Talking, Gawking, or Getting It Done: Provider Trainings to Increase Cultural and Clinical Competence for Transgender and Gender-Nonconforming Patients and Clients

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Abstract: This article presents a set of preliminary policy recommendations regarding competency trainings for health care providers to improve service delivery to transgender and gender-nonconforming clients. These recommendations are based in part on a program evaluation of trainings conducted in the northwestern United States in 2005–2006. Using a mixed-methods approach, the evaluation assessed the effectiveness of 3 competency trainings administered by a nonprofit health education and outreach organization serving lesbian, gay, bisexual, transgender, gender-nonconforming, and questioning people. Quantitative data indicated that the trainings were effective in transferring knowledge. Qualitative data confirmed this finding and elicited a number of themes about providers' experience of the trainings and their posttraining questions about interacting with transgender and gender-nonconforming patients and clients. The authors propose policy recommendations to guide curriculum developers and trainers in developing content and structure and to facilitate implementation of lessons learned in trainings at an agency- or organization-wide level.

Key words: health disparities; LGBTQ; LGBT; training; Transgender 101; cultural competence; quality of care

In the past decade, an increasing number of publications have focused on transgender health (Israel & Tarver, 2003; Lombardi, 2001; Xavier, Hitchcock, et al., 2004). Transgender individuals experience a variety of challenges in gaining access to primary health care, and although research on this topic has been sparse, it is clear that transgender and gender-nonconforming individuals experience profound health disparities compared with the general population (Dean et al., 2000; Minter & Daley, 2003; Xavier, Bobbin, Singer, & Budd, 2004). Lack of knowledge on the part of providers about how to deliver competent care to transgender communities has been cited as contributing to this problem (Minter & Daley; Xavier, Hitchcock, et al.).

Background

Transgender is a perpetually evolving term and, therefore, is somewhat difficult to define. Unlike some of the clinical terms applied to members of the transgender and gender-nonconforming communities, the term *transgender* evolved from within these communities. Generally, the umbrella term *transgender* describes individuals whose gender identity or experience is different, discontinuous, or more complex than that for the gender to which they were assigned at birth. Transgender individuals outwardly express their internal gender (their *gender identity*) in a variety of ways that may or may not include pursuing medical treatment (hormones, surgeries, or a combination of these) to alter their appearance. This outward expression of gender identity is called *gender expression*. Although nontransgender individuals also have a gender identity and expression, these are generally coherent (to a greater or lesser degree) with the gender to which the individuals were assigned at birth. Individuals with experiences, behaviors, interests, or identities that fall

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outside of gender-stereotypical expectations (and who may or may not identify as transgender) can be described as *gender nonconforming.* In the broadest sense, transgender and gender-nonconforming individuals can be defined as those whose bodies, genders, or behaviors fall outside cultural gender norms, stereotypes, or expectations.

In recent years, trainings to increase organizational competence in serving transgender and gender-nonconforming individuals have evolved as a strategy to reduce barriers to service delivery. Often referred to as Transgender 101 trainings,[1] many of these are geared toward health care staff and providers. At the time of writing, we do not know how many such trainings are offered, but an Internet search yielded an extensive list of training contacts, resources, and curricula.[2] In addition, recent publications have called for increasing provider trainings as a key strategy in increasing quality of care to transgender and gender-nonconforming patients and clients (Kenagy, 2005; Lombardi, 2001).

Cultural Competence

The concept of *cultural competence* was developed in the late 1980s to help meet the mental health care needs of children of color (Cross, Bazron, Dennis, & Isaacs, 1989). Since that time, cultural competence has gained popularity as a way of training health care providers to improve their ability to deliver quality care to marginalized and oppressed populations, particularly those with limited English language proficiency, immigrant or refugee status, and barriers due to race or ethnicity. Such trainings have gained acceptance in health care clinics, schools for health professionals, and health organizations.[3]

Cross et al. (1989) originally defined cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among

professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13). Based on this definition, trainings are only one aspect of cultural competence. Accordingly, agencies, organizations, and clinics must take a system-wide approach to cultural competence, incorporating it at all levels of organizational structure.

