people in Victoria. There's not one cent outside of the medical clinics per trans person in any way".*

(MG1) Liam: *"So there's a change we need right there; more hospitals who will assess trans people for suitability for the injection programs".*

(MG4) Dan: *"I had a thought for a project (but I haven't been able to get any funds for it yet) where it's a similar sort of thing to a location-based Google Map service where we could review services, so that ...".*

5.   Participation in community care to ensure consistency in healthcare practices and information delivery

(FG11) Ruby: *"Why take one person's opinion and make that the whole picture (if you like) because, you are going to miss out on a lot of people you know? And, if you are looking to accommodate us, then do it proper"*.

Appendix IV: Findings: (T2) Factors Enabling or Hindering Good Health and Wellbeing and Access to Healthcare

Corresponding with Chapter 6 of main body thesis.

ST1 (T2): Factors enabling good health and wellbeing

1. *Having the means to feel authentic*

(NBG1) Toni: *"I sort of decided that I would go for the Peter Pan option of being neither female, nor male, and just minimise the chemical interference with the body".*

(FG7) Abigail: *"My voice had been, sort of, a bit deeper before, I managed to bring up into sort of female, male, cross-over range, sort of thing. And that doesn't give me any problems nowadays - occasionally on the phone, but it doesn't worry me does it".*

(FG3) Charlotte: *"Within 48 hours of starting on female hormones, I felt complete as a person for the first time in my life".*

(NBG3) Charlie: *"I'm going to have top surgery next year, but just so I feel less gendered (less female gendered)".*

(MG1) Liam: *"At the moment I'm just thinking of (hopefully) settling down on the "T" and actually, not getting called Ma'am quite so often".*

2. *Good social connections: strengthening feelings of authenticity and wellbeing*

(FG1) Ellen: *"I've just had an experiment, if you like, of re-meeting two [previous acquaintances] that I haven't seen for 36 years – and they were just wonderful. They actually sensed that it [our connection] is different. And their relationship to me was different, and I thought it's interesting, these are robust blokes, and I felt feminine in their response to me".*

(FG2) Amelia: *"Exercise a lot, work a lot and a study a lot"*

(FG4) Ava: *"I thought I would go and do myself in, or something was going to happen. I spoke to [my ex-wife] about it. I said, 'this is it, I'm going to make a transition'".*

(FG10) Penny: *"Five years including recovery from the surgery, which is about a year. I think you just need that time, for things to go through your head as you change because part of yourself inside does change".*

3. *Understanding good preventive health measures*

(FG3) Charlotte: *"I don't go to the gym, but I do a lot of walking. My weight is under control".*

(FG6) Rose: *"I've had breast screening".*

(FG8) Chloe: *"I get help by seeing the GP for hormones or you could end up with osteoporosis".*

(MG1) Liam: *"I had a likelihood of pre-diabetes if I didn't mend my ways type thing… I have actually managed to do [lose] at least eight kilos, and also, taking the Reandron (1000) makes you want to exercise".*

ST2 (T2): Factors enabling access to healthcare

1. *Gaining funding for services and prescriptions*

(FG2) Amelia: *"I am not employed. I get my hormones, and when I need androgen blockers, they are done (prescription rates) at a cheaper rate".*

(FG10) Penny: *"Paying for HRT* [hormone replacement therapy] *or anything associated with it, that comes first".* Also, *"I still have a mortgage. But, if I can sell up there will be enough there so I could fund my transition completely".*

(FG1) Ellen: *"He* [my psychiatrist] *doesn't charge me anymore. He hasn't for a long time".*

(FG1) Ellen: *"If I hadn't got work immediately? I probably would have to visit Centrelink: which I would imagine, although I might be wrong on this, but I would imagine I could go there at 62…. Trans woman, being treated under the Mental Health Act, and not have great difficulty getting on Centrelink. I can only imagine that. I would get a letter from my psychiatrist saying I had anxiety issues. But, I don't want to do it".*

(FG2) Amelia: *"Because I am not employed, I get my hormones. And, when I need androgen blockers they are done (prescription rates) at a cheaper rate".*

(MG4) Dan: *"I was on such a low income I'd get the hormones on PBS".*

2. *Gaining recommendations from online communities and health provider sites*

(FG1) Ellen: *"I could follow a* [Google] *path on a computer with help from the librarians".*

(FG5) Clara: *"I would pull up the* [gender clinic] *website and read the pamphlet every day for like six months".*

3. *Access to referrals, service availability, and good relationships with health providers*

(FG3) Charlotte: *"My doctor ended up prescribing hormones before I'd been approved by Monash at the end of the day".*

(FG1) Ellen: *"He* [doctor] *gave me a referral, and from then on you are in the hands of the psychiatrist. That's a reasonably secure environment".*

(FG2) Amelia: *"I went to a General Practitioner, who I found out through other friends (online). She was able to refer me to psychologist".*

(FG5) Clara: *"My GP gave me another referral and I talked to them about surgery. It was pretty easy".*

(FG10) Penny: *"*[Whilst there are no surgeons to perform genital surgery for trans women in WA] *There's a couple of surgeons over East* [in Australia]*".*

4. *Access to affordable care*

N/A

5. *Encouragement to transition*

(FG5) Clara: *"So my partner, sort of, knew the social worker. She talked to them".*

ST3 (T2): Barriers to good health and wellbeing

1. *Concealment and experiencing or fearing discrimination and misgendering (prior, during, post-transition)*

(FG2) Amelia: *"I don't go out a lot"*. And, *"People who have never known me before just misgender me. Some people are deliberate. I went to a shop in Brisbane [department store] wearing a skirt and top, wig and makeup. And she said, 'yes sir, what can I do for you?' I thought, 'OK, do you really need me to point this out'. It comes out many times. At Medicare and Centrelink, when I went to their offices, said, 'this man needs some help over here'. Called somebody over. And I said, 'lady'. Boom. Didn't even look at me, just said 'sorry,' and continued on, as if it means nothing. A lot of the times its - in some ways I'm used to it because – even at school because I was different with my Asperger's - my social interaction is different, so I'm still experiencing that in some way. I'm used to it, but it doesn't help"*.