Since the inception of the term, however, *cultural competence* has been applied in a somewhat more generalized sense. In the 1990s, national focus on racial and ethnic health disparities in the United States set the stage for an expansion of cultural competence as a means of improving health care provision (Beach, Saha, & Cooper, 2006). During this time, cultural competence grew in scope and popularity. In contrast with the definition set out by Cross et al. (1989), the expansion of cultural competence curricula and trainings did not necessarily involve a system-wide approach—the core educational content shifted primarily to the provider-patient interaction (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003).

Three review articles (Anderson et al., 2003; Beach et al., 2005; Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007) discussed the lack of comprehensive evaluation and published discussion of teaching and learning methods for cultural competence. The most recent of these located only 9 evaluated trainings or curricula out of 109 potential papers (Bhui et al.). In the absence of evidence about training structure and effectiveness, it is difficult to ascertain how many trainings take a system-wide approach and the extent to which this approach might be more or less effective than trainings focused on particular aspects of service delivery. What is clear, however, is that the term *cultural competence* has come to signify something less specific than was initially intended by Cross et al. (1989): The system-wide approach is no longer assumed to be a vital component of such processes.

Lesbian, Gay, Bisexual, Queer, Transgender, and Gender-Nonconforming Issues and Competence Trainings

Trainings focusing on cultural competence for lesbian, gay, bisexual, and queer (LGBQ) individuals are not generally integrated into curriculum for health professionals (Corliss, Shankle, & Moyer, 2007). Trainings that educate providers about interacting with transgender and gender-nonconforming individuals are even less integrated. Where formal education for health professions has fallen short, nonprofit and community-based organizations have developed educational strategies to increase quality of health care to lesbian, gay, bisexual, transgender, gender-nonconforming, queer, and questioning individuals.

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1 Although such trainings are known by a variety of names, the authors will use either *Transgender 101* or *Transgender 101–style* to generally refer to trainings that aim to increase service providers' competence in delivering care to transgender and gender-nonconforming individuals.

2 We used *transgender training* and *transgender 101* as search terms.

3 Although the idea of cultural competence was developed in the specific context of serving severely emotionally disturbed children of color, the concept has been developed and expanded to apply to various communities, groups, and cultures. Although Cross, Bazron, Dennis, and Isaacs (1989) did not develop their ideas with transgender and gender-nonconforming groups and communities in mind, it is possible to extend the concept to these groups and communities.

One of the main challenges in administering cultural competence trainings to health care providers with regard to LGBQ and transgender or gender-nonconforming people is that there are no formalized expectations regarding the need for providers to acquire such knowledge and integrate it into practice (Bonvicini & Perlin, 2003; Corliss et al., 2007; Feldman & Goldberg, 2006; Israel & Tarver, 2003). This lack of information and prioritization constitutes an implicit message that expertise in lesbian, gay, bisexual, transgender, and queer (LGBTQ) health is optional for health care providers and that only those who are so inclined need to seek out this knowledge.

Transgender and gender-nonconforming individuals experience a number of specific barriers to quality health care because their identities are highly medicalized. In a number of social and legal arenas, the status quo is "a heavy reliance on medical evidence to establish gender identity" (Spade, 2003, p. 16). This state of affairs is in part due to the fact that the clinical psychiatric diagnosis of gender identity disorder (American Psychiatric Association, 2000) is generally expected to precede medical prescription of hormones or referrals to surgery. Although there is no consensus in the transgender and gender-nonconforming communities about whether the existence of this diagnosis is beneficial or damaging, they generally agree that the criteria upon which the diagnosis of gender identity disorder has been based have been—and, to a large extent, continue to be—too narrow. These specific, unique concerns of transgender and gender-nonconforming individuals are seldom given enough attention even in existing LGBTQ trainings.

Based on existing standards of care (Meyer et al., 2001), therapists and health care providers are expected to evaluate the authenticity of a transgender individual's personal narrative and desire for medical treatment prior to making a referral (Lev, 2004). Although intended as a useful tool, the dominant standards of care are fraught with both diagnostic and ethical problems (Lev). Some transgender and gender-nonconforming individuals rely on medically assisted gender transition[4] to obtain gender-congruent legal identification, employment, and housing. Because mental and medical health care providers make decisions about who will gain access to medical transition—and, thus, who will have access to gender-congruent services—providers must have at least minimal competence and knowledge in transgender health care if they are to meet the needs of this population.

Providers may also play a part in advocating for alternatives to such gatekeeping systems. Some providers have already taken on this role, establishing guidelines or recommendations that increase transgender and gender-nonconforming individuals' degree of self-determination in seeking care (Lev, 2004; Tom Waddell Health Center, 2006). Nevertheless, in the absence of individuals being able to obtain insurance coverage for such services, access is still a problem for people who do not have the financial means to get the medical care they need.

Whether or not transgender individuals seek medical assistance that is specific to their gendered appearance, they still face a number of challenges associated with obtaining primary health care treatment. All of the transgender health needs assessments that have been conducted to date (Bockting, Robinson, & Rosser, 1998; Clements, Katz, & Marx, 1999; Kenagy, 2005; Sperber, Landers, & Lawrence, 2005; Xavier, Bobbin, et al., 2004) demonstrate a profound lack of access to care. Barriers to access include lack of insurance, inability to pay, and insensitivity or hostility on the part of health care providers. Compared with the general population, transgender and gender-nonconforming individuals disproportionately experience poverty and unemployment or underemployment (Badgett, Lau, Sears, & Ho, 2007), all of which create additional barriers to gaining access to care (Clements et al., 1999; Kenagy; Xavier, Bobbin, et al.). A recent needs assessment conducted in Boston (Sperber et al., 2005) found that providers who see transgender individuals often refer to transgender issues or patients' transgender identity when treating unrelated conditions.

Of the needs assessments we reviewed (Kenagy, 2005; Sperber et al., 2005; Xavier, Bobbin, et al., 2004), all recommended the development of educational or training programs for health care providers to increase awareness and capability in transgender care. A qualitative needs assessment identifying the training needs of health care providers in HIV treatment services (Lurie, 2005) found that lack of information and treatment guidelines were among the central barriers to the provision of competent and respectful care to transgender patients or clients.

Trainings can be one component in the process of bringing to light how providers can increase quality of care to transgender and gender-nonconforming individuals. Such trainings not only can familiarize health care providers with the barriers these groups encounter in

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[4] Many individuals who seek hormones or surgeries to change their appearance to achieve a desired gender expression refer to this process as a *transition*. However, transgender and gender-nonconforming communities use the term *transition* very broadly, not exclusively in terms of using medical intervention to change one's appearance.

gaining access to care but also can provide a context in which providers can improve their skills at delivering care to transgender and gender-nonconforming individuals. The goal of trainings is to equip health care providers to deliver quality care to all transgender and gender-nonconforming patients and clients. Because barriers to care exist at every level in health care delivery (from insurers, to doctors and mental health care providers, to front desk staff), the system-wide approach advocated by Cross et al. (1989) is appropriate.

Currently, there is no broadly accepted curriculum with regard to training health care providers about transgender and gender-nonconforming communities and individuals. Nevertheless, Transgender 101–style trainings seem to overlap in content and approach, providing several general components: (a) Terminology, information, and background about the transgender and gender-nonconforming community; (b) The distinction between sexual orientation and gender identity[5]; and (c) Clinical information about unique health care needs, as well as strategies on how to conduct clinical interactions in a respectful, affirming manner. Resources are commonly offered as well, either throughout or at the conclusion of trainings. The training we evaluated employed this general approach; in this article, we assume that many other transgender trainings adopt a similar structure.

Trainings administered to providers in the style of cultural competence education (Cross et al., 1989) may be one way to improve quality of care at an individual, staff, and systems level. However, in a number of ways, these trainings may be less effective than intended or may benefit only a small proportion of transgender and gender-nonconforming individuals. For example, if trainings focus expressly on transgender individuals who seek medical intervention to change their gendered appearance, providers may be unprepared to deliver care to transgender or gender-nonconforming individuals who may have similar needs but whom the provider perceives as not fitting into these groups. Recent scholarship in the field of cultural competence education discussed the ineffectiveness of using a formulaic approach (Culhane-Pera, Reif, Egli, Baker, & Kassekert, 1997) and examined the tension between providers' desire for certainty and the critical importance of reflection, uncertainty, and a focus on patients' self-definitions (Dogra, Giordano, & France, 2007). Building skills to cope with ambiguity serves a

larger and more varied set of patients than the checklist- or stereotype-based approach to clinical encounters. Centralizing ambiguity provides a foundation for developing effective, useful training curricula and programs. However, because providers and staff have a great desire for certainty (Shapiro, Lie, Gutierrez, & Zhuang, 2006), such a process requires sound planning on the part of curriculum developers and trainers, as well as a depth of commitment from health care organizations, agencies, and institutions that participate in such trainings.