(FG10) Penny: *"I can't imagine what it is like if you cannot pass? Someone who looks very masculine. It would be awful"*. And, *"He [help line person] started misgendering. I know that that was gay man. I know that for certainty. And he, without saying exact words, but what he said was, basically, 'get off the line so I can talk someone about sexual issues'. Really? And there is a lot of transphobia amongst gay men for some reason, and it's a weird thing. I don't care. But, that made me feel terrible"*.

(FG3) Charlotte: *"It becomes exhausting for people if they have to always feel on the defensive; feel that they are being challenged for who they are; and, they just want to get on and be themselves"*. And, *"I guess three times in the last month, has been transmen in hospital being offered bottles for them pee into when they can't, and hospital staff not recognising different physical characteristics of different bodies. That can be embarrassing particularly if it happens in a public environment"*.

(FG1) Ellen: *"Experimenting with women's' clothes: It's been a vicious cycle over the years and going out and walking up and down the street – which is very terrifying I can tell you"*

(FG8) Chloe: *"Well - in particular sports - I just tried my hardest to hide who I was"*.

(MG2) Dylan: *"I hadn't mentioned it to anyone, and I was still thinking about it, and it would pop into my mind often, and I would just push it aside"*.

(NBG2) Jo: *"Probably in the 80s... there was only female to male that I had ever met in my whole life time"*.

(MG4) Dan: *"I got it wrong on every count. I could never see what people saw. Days I thought I might pass today, I thought I looked a bit more male – apparently, I didn't. Days where I thought I was horribly female, I wasn't"*.

2. *Having aged-related, co-existing, or secondary conditions*

(FG5) Clara: *"I was heading towards my 50's and my health was draining, going towards middle age – eyesight was another one I had to go and look at. All those sorts of things happened before my transition"*.

(FG8) Chloe: *"I had a major hip problem. It's called osteomyelitis... that was a lot of operations to sort that out over many years"*.

(NBG2) Jo: *"I saw the condition of my spine, well even I was shocked"*. Also, *"I guess, if you are going at 60-miles per hour and you have a head on collision, well yes, it is going to [do damage]."*

(NBG3) Charlie: *"I got diagnosed with Hepatitis C, Ross River Fever, and had recently had Glandular Fever"*.

3. *Barriers to gender affirmation*

(FG4) Ava: *"When you are suppressing transgender you try to be tougher than what you really are. You know, you try and be more masculine. You work hard, play hard... I ended up getting a girlfriend"*.

(FG10) Penny: *"It came to a point where I realised that it's a life and death decision: between living as I was, and just, and inside its killing. It's like whipping"*.

(MG5) Ben: *"It can be detrimental for your psychological health if you don't get the final surgery"*.

(FG2) Amelia: *"I went through a lot of self-harming which was a few years before study"*. And, *"I mentioned Asperger's, ADHD* [attention deficit hyperactivity disorder], *anxiety, depression is basically fine. I'm on tablets morning and night"*.

(FG4) Ava: *"He* [my doctor] *said to me, 'I think you might have had a panic attack'"*.

(FG5) Clara: *"The psychiatrist said 'yes, it's serotonin* [syndrome]' *... I simply was off my head. I was on a small dose, not even a heavy dose. And, basically, the changes in my head just sent me into like a weird spinning movement"*. And, *"My mood goes up and down. I found out I'm on the Bi-polar II* [scale]*"*.

(FG10) Penny: *"*[I have a SMI] *It is PTSD* [post-traumatic stress disorder]*"*.

(MG1) Liam: *"I had a lot of anxiety problems"*.

4. Adverse side effects of gender affirmation processes

(FG8) Chloe: *"It's hard to do this. We don't decide to do this. We are born this way. We don't just decide to change over just for the hell of it"*.

(FG1) Ellen: *"It* [GAHT] *can be extremely traumatising. because you are replacing all the hormones in your body. You are replacing some very insensitive hormones with very sensitive hormones. Testosterone, (you know the stereotypical) for, now I'm very emotional"*.

(FG1) Ellen: *"The dangers of it all (commercially). For older people, it* [GAHT]*is extremely dangerous"*.

5. Difficulties understanding health concerns and gathering related information

(FG7) Abigail: *"I don't have a lot of people saying to me, you know, you need to do this"*.

(FG5) Clara: *"There were a few general health problems that had been around* [and didn't get identified] *for a few years, from when I wasn't attending a GP"*.

(FG7) Abigail: *"I have been lapse* [having my bloods checked] *about doing that for a while"*.

(MG2) Dylan: *"I could not, for the life of me, work out the private health cover stuff?*

(MG4) Dan: *"Sometimes it's, as I said, silent tracking* [and] *lack of knowledge* [or] *lack of insight knowledge of where to go"*.

(NBG3) Charlie: *"I knew nothing of gender transition when I was young..., this was learning about it in my late 30s, 40s, something like that"*.

6. Past alcohol and substance issues

(MG2) Dylan: *"I smoke – I know I shouldn't, but I do"*.

ST4 (T4): Hinders access to healthcare

1. Health provider access issues

(FG2) Amelia: *"He* [psychiatrist] *was only doing children. He was not interested helping at all - Not interested in adults at all"*.

(MG1) Liam: *"I would add here that my doctor did try to get me an appointment at the only WA public hospital with an endocrinologist who sees trans people, but they refused the*

application because it turns out I live out of the catchment area".