As we stated previously, cultural competence trainings have not been extensively evaluated. At the time of this writing, we found no articles about evaluations of LGBT or Transgender 101 trainings. Our preliminary research, taken together with existing scholarship in the field of cultural competence, provides a starting point for assessing some of the strengths and limitations of such trainings. To that end, this article discusses some of the ways that curriculum developers and trainers can build effective trainings for use in health care settings and offers recommendations for health care clinics and organizations that aim to increase quality of care to transgender and gender-nonconforming patients and clients.

Research Background and Context

From April 2005 to September 2007, the authors and two other community researchers conducted a small-scale community-based program evaluation of a clinical and cultural competence training program administered by a local nonprofit health agency in Seattle, Washington. The primary author undertook this study as part of his research in a master's program in public health. Researchers also included a community research team comprising four transgender or gender-nonconforming members, one of whom is also a health care provider. The findings of this study will be presented in detail in another publication (Hanssmann, Morrison, Russian, Shiu-Thornton, & Bowen, 2007)

The clinical and cultural competence trainings we evaluated aimed to increase clinical and cultural competence in providers who deliver care to transgender patients and clients. The objective of our study was to determine whether these trainings were effective in increasing the clinical and cultural competence of health care providers in delivering care to transgender clients or patients.

The trainings we evaluated were part of an ongoing series from a local community organization[6] that offers a

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5 Making this distinction is generally considered an important aspect of trainings because transgender communities are often folded into lesbian-gay-bisexual-queer communities despite the important distinctions between them.

6 The name of the organization has been omitted to protect the identity of the trainer.

variety of programs, most of them focusing on education and outreach to LGBTQ communities. The organization (in a prior incarnation) began offering health care provider trainings regarding provision of care to lesbians and bisexual and queer women in collaboration with the Mautner Project's (2000) Removing the Barriers curriculum. Over time, the organization revised the original curriculum by adding content about gay and transgender individuals and offered trainings independently to its organizational partners and to other organizations, agencies, and clinics in the region.

The organization's staff members developed the training curriculum using information from clinical publications and feedback from community members. Initially, the trainings focused on LGBQ health and included some information about transgender health; as the organization began fielding requests from providers for more information about transgender and gender-nonconforming health care delivery, the need to focus on such information became clear. Although the trainings continue to include information about LGBQ health, the emphasis is currently on transgender and gender-variant (an alternative term for gender-nonconforming) health care provision.

The organization does not actively publicize the trainings; most organizations, agencies, and clinics learn about the trainings through word of mouth.

The trainings, ranging in duration from 1 hour to a full day, used a PowerPoint slideshow to guide a lecture format. The terminology section included written definitions of various terms associated with and used by transgender and gender-nonconforming individuals. Trainers also explained these definitions verbally and, in some cases, offered examples. Participants learned about health disparities in transgender and gender-nonconforming communities via slides, statistics, and lecture material. Trainers cited clinical research to offer recommendations to providers about delivering health care to individuals in these communities. Trainings generally focused this information on the field in which participating providers practiced.

Trainers welcomed discussion throughout the program, although time constraints sometimes limited the extent to which this could take place. Each of the trainings finished with a question-and-answer session. One of the trainings, which was longer in duration, included an interactive exercise. The trainings provided extensive coverage of certain issues, such as hormonal transition, surgeries, health disparities in transgender and gender-nonconforming communities, issues with health insurance, specific or common health concerns, and pronoun

use. Other issues, such as gender fluidity,[7] intersex,[8] and intersecting identities (gender in context of race, class, religion, geographical location), garnered less extensive mention or discussion. Regarding barriers to care, main topics for discussion included lack of health coverage, mistrust of health care providers, and previous negative experiences with health care providers.