(MG1) Liam: *"It's like they [surgeons] consider it for a while, and then I got a call saying he doesn't do that. It was not helpful, it was not, 'I'm suggesting anyone else,' it was just, 'ok, he doesn't do this'. You know, 'I am waiting for you to dry up and go away'".*

(MG4) Dan: *"It took me two years to find a government funded dentist service to fill a filling".*

(NBG1) Toni: *"Because I travelled around, you don't necessarily have a lifelong GP".*

2. Gender affirmation healthcare affordability

(FG3) Charlotte: *"The breast implants: the hospital cover [health insurance] covered the hospital stay, but not much of the cost of the operation".*

(FG10) Penny: *"I spent that [funds for surgery] on the mortgage".*

(FG6) Rose: *"I guess I would have had to pay a lot of money [for SRS] but it was hard enough just covering rent and everything else".*

(MG5) Ben: *"I had health insurance when I was working, but, after I got hurt (and everything else) I just couldn't afford it, so I gave it up. I probably couldn't really claim anything back on private insurance for the lower surgery anyway".*

(FG1) Ellen: *"I had five speech therapy classes at $150 each. I had to give all that up. It was very expensive".*

(FG10) Penny: *"Perth, you've only got breast reconstruction really. It costs about $10,000. I wouldn't do that in Thailand and other surgery is somewhere between $20,000 to $30,000; but plus, because it's not here, you've got to travel, so that's accompanied with staying somewhere, and all that".*

(MG1) Liam: *"That's why I didn't go for the chest surgery for quite a while because it's bloody expensive. It's like, $5,000"*

(MG4) Dan: *"It would be nice to think bottom surgery was possible in Australia, but it is not... the latest quotes are $98,000 overseas, so forget it!"*

3. Mistrusting health providers and discrimination issues

(FG3) Charlotte: *"I know many people take a few goes to find somebody that they are comfortable to work with. But, it really was very hard. It was like peeling onions [for instance] with the layers of an onion".*

(FG2) Amelia: *"I dread the day I have to go to a casualty unit because I know what the treatment can be like".*

(FG3) Charlotte: *"People fearing they won't be accepted for who they are. People fearing that they will judged; that they will be belittled; that they will end up providing training to somebody at their own expense; and, that they are not going to be respected for who they are. And, for the majority of trans people that I have met, they prefer not to face that situation, and therefore, they will avoid making medical contact if they can".*

(FG10) Penny: *"I don't know about going into an aged care facility, yeah, I really don't. I would hate to think about - that when you see some the reports of horrible things going on to normal people".*

(MG4) Dan: *"The GP that I would've seen for other things, at the time, was actually (kind of) linked in with my social networks [and] any friends that I had or anything, so I did not feel that [disclosing my identity to him] was a good idea".*

(NBG3) Charlie: *"I've been quite cross because I keep finding out more information, and I tell him [my GP], so that when new people come to him, he will have the knowledge, and the*

names, but he doesn't write it down. So, I'm really dissatisfied with him. So, he is supportive, but not actively".

(FG3) Charlotte: *"1998 (I think) and being diagnosed as being transgender - which at that stage was still fairly foreign; and, when I tried to get help from my GP, it wasn't easy" .*

4. Travel and transport problems

(FG10) Penny: *"What's helped me not access it...I literally couldn't get there [hospital] and they just kicked me. Without a word without anything. Just done. No help. No, none. There's no transport. I couldn't ring the carers because my hands were so bad. You know, [hospital staff said] 'nothing up your end. Take the bus. You can take the bus right to the hospital'. [Me] 'No I can't, because I don't have the bus fare and I can't walk seven kilometres to the nearest bus stop". That is the instructions I got from Trans Perth. Walk seven kilometres to the nearest bus stop with a broken knee?".*

(MG4) Dan: *"There are good surgeons working in the UK, in America, and Serbia... The difficulty is knowing someone in the country, getting into the country, having the funds in the first place, having enough time there for recovery".*

5. Fear of change, health provider competency, or safety

(FG6) Rose: *"I figure it [hair transplant] could be a cheaper if I went to Thailand and got it done, but then you've got the concern of if it's going to be good: who are you going to see: is it going to be good? Even then it's [a hair transplant] a fair few dollars and not that much... It might be nine or ten grand, or something (a bit cheaper). But, then you've got to stay there and fly there, and fly back. And, then the concern was you might pick up some bug, or it might get an infection of some sort".*

(FG7) Abigail: *"Yeah, so that was actually incredibly scary at the time because I thought, "Well, I'm a boring XXX geek. I'm not one of these glamorous people," (you know) who are involved in high society, and all those things. So, I thought, I can't possibly, I can't possibly do this".*

(MG4) Dan: *"For me lower surgery to avoid discrimination in aged care is not an option because our operation is so much bigger, and so much more expensive, and so much more prone to fail".*

6. Delays caused by specialist health providers (gatekeepers)

(MG1) Liam: *"I got into that this person [therapist] also says that basically she is not a specialist in this. I went back – I talked to Dr XXX who put me onto [specialist] ... She was very good [but] like I said, it's annoying that they make you go through all these hoops because it's not cheap, even though you get help".*

Appendix V: Findings: (T3) Resilience Enablers or Barriers

Corresponding with Chapter 7 of main body thesis

ST1 (T3): Macro-environmental systems

ST1 (T3): Macro-environmental systems: Resilience enablers

1. *Living in well-served regions: support organisations, healthcare provision, and state legislation*

(FG6) Rose: *"Practitioners, I found in Sydney, are a lot easier to access. A lot of them are capable of doing – from my point of view – Medicare".*

(FG11) Ruby: *"I said, 'I would love for us to have that meeting, that conference, whereby we sit around and talk about identifying the issues that we feel impact us, and our needs, as indigenous LGBTI people'. He [politician] was very nice. He said, 'well, you are not behind eight ball. The opportunity will be made for us to talk to you'.*

(MG4) Dan: *"The [support organisations in Victoria] once again are incorporated, and once again are completely unfunded with volunteers".*

2. *Feeling included and accepted in society*

(FG10) Penny: *"There's a generation of us that have lived with dysphoria for decades; you know, 20, 30, 40, years. And eventually, most of us will disappear with the [increasing social] awareness [assisting us to merge into society] because we won't be so obvious".* Also, (FG10) Penny: *"[To help us socially] it's about inclusivity, and awareness [with] studies like this [current study]. Get this out there".*

(FG9) Mila: *"I very rarely get harassed when I'm out and about. I don't have too many problems. Just the odd the bottle thrown, but on the whole it's been pretty good".*

(MG4) Dan: *"Men didn't care who walked in [the public toilets]. It wasn't about whether they thought I was male or not. They really didn't care if a woman walked in. Whereas women do care if a guy walks in the womens'. So, that was easier just to go in the men's in the end".*

3. *Simple pathways to legally changing gender*

(FG8) Chloe: *"The [identity] documentation process... was just making an appointment back then with Birth, Deaths, and Marriages... I had to sit down for half an hour while they ask you a few questions: what you are there for, and everything else, and you get a change of name certificate within three days of seeing them, and then you have to go around to all the banks, and tax department, and god knows what else, and change your name. Most of them were pretty good".*

4. *Educating and training service providers: health, age-care, support*

(FG3) Charlotte: *"The [support organisations] helped raise questions [concerning care standards and quality] which the accrediting agencies use when they are accrediting aged care providers. And, they are able to ask LGBTI questions under each of the existing standards".*

(FG7) Abigail: *"Just [when I am running workshops] trying to educate people that, you know, that trans people come in all shapes and sizes, and presentations, and things like that... It's education basically, you know, trying to get people to understand. But very often they will*

just go, 'oh well, they shouldn't even try to affirm their gender'. So, I think, oh dear; yes, we will just have to do more work here I suppose".

5. *Good healthcare and government systems management and operations*

(FG11) Ruby: *"40 years ago, the Aboriginal Medical Services set up a very small room on Beaufort Street within the Aboriginal Advancement Culture building. And, from there it has grown to where it is today. Where it has about $40 million worth of funding that they are given each year in Government funding to service Perth".*

6. *Positive role models and social media*

(FG8) Chloe: *"I had no idea* [what transgender identities were] *until reading the 1st four pages of a book, Orlando's Sleep".*

7. *Employment support*

(FG8) Chloe: *"Some of the companies* [I worked with] *didn't care* [that I had changed my gender]*".*

ST1 (T3): Macro-environmental systems: Resilience barriers

1. *Societal discrimination and misrepresentation*

(FG1) Ellen: *"*[People in society can be] *just mean, they are just totally unaware, and even that there is an awareness to be had... In that respect, they are really just actually acting naturally".*

(FG6) Rose: *"I've had a situation where a guy and a few boys together were walking up Oxford Street, and said, 'oh, you are trans, we are going to bash you'".*

(NBG3) Charlie: *"There is still transphobia. There's still homophobia".*

(FG10) Penny: *"I guess when people see me it gets a bit confusing for people. You know, people* [react negatively when they] *get scared when they are confused".*

(FG2) Amelia: *"I think, as* [my partner] *has said, there are a lot of people who just think I am a dirty old man in lady's clothes; a cock in a frock".*

(NBG1) Toni: *"People were obsessed with what other people think and they* [mainstream society] *are obsessed with performing. You only have to look at the crap – shall we say – on the television; about how (I mean we have grown up in another era). I mean younger ones, these days obviously not so much the indoctrination as to how a woman should behave, and how a man should behave - and there's nothing in between: and there's nothing else is drummed on kids from the cradle".*

(FG1) Ellen: *"It is considerable, to change your identity with everybody that you ever have to deal with. You don't realise how many people* [even] *the library* [and] *the paint shop".*

(FG3) Charlotte: *"The damage that people who are in the media can do to those in an out community is never ending. And, I just find it so difficult that people think it's appropriate to belittle people the way that they do".*

(FG2) Amelia: *"For people who have not had their gender reassignment done, they still have everywhere – depending on which way they have transitioned -the staff still then will use male pronouns on a female name and a female appearance. Or male depending on which way you are going".*

(FG2) Amelia: *"I was getting my eyebrows tinted and waxed – at one place – and when I went back to have them done again, she said, 'no, my treatment doesn't work on you very*

well,' and I said, 'but, that was quite good,' and she said, 'No – my treatment doesn't work on you very well, does it' … And I was pushed out the door".

(FG3) Charlotte: *"We wanted a birth certificate reform for 'other than male and female'. And, some of the comments were, 'well why would you want other than male and female? Everyone knows there is only males or females?' And, 'ha ha, if you think you are not one of those'.*

2. Exclusion from health and governmental systems, support, or legislation

(FG2) Amelia: *"Medicare wouldn't pay for any of my transition".*

(FG2) Amelia: *"I think Tax still think I'm a man. I have a female name, but I think the Tax Department still have my male name".*

(MG1) Liam: *"Thinking about getting the name changed, and all that, I was really scared about actually doing anything to get attention. I don't like attention. That put me off".*

(FG4) Ava: *"I did have my name down for a Homes' West home, but, because my income is above $35,000 (or whatever it is now), between the pension, and the job I do, they have taken me off the list… You would have to go off, and probably be homeless".*

(MG4) Dan: *"Why they [Government] think the GPs are so ignorant that they can't actually diagnose this [gender dysphoria] I don't know?"*

(NBG1) Toni: *"It bugs me that the whole health system has been allowed to be infiltrated on religious grounds … the way they now they get a huge whack of taxpayers' funds to provide health cherry picked services for what they will and won't provide (as in abortion)…,If they do that to women in general, then there is no surprise, whatsoever, that they are not going to be supportive of non-gender conforming people who don't conform with their religious beliefs".*

(FG6) Rose: *"When you've got the driver's license and a picture that says one thing, and when you stop for a Breathalyzer or something, you present differently. And, that can be quite humorous in some ways, and quite difficult in others (that's the best way I can put it)".*

(FG10) Penny: *"I've only just, after 18 months, with Centrelink, started getting a healthcare card, or any sort of Centrelink benefits. After 18 months, because I lived on nothing, with no money, no food, sometimes, I didn't eat for days so my son could eat. I had no help from anyone".*

(FG11) Ruby: *"The white fellas' attitude is, why do you have to be stand-alone on this. Why do you LGBTI people need to have your own services".*

(MG1) Liam: *"It's Just generally it's not all 10s and 20s type people: Which is most of the stuff I have seen – as in media presentations or information – is aimed at them".*

(NBG1) Toni: *That health and this business of a penalty being imposed on people after they have had a break from private insurance while on a healthcare card. That needs to change.*

3. Funding problems

(MG2) Dylan: *"I could not, for the life of me, work out the private health cover stuff?"*

(NBG1) Toni: *"There you are, struggling to re-build your life and your finances, and you are hit with this [health insurance] massive bill. And the option is to not go with private health insurance because it is just to prohibitive, which means you being totally reliant on the public health system".*

(MG4) Dan: *"There wasn't any subsidies for the binder [needed for assisting recovery from surgery]".*

(FG4) Ava: *"I couldn't afford full health benefits because she [my ex-wife] was paying for it, so that wasn't fair on her"*.