Method

The study used a mixed-methods approach to gauge the effectiveness of the trainings ($n = 3$). Using a pretraining and posttraining survey ($n = 55$) to gather quantitative data, researchers ascertained whether participation in the trainings was associated with an improvement in self-assessed knowledge about cultural and clinical competence with regard to the provision of care to transgender individuals. With qualitative data collected in follow-up interviews ($n = 9$) with providers who completed the training, researchers sought to understand in greater depth and detail what knowledge participants had gained. The semistructured, open-ended interviews included the following questions: (a) What do participants recall about the training (4–30 days after training)?; (b) What do they feel they learned from it?; (c) What questions remain for them after the training?; and (d) In what ways do they feel prepared to implement knowledge they learned in the training, and what steps have they taken to do this?

The research took a community-based participatory research approach (Minkler & Wallerstein, 2003); the primary researcher assembled the community research team with connections he made as a result of his membership in the transgender community. All of the members of the research team had an interest in transgender health,

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7 For the purpose of this article, *gender fluidity* refers to the range of gender identities that veer away from expectations that males are masculine and females are feminine or that male and female are mutually exclusive gender identities. This concept incorporates a set of identities too numerous to list here, but may include people who identify as genderqueer, bigendered, androgynous, or mutligendered, for example.

8 Often included under the gender-nonconforming umbrella but distinct from transgender, intersex conditions (also called disorders of sex development and differentiation) refer to a variety of genetic or biological variations that can result in atypical genotypic or phenotypic sex organs or characteristics. These biological conditions are differentiated from transgender identity (although some intersex individuals identify as transgender); however, some argue that the intersex and transgender communities have enough overlapping issues that it is appropriate to include intersex in the context of trainings about transgender and gender-nonconforming individuals.

and all were familiar with the organization that offered the training. The data-gathering instruments were designed in part to measure knowledge that the research team felt would predict a positive clinical encounter between providers and clients.

The researchers[9] used a pretraining and posttraining survey to determine whether providers gained knowledge over the course of the training. To the authors' knowledge, no validated surveys measuring health care providers' self-assessed knowledge of clinical and cultural competence have been published. The research team developed a survey instrument based on an existing instrument measuring cultural competence regarding race, ethnicity, and English-language proficiency: The study used three subscales from the Cultural Competency Self-Assessment Questionnaire (CCSAQ; Mason, 1995) and adapted items to address issues that pertain to caring for transgender and gender-nonconforming patients and clients. The adapted subscales were (a) Knowledge of Community, (b) Service Delivery and Practice, and (c) Resources and Linkages. In order to capture data about providers' communication style and self-assessed bias—topics the CCSAQ does not address—the researchers also developed an additional subscale, called Cultural and Clinical Competency in Transgender Health Provision: Self-Assessment, using the Association of American Medical Colleges (2005) *Tool for Assessing Cultural Competency Trainings (TACCT)* guidelines. All items used a 5-point Likert scale with 1 reverse-scaled item.

Follow-up interviews were digitally audio recorded and professionally transcribed; ATLAS.ti software was used to code and manage the data. The researchers formulated a codebook that included the following thematic categories: (a) General (training experience, recalled information, most important information); (b) Knowledge in Practice (challenges, opportunities); (c) Knowledge Gained (definitions, specialized information); and (d) Remaining Gaps in Knowledge (questions remaining, missing from training). The study used a combination of open coding that emerged from data and a priori codes developed from research questions (Strauss & Corbin, 1990).

Primary codes that were developed a priori were specific to the training and included Content, Length, Trainers, Style of Delivery, and Post-Training Action. Open codes that emerged from participants' answers to open-ended interview questions included Provider Setting, Challenges (to providing care to transgender clients and

patients), Provider Needs, and Identified Training Needs. Using these codes, researchers elicited a set of themes that provided insight into the experiences of individuals who completed the trainings. These themes illuminated some of the issues that arose in interviews with providers pertaining to gaps in training content and challenges to integrating knowledge into practice.

Research Results

Based on provider responses, participants in the trainings showed a relatively small but statistically significant overall gain in self-assessed knowledge. Using a one-sample *t*-test of the difference in mean score by respondent between pretraining and posttraining, the results showed a 0.6-point increase in overall score associated with completion of the training. The null hypothesis was rejected at a .05 significance level.

Qualitative data were used primarily to confirm quantitative data. They also revealed particularly effective or resonant aspects of the training, as well as some of the gaps in or less developed areas of the training. Interview participants were generally very impressed by the training and felt that they had learned a great deal about delivering quality care to transgender and gender-nonconforming individuals.

Themes that arose in the interviews with training participants fell under three main categories: (a) Training, (b) Provider Settings, and (c) Identified Training Needs. Most themes fell under categories *a* and *c*. Themes about the training centered on terminology, the presence of a transgender trainer, the availability of resources, and the availability of medical or clinical information. Themes about gaps or needs in the training centered on the duration of the training, the topic of race and ethnicity, the issue of gender fluidity, the presence of interactive training methods, and the concept of posttraining follow-up.

Participants discussed the terminology section as being one of the most memorable or significant aspects of the training. Most also commented on having a transgender presence at the training, referring to the trainer (a female-to-male transgender individual) or to a trans youth panelist. The researchers interpreted these data as an indication that providers wanted a degree of community connection as they gained information. However, qualitative data demonstrated some of the ways that these training components presented unanticipated problems. Some of the participants' quotations illustrated that they came away from the training with inaccurate or incomplete understandings about transgender or gender-nonconforming individuals.

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9 The researchers included the three authors of this article, as well as two additional researchers who were members of the community research team.

The training defined *transgender* as an umbrella term that includes but is not limited to transsexuals (described as individuals who seek medical intervention to achieve a gender-cohesive appearance).[10] A brief mention of *transvestite* and *cross-dresser* during the introductory part of the training placed these terms within the category *transgender* and defined them as being a form of gender identity that includes inhabiting the opposite gender role some or much of the time and usually expressing this role through the use of clothing, makeup, or both. One of the points the training emphasized was that *transgender* and *gender variant* are broad terms that incorporate a large range of different identities with regard to gender. However, in responding to a question about how she defined the term *transgender,* one participant gave a response that showed she came away with a narrow definition of the term and that she distinguished the category of *transgender* from that of *transvestite*:

> [A transvestite] either identifies themselves as female or feels female sometimes, [but is] a male…has male genitalia. And so then, either lives most of their life or part of their life dressed up as a female. Or vice versa. As opposed to a transgender person who I guess I see…as someone who's taking more steps by taking hormones or doing surgeries or really transforming the physical nature of their body to be like the gender that they think they are.

The researchers interpreted this response as indicating that the respondent equated the desire to physically change one's body (particularly one's genitalia) with transgender identity. This belief has several possible consequences in the context of health care delivery. For example, based on her understanding, this provider might use a person's surgical status (or desire for surgery) as the sole indicator for transgender identity. Doing so may have an effect on her use of patients' or clients' preferred pronouns[11] or on the manner in which she conducts medical

exams that may cause discomfort or distress for transgender patients or clients (e.g., breast, chest, rectal, or pelvic exams).[12] Such a distinction is also likely to create a context in which transgender or gender-nonconforming individuals who have not used hormones may be read as nontransgender and so would fail to receive culturally and clinically competent care.

Some participants believed that they could use visual cues to conclusively determine whether a person was transgender or transsexual. Again, these participants drew a distinction between transgender individuals and transvestites or cross-dressers—a distinction in which researchers noted an underlying assumption that these individuals would require different types of care. One respondent commented: "[A] transvestite walks into your office, and…you can get a good sense that…it's either a female dressed as a male or a male dressed as a female."

The researchers saw this response as indicative that this participant missed a key point: Transgender and gender-nonconforming individuals use language and terminology very differently depending on social or geographical context, class, race, and other factors, and so it is impossible to determine an individual's gender identity based on visual assessment alone. The training had covered this concept during the section on terminology (as well as briefly in the clinical section during the discussion about the surgeries and hormone treatments pursued by some transgender individuals). This participant's comment demonstrated a gap in comprehension about the danger inherent in presuming gender identity based entirely on visual cues.

Participants consistently cited the section on terminology as one of the most memorable and useful aspects of the training. However, when they offered their own interpretations of the terms covered in the training, they often supplied definitions that were inaccurate or incomplete. Often, training participants discussed the category *transgender* in terms of the people that they would exclude from this group (e.g., transvestites). Such narrow definitions of who qualifies as transgender could lead to situations in which

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10 The term *transsexual* has been used to specifically describe those individuals who pursue hormones or surgeries, but it is not exclusively used as such in transgender and gender-nonconforming communities. The definition offered in the training does not necessarily match the researchers' interpretation of the term.