(MG1) Liam: *"I was thinking about things like the haircut and the chest surgery and all that for years before I could do anything about it because it took a while to be able afford it"*.

4. Employment problems

(FG2) Amelia: *"My employment company called Newstart. They suggested I look at other ways of gaining employment by trying NIES [new enterprise incentive scheme]. My first day on the NIES program the tutor said, constantly referred to me as a man. Constantly used male pronouns and laughed about it. Thought it was a great joke. It was extremely embarrassing. I didn't continue with NIES. I had to go back to my employment agency and said, 'this is just not working'. They had their person, then wrote to the people who were running the NIES program and I received a formal apology, but I just didn't want to be there anymore"*.

(MG4) Dan: *"Employment, and things like that, it is hard [to do a job] when you go up and down emotionally so much – yes"*.

5. Aged care fears: stigmatization and abuse

(MG2) Dylan: *"I wouldn't do it to my mother, and I won't do it myself so… I've been in a few [nursing homes] in my time, and they seem to just leave you… Older people that I've known that have gone into homes haven't lasted very long in there"*.

(FG10) Penny: *"The one place [aged care facility] where I wouldn't use my true gender – as in transgender… Because you are totally vulnerable, and I am not at all convinced that people [aged care workers] are professional enough, or trained enough, and have ignorance, in dealing with transgender people. And, there is just going to be an age-old prejudice there, and stuff like that"*.

6. Human rights abuses

(FG3) Charlotte: *"Without a doubt, the hospitals have got a long way to go to be not treating trans and gender diverse people as people who don't fit in. And, I think some of the treatment that I know about – and I'm involved in in terms of human rights complaints – are absolutely appalling"*.

ST2 (T3): Community systems

ST2 (T3): Community systems: resilience enablers

1. Local community inclusivity (including workplace & organisations)

(FG5) Clara: *"The sports groups I was with were accepting. I had no real issues there. They just came up to me. And, one of them took care of the records for the orienteering group that I belong to, and said, 'ah, do you want me to amend your account from when you were a boy to when you were a girl,' sort of thing"*. And, *"when I went to transition I had to tell him [my line manager]. So, I talked to HR about it [my transition and GAS]. There weren't any hassles. The person in HR said they wanted to take care of it personally"*.

(FG8) Chloe: *"I had found a lot of acceptance in a male dominated transport industry"*.

(FG10) Penny: *"In small businesses or services, and things like that (the ladies at the bank), all those things, they've been fantastic. They've been really, genuinely, accepting and inclusive"*.

(FG11) Ruby: *"I was* [known as my female identity and name]. *I lived in a big Aboriginal community"*.

(MG1) Liam: *"I do know other trans guys via the* [my interest] *community. Again, there's overlaps* [with LGBT communities] *"*.

(MG3) Oliver: *"We* [myself and male workmates] *talked about issues around acceptance in the workplace, and generally in society; and, some of the problems you run into"*.

2. *Cultural competency: local HPs and support providers*

(FG2) Amelia: *"I am often accompanied* [outside home] *by people who do volunteer work. They are very accepting"*.

(FG7) Abigail: *"They had gay GP there* [local clinic] *who is great. So, that general practice, they were full of really great very holistic in their treatment of* [transgender] *people"*.

(MG1) Liam: *"You can actually get a nurse to come around* [after top surgery]. *There is a system... it's probably hugely expensive to get a nurse to come and visit you, but you can if you have to"*.

(MG4) Dan: *"If we* [local transgender support group] *were there to support people, they* [doctors] *would support us better"*.

(FG9) Mila: *"I had the same GP for gender affirmation and general health... I wouldn't want to go anywhere else. She is beautiful, she understands"*.

(MG3) Oliver: *"I explored it. I was spending a lot of time sitting down with that GP who I knew really well"*.

(NBG2) Jo: *"They* [medical clinic] *are very supporting. They have art exhibitions for trans who use ice"*.

3. *Communication with online communities*

(FG2) Amelia: *"I have a group of friends from a* [XXX] *club down in Sydney that I helped start about 35 years ago, maybe a bit longer. They say 'hello,' through Facebook"*.

(FG6) Rose: *"I belong to an online group – a trans community. If I need some help or something on something I might throw up a message and I will get other people's views on, which will also help towards ... if it was medical as well"*.

(MG3) Oliver: *"I'm part of the group called XXX down in Melbourne. I put feelers out on there to see if anybody (and everyone does it...I put question up* [that others will help with, for example] *'can anyone give any recommendations of best rural places in Victoria to live?"*

4. *Socialising and psychosocial support from local transgender and LGBTI communities*

(FG4) Ava: *"*[There was] *A lady out at XXX who would allow you to go out there and dress up"*.

(FG5) Clara: *"I sort of didn't know until the 1990s when someone where I worked transitioned with surgery... I remember looking at them and saying, 'oh, I can do that!'"*.

(FG7) Abigail: *"I'm predominantly attracted to women, so I do identify with the lesbian community"*.

(NBG1) Toni: *"I have found that I have more in common with the transgender guys, and the gender neutral"*.