11 Use of correctly gendered pronouns (according to the subject), such as *him/he, her/she,* or *hir/ze* are often very significant to transgender and gender-nonconforming people, who perceive the correct use of such pronouns as an indicator of being seen, recognized, or affirmed in their gender identity. Failing to consider pronoun preference or consistently using incorrectly gendered pronouns (again, according to the subject) is likely to cultivate distrust and frustration on the part of transgender and gender-nonconforming individuals.

12 Although such distress may not occur for all transgender and gender-nonconforming individuals, many have a discomfort or disconnection with areas of their bodies associated with what, for them, is the wrong gender—breasts, vagina, uterus, or ovaries for male-identified individuals, for example, or testes, penis, or prostate for female-identified individuals. Culturally and clinically competent care includes sensitivity to the possibility of this discomfort and may include strategies or methods to reduce discomfort and cultivate trust. Failure to consider this possibility may cause distress for the patient or client and damage trust.

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providers make important decisions about treatment based on misinformation or mistaken assumptions about patients' or clients' gender. If used in an exclusionary manner, providers' understandings of terms and definitions may limit the ability of patients and clients to describe and define their own identities as they are relevant to clinical encounters.

The presence of a transgender trainer also had both a positive and a negative effect on providers. Participants were generally excited to have the opportunity to interact with a transgender individual. In particular, they appreciated hearing from the perspective of a transgender individual who has navigated the health care system:

I liked the idea that there were transgendered people involved in the process as opposed to just having someone educate you but have not walked in the same shoes, so give a better insight or experience. I think the experiences that were shared were really rich and it helped people feel, oh, that this is real and they're OK people and they're not these aliens.

Although including transgender individuals in the training may benefit providers and satisfy their desire to see what a transgender or gender-nonconforming person looks like, it can also lead to the same exclusionary tendency to use bounded terms and definitions. One participant described a positive moment of realization about gender expression:

[W]hen [the trainer] finally identified himself as FTM, that was the first time that it struck me…you know, this is what an appointment's going to look like, and this is what a transgendered person looks like, and this is what it's all about.

However, regarding the moment of the trainer's disclosure, the same participant said:

I'm sure my jaw just dropped to the table! Just because…it was not at all who I was envisioning…this population we had been talking about. And because I guess I wasn't really thinking…that there was a large female-to-male population, I was more thinking of male-to-female.…I think it goes back to the transvestite image of the tall,…"male dressed as a female" type thing.

The researchers interpreted this response as an indication that the participant had both broadened her understanding of transgender identity (to include masculine-identified transgender and gender-nonconforming individuals) and had simultaneously narrowed it (to exclude what she described as the transvestite image), replacing one vision of what a transgender person looks like with another, equally reductive vision.

One of the participants expressed a desire to see more transgender and gender-nonconforming people visually represented in the training:

[I would like to see] pictures…like, this is who your patients are, and this is who we're talking about…I mean pictures sounds so, like, animals in a zoo.…I don't mean to come off like that, I just mean…to make it more real.

The researchers thought this response touched on an important point: Participants should have the opportunity to see a multitude of gender identities and expressions in the course of a training so that they will be prepared to deliver competent care to people with a variety of gender identities and expressions. The researchers also discussed the ways in which heightened scrutiny of and attention to gendered appearance is directed toward transgender and gender-nonconforming individuals. The participant touched on this tendency with her comment about "animals in a zoo," referencing a form of observation that researchers described as being "gawked at." Although the participant expressed a desire to avoid this type of gaze, the focus on gendered appearance (e.g., pictures, seeing what a transgender individual looks like) remains.

The training discussed racism and health disparities based on race and ethnicity as barriers to care. Greater levels of violence against transgender people of color (as opposed to White transgender individuals) was also brought up, presumably to illustrate the ways in which transgender or gender-nonconforming people of color experience intersecting oppressions. However, qualitative interviews with providers revealed that participants did not necessarily integrate this information in thinking through their delivery of care to transgender individuals. In fact, their comments seemed to indicate that they assumed transgender or gender-nonconforming individuals were White unless otherwise mentioned:

It didn't occur to me during the training, I wasn't thinking, like, what if it was an African American transgender person…or an Arab American. I was just thinking the whole time, like if a transgender person walks into the room.…I didn't even factor in cultural differences.

Such an assumption on the part of providers would disproportionately limit access to quality care for transgender and gender-nonconforming people of color.

Participants responded very well to receiving specific clinical information in trainings. They also valued receiving information about structural barriers to care, such as insurance coverage exclusions. In fact, most of the participants independently formulated action steps in response to learning about such barriers even though

such an expectation was not a component of the training curriculum. One provider described feeling horrified at insurance companies' policies regarding transgender individuals. Insurance companies generally exclude hormones and surgeries from coverage and at times have even denied coverage for unrelated care due to a person's transgender status (Israel & Tarver, 2003; Minter & Daley, 2003). This provider described her potential role as an advocate: "We [providers] could send petitions to insurance companies that we contract with saying that we feel this is a very important issue." Another provider commented that she intended to explore options for changing medical charting software to reflect that the terms *male* and *female* are not sufficient options for all patients; she was struggling with how to accomplish this change while keeping such information out of insurance records.

Qualitative data also reflected that providers responded very well to the discussions and the interactive aspects of trainings but less well to an entirely lecture-style format. A participant in one of the longer trainings that included interactive components commented that he "got a lot more out of it" than he would have gleaned from a straightforward lecture format. One of the participants in a shorter training without interactive elements (except for the question-and-answer session) said that "it could have been more interactive" and expressed the desire to see games, demonstrations, or activities in addition to lecture. Another participant in this training mentioned that she would have liked the opportunity to do role playing exercises.

Discussion

Quantitative data analysis is promising in terms of showing an increase in cultural and clinical competence in health care delivery to transgender and gender-nonconforming individuals as a result of the training. However, a number of factors limit our ability to make a conclusive determination of causality. Some of these factors are internal to the study (small sample size, issues of internal reliability), whereas others have to do with the lack of research in evaluation of cultural competence trainings in general and the dearth of research among transgender and gender-nonconforming communities in particular.

Regardless of these limitations, qualitative results confirmed our initial findings about the effectiveness of trainings: They highlighted some of the strengths of the training (developing shared language, having contact with transgender and gender-nonconforming community members, gaining resources), as well as some of the gaps in the curriculum (delivering effective care to marginalized members of these communities, interaction and discussion).

The relatively small shift in overall change in score from pretraining to posttraining (0.6 point) may be attributed to the limited length of the training, to the mostly lecture format, or to the fact that the training was provided only once. A recent meta-analysis (Mansouri & Lockyer, 2007) of the effectiveness of continuing medical education (CME) courses showed positive correlations between the size of the effect and the length of the intervention. It also showed that CME courses offering multiple interventions over time and those that incorporate interactive elements and multiple learning methods are more effective than those that do not (Mansouri & Lockyer). The observed effect size in this evaluation may also be attributed to a possible selection bias. Because trainings are offered on demand, organizations that request them may be more familiar with LGBTQ issues than others, which could attenuate the overall change in self-assessed knowledge between pretraining and posttraining. However, it is also possible that this selection bias could predict a greater level of acceptance for the importance of the topic among participants, which may have the opposite effect on overall change in score from pretraining to posttraining.

Although our evaluation was limited by its small scale, findings indicated that training may be an effective tool in raising providers' awareness of delivering quality care to transgender and gender-nonconforming individuals. More research is needed in this area. However, preliminary results, taken together with scholarship in the area of cultural competence in general, can be used to examine strengths and weaknesses in one such training and thus guide future curriculum development.

Participants in the training described learning a great deal about transgender and gender-nonconforming communities. They felt empowered by gaining knowledge about language, connection with communities, and access to resources that they could pass on to patients and clients.

Participants felt that learning about barriers to care put them in a position to advocate for transgender and gender-nonconforming patients and clients. In response to information about specific barriers to care, some participants independently developed specific plans of action with regard to advocacy. We found this outcome to be particularly significant because it demonstrated a willingness (or at least an intention) to implement skills and knowledge gained in the training. Furthermore, we thought that this response showed that some providers viewed clinical and cultural competence as existing beyond the clinical encounter.

One of the major shortcomings of the training was that it did not adequately prepare providers to deal with more marginalized members of transgender and gender-nonconforming communities. We concluded that, in particular, providers were ill equipped to deliver quality