(FG7) Abigail: *"I was beginning to know some other transgender people and beginning to know some gay gentlemen and some lesbian folk as well because of the safe environment I was moving in"*.

(MG2) Dylan: *"I think the gay community has become a bit more accepting of trans people"*.

(MG3) Oliver: *"[Working at Mardi Gras] I sort of got to meet a really diverse range of people. And, it was in conversations and things like that. That there weren't just these guys who were running around in drag, there was actually this real gender diversity out there"*.

5. Involvement in trans and LGBTI community organisations, training, and advocacy

(FG3) Charlotte: *"We were providing training, to train the trainer, LGBTI aged care trainers"*.

(FG11) Ruby: *"Well, we often have conferences and workshops, and that sort of stuff… [for example] the National Conference on Suicide Prevention, Australia"*.

ST2 (T3): Community systems: resilience barriers

1. Participation barriers: broader communities (mainstream, all age trans, LGB)

(FG1) Ellen: *"The only contact I have had with other trans people, unfortunately, is with [my support role]"*.

(FG4) Ava: *"I went to a couple of transvestite/transgender group, sort of, meetings [to socialise with other people]. No, it, sort of, seemed a bit artificial to what I was. Probably being a country person, to a city person, I was different. And, I was always a bit of a loner, also"*.

(MG3) Oliver: *"Now [I], being a newcomer to town, it's a very difficult situation to get into"*. And, *"so, one of the things that I noticed the difference of with transgender issues, was that I didn't have that really close intimate support network around me, that I would've used as my other eyes to ground that move in; and, I can describe it with perceptively now understanding it, having gone through the process"*.

(MG4) Dan: *"I found it very confronting to be in a space with other [transgender] people like me because it reminded me where I was. That [meeting other transgender males] wasn't as reassuring instantly. It was love / hate relationship with the whole thing. I wanted to be with them, but I'd already transitioned by then. So, a lot of the people that I met just wanted to start, and it pulled me back into that grief"*.

(MG5) Ben: *"[Transgender] people who are not genuine are annoying because it reflects on all of us"*.

2. Misunderstandings within LGBTIQ communities and community health providers

(FG3) Charlotte: *"We've got a lot of [aged care] workers who are unaccepting of LGBTI"*.

(NBG1) Toni: *"I think most GPs know about family medicine, as in, you know, you are having a baby, or you've got the measles or, you are old, and you have got arthritis. But, anything outside of the standard GP umbrella, they don't know how to cope"*.

(MG3) Oliver: *"I had [local] GPs refuse to treat me [and my gender affirming needs] on cultural grounds that they were against it"*.

(FG4) Ava: *"I pulled out the transgender thing, and that I'd worked hard [when being consulted by the psychologist], and all the rest of it. With that, she did a lot of hypnosis stuff and that, which sort of helped. Bringing up the transgender thing. In the end, she went crook at me, and she said, 'if you don't go and do something about the transgender stuff I can't help you anymore!' See you later! Oh, I felt hurt, because I had no-one I could talk to again"*.

(FG3) Charlotte: *"Many of our transwomen are reluctant to have breast screening [because they fear discrimination]"*.

3. *Being misunderstood and not fitting into mainstream employment roles*

(FG6) Rose: *"[Before changing my gender] I was still male at work; female at home"*.

(FG9) Mila: *"I was living out of car and living out of my mum's house. I lost my job through that period [coming out] because they didn't want to re-employ me"*. And, *"When I did come out to them everybody said they would be supportive. Even the most difficult ones said they would be supportive. But, once I started being me it became a problem"*. Also, *"You know, you try and do your job, and you couldn't do it"*.

4. *Family related community problems*

(MG3) Oliver: *"That [cisgender] was all they [family] understood. They were God fearing Christians and you know? And, a lot of the town, they were similar, it was a shared common view in the community"*.

5. *Community information sharing difficulties*

(NBG1) Toni: *"I stay off gossip sites. I'm not interested in the, 'I had this, what did you think?' type stuff. A size of one is not statistically valid"*.

6. *Difficulties using public facilities*

(FG9) Mila: *"So, a lot of transgender persons are just continually worry that someone is going to harass you. I mean, especially the toilet issue. Oh my God. The toilet issue is probably the single most difficult thing I face, personally"*.

ST3 (T3): Interpersonal systems

ST3 (T3): Interpersonal systems: resilience enablers

1. *Families being accepting and supportive*

(FG3) Charlotte: *"As a family, we worked through my issues [when I affirmed my gender]"*.

(FG5) Clara: *"My parents helped me (I had a lot of money from that – savings, shares, and investments, and things)"*.

(FG9) Mila:*" Mum and dad, after all those years, were fantastic... So, thirty-odd, forty, years of panicking about them was blown out the window"*.

(MG4) Dan: *"My son said to me, about three days later [after starting hormones], "oh, that really suits you"*.

(MG5) Ben: *"It's only my family, XXX [my partner's] family, and very close old school friends, that do know"*.

2. *Friends that accept, support, and assist with gender affirmation*

(FG5) Clara: *"They [friends] did research, they got books (I brought them a book) so they could understand"*.

(MG1) Liam: *"He [my friend] used to be a nurse so he knew more about the system than I did – which was useful"*.

(MG3) Oliver: *"A good friend of mine works as an LGBTI support network person for health on the west coast of XXX... So, this mate of mine turned up on the doorstep [of my parents] and said, 'Oh I'm just dropping by to have a coffee with you. I want to know if you are alright?'"*.

(NBG1) Toni: *"There's dog walking ladies. They are the only people that know that I have had surgery – one of whom took me up to the hospital on the morning of the surgery… Another one took me up for my follow up three days later when I had the drains removed; and the other one brought around meals and stuff, and what have you, to keep me going on my own".*

(MG3) Oliver: *"I love my hens, they are my social network. I've got six of them. Who need's friends when you've got these little bantam hens?"*

3. *Partners and spouses being accepting and supportive*

(FG2) Abigail: *"Because (my partner) and I are out all the time. We hold hand, and we kiss".* And, *"Transition-wise I look after myself, and (my partner) looks after me".*

(FG3) Charlotte: *"We've now being married [decades] years".* Also, *"we had to set new expectations for the future".* And, *"I think because of what we have been through, we actually have a better relationship than many heterosexual couples because we had to really work out what was important to us".*

(FG9) Mila: *"We [my wife and I] started it all over as, essentially, a female couple. At that point she understood, and she saw me for the first time properly, and understood all the years of confusion, and, being scared of her own issues of rejection by me. And, well we found ways to be happy".*

ST3 (T3): Interpersonal systems: resilience barriers

1. *Family struggles and/or rejection*

(FG1) Ellen: *"I have a brother, and he was quite difficult because he was losing his brother".*

(FG10) Penny: *"My gynecomastia (breast growth in male puberty) didn't go away. It was obvious. And, for some reason, over a few years, they had grown more. But, my parents wouldn't … they did nothing".*

(FG3) Charlotte: *"I had to always be under control [to avoid revealing my social differences]. So, I never allowed myself to get drunk. I was very guarded in work situations, and I had a very limited number of friends as a result. And, therefore, (before transitioning) I had to work hard to maintain the image that others expected; that was, from family, and at work, and with friends".*

(FG5) Clara: *"I didn't want to tell them [children] until they were a bit older because I knew my marriage would pass".*

(FG6) Rose: *"My sister said at one stage, 'you will never be a female, you don't know what it means. You will never give birth, you've never had a period. There are so many things you will never know'".*

(FG7) Abigail: *"I can understand why families did it (buried her in a male name). And, I think they still do it to this day sometimes…it's so that they don't have to explain. So, they don't have to acknowledge that that person ever existed I suppose".*

(FG11) Ruby: *"Our white brothers and sisters… they are not so much accepted as what we are by their families, you know, with very set ideas and values".*

(MG3) Oliver: *"At the age of 12, I was told I had an unhealthy interest in the female gender, and I was dragged to a psychiatrist to be cured!"*

(MG3) Oliver: *"Three times she [mother] referred to me as female in packed shops. She mentioned, in front of everybody, called me by my former name".*

(NBG1) Toni: *"My mother was horrified that going to university had put things (ideas) into my head"*.

(NBG3) Charlie: *"I wouldn't have done it whilst my father was alive"*. And, *"because they are old I would hate it if they* [my Catholic relatives] *dis-owned me"*

2. *Partners and spouses: negative reactions*

(FG5) Clara: *"I was getting more and more depressed and started writing a letter. At some point my partner found about that (where I'd kept it from her). Then it started to fall apart"*.

(FG9) Mila: *"[Before I came out] I was hiding from my wife because I felt that she would probably not be able to handle the reality, and that our relationship would die, and that she would walk out on me. And she did struggle"*.

(MG3) Oliver: *"I came out to her* [my ex], *and said, 'look, I really am convinced I'm transgender and I want to go down this track'. And, she basically gave me an ultimatum"*.

3. *Friendships: negative judgements and/or feeling distanced*

(FG5) Clara: *"Just the one friend, who was very religious and was homophobic, I think because of their religion, and their upbringing"*.

(FG8) Chloe: *"I just knew that where I was going was not going to be good having them* [my previous friends] *around. So, I didn't have too many friends"*.

(MG4) Dan: *"I don't have any friendships from the first part of my life other than the ones I made, at that point where I realised I would transition"*.

(NBG2) Jo: *"I'd grown up in a sexually isolated situation and I had no clues"*.

ST4 (T3): Individual systems

ST4 (T3): Individual systems: resilience enablers

1. *Empowerment: self-confidence, participation, self-efficacy, independence, and authenticity*

(MG2) Dylan: *"Because I had gained confidence through transitioning, I was finally able to voice my concerns about our relationship [with my ex-partner]"*.

(MG4) Dan: *"You've got to be able to pull it off [by passing and] how you look as a bloke"*.

(FG3) Charlotte: *"On meeting situations, I made an arrangement with the chair to signal to the chair if I wanted to speak, rather than just to speak over the top of others to be heard"*.

(FG5) Clara: *"When you are open and up front, and that thing, they see a real person and accept you"*.

(FG7) Abigail: *"I'm very lucky that I am outgoing, and I'm a networker, and if I'm not happy with something I will change it"*.

(FG8) Chloe: *"I was the first crossdresser at the time to win the bravery award for going out in public dressed"*.

(FG9) Mila: *"I can maybe have a little bit of a water off a duck's back sort of attitude: and, I can deal with it"*.

(FG3) Charlotte: *"My approach, very much, was to accept myself as myself"*.

(FG4) Ava: *"I didn't have any other sources. I just knew I wanted to be a girl"*.

(FG5) Clara: *"I just said, 'oh stuff this, I just need to be me'"*.

(NBG3) Charlie: *"Because I've lived all my life in a female body, I'm not going to deny that experience. I'm not going to deny the experiences or the discriminations that had come with being in a female body, so that's the majority of my life"*.

(FG3) Charlotte: *"My father was a boxer, a football player, and ex-army; and, consequently, it was part of me, as a young person, that was very much driven; and, as best I could, kept to myself"*.

(FG11) Ruby: *"I didn't have any inhibitions about what it is that I wanted to do. You've got to understand that I had no – I didn't have any nurturing years – if you like – where I was taught what was right and what was wrong. My whole life was about me creating who I wanted to be... I just created [my female-self] out of my needs"*.

(FG10) Penny: *"I don't believe in trying to force myself or anyone, or my gender. So, it's been great, it's been really good"*.

(FG1) Ellen: *"They said, 'he [psychiatrist] is not taking any more people on '. And I said to myself 'well that is unacceptable'"*.

(FG3) Charlotte: *"I am a very driven diligent person"*.

(FG5) Clara: *"I've suffered abuse a couple of times on the street. And, it's just like, oh well – it's their problem"*.

(FG7) Abigail: *"I don't think that they [younger people] have got some of their, maybe the life coping skills that, you know, an older person, such as myself, might have"*.

(FG8) Chloe: *"But no, suicide had never entered my mind at this stage. I was just determined to get through it somehow"*.

(FG9) Mila: *"I had to train myself up to go, I'm okay, I'm not going to look for just the disabled toilets (where I've got involved in some issues) and I'm going to walk in there, and pee, and I'm going to do my makeup, and I'm going to walk out – and damn anybody"*.

(NBG1) Toni: *"If I don't like a doctor saying, "no, you can't have this," I will just go somewhere else"*.

(FG7) Abigail: *"I'm very lucky because of my stature at the time, and my weight, and all those sorts of things. You know, plus, working as a XXX, I could afford to buy nice clothes, nice makeup etcetera. So, the financial costs of – let's call it transitioning, as it was called then"*.

(FG11) Ruby: *"I was comfortable being called woman as well because I looked like a woman anyway"*.

(FG1) Ellen: *"99 percent of the time - nearly all the time - I take on a gentle educational role. I will say 'Look I would prefer that you did this and this'"*.

(FG6) Rose: *"He [my family member] said, 'you know XXX, I haven't really much to do with transvestites and I've always – you've totally changed my perception'"*.

(FG7) Abigail: *"If somebody says to me, 'ok, I'm trans, I have to do what I have to do;' and I will say, 'ok, you have an amazing journey in front of you, but I won't say to you it's going to be easy: you know, there are going to be some really hard times to, but you shouldn't miss this journey for anything you know. It is a fantastic thing"*.

(FG9) Mila: *"I was very keen to help others and help myself by helping others"*.

(FG8) Chloe: *"I used to go along and give talks for an hour or so, for the trainee psychiatrists"*.

(FG10) Penny: *"He [my friend on the phone] said, 'I don't know anyone who wants have a sex change'... I said, 'well actually no, you do, because you are talking to one. Because I do,*

more than anything'. And he, you know, he was a bit taken aback. And, I said to him, 'I'm no different to the person you were talking to two minutes ago'. And he said, 'right yeah'".

(FG11) Ruby: *"Whilst I was creating me, I was educating the health care professionals along the way. And, the reason I did that is because, you know, I had to access these services. So, I wanted them to understand who I was".*

(FG11) Ruby: *"I understand my politics, and that's who I am today*

(FG7) Abigail: *"I find it incredibly liberating because, if someone says to me, 'oh, look – look at that person – why is that person wearing a woman's dress,' and I will say, 'I don't understand what you are saying? I think that is their dress' (of that person. I don't know who that person is anyway)".*

(FG3) Charlotte: *"I was well paid in my job, and we – I did what I wanted to do".*

(FG4) Ava: *"My aim, at that time was to try and make enough money to buy my wife a house for the children, so that I could go my own way".*

(FG5) Clara: *"I have a few hundred thousand in the bank I could put towards a house".*

(NBG1) Toni: *"I'm perfectly capable of working. I've a got a reasonably good brain".*

(FG3) Charlotte: *"I started to make major steps towards doing something about my gender identity when I was in XXX [a city away from my family] by myself".*

(FG7) Abigail: *"I was just writing something [in my job] about advance [health] care directives and that got me thinking about, 'oh, do I need some of these yet?' But, I know the answer is, 'not yet'. But, you know, I'm aware that these are available for the future.*

(FG11) Ruby: *"I will Google [to find the health-related information I need]".*

(MG1) Liam: *"This is all my notes [from my research] about the various [health] funds and what they have got".*

2. *Concealment from society*

(FG7) Abigail: *"Right at the beginning of my journey I would have been very careful, and very quiet, and not wanting to attract attention".*

ST4 (T3): Individual systems: resilience barriers

1. *Gender dysphoria: impact and confusion*

(FG3) Charlotte: *"I couldn't name what my situation was, but I was very aware that I struggled (was struggling) and wasn't like others".*

2. *Delaying transition*

(FG9) Mila: *"A lot of them [friends] cannot afford, and a lot of them, medically, are not allowed. Whether they have got heart issues, or surgery issues that mean that they cannot go under the knife but are relating as a female. So that is a real problem for them".*

3. *Personal vulnerabilities and resilience issues*

(MG3) Oliver: *"[Ageing transgender people have additional challenges to young transgender people]. Young people don't necessarily have a history, so they don't have (for instance) a work history, they don't have previous lives that they have got to flick a switch in [as ageing transgender people do]".*

Glossary

This Glossary has been resourced from WPATH's *Standards of Care (SOC7).* The authors have asserted that "terminology in the area of health care for transsexual, transgender, and gender nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing" (Coleman et al., 2012, pp. 95-97). As mentioned in the introduction, there has been much debate about appropriate language use. Coleman et al. (2012) intention for the terms listed in the SOC7 glossary has been to indicate some most commonly used terms and assist researchers from varying world regions to be understood within health and healthcare contexts. This reasoning is also applicable to this study.

Crossdressing (transvestism):	Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.
Disorders of sex development (DSD):	Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (Diamond, 2009; cited in, Coleman et al., 2012), preferring the terms *intersex* and *intersexuality*.
Female-to-Male (FtM):	Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.
Gender dysphoria:	Distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010; cited in, Coleman et al., 2012).
Gender identity:	A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964; cited in, Coleman et al., 2012).
Gender nonconforming:	Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender role or expression:	Characteristics in personality, appearance, and behaviour that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006; cited in, Coleman et al., 2012). While most individuals present socially in clearly male or female gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008; cited in,Coleman et al., 2012).
Genderqueer:	Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008; cited in, Coleman et al., 2012).
Male-to-Female (MtF):	Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.
Natural hormones:	Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.
Sex:	Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte, 2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000; cited in, Coleman et al., 2012). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth.
Sex reassignment surgery (gender affirmation surgery):	Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

Transgender: Adjective to describe a diverse group of individuals who cross or transcend culturally defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999; cited in, Coleman et al., 2012).

Transition: Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in "the other" gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized.

Transphobia, internalized: Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

Transsexual: Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through femininizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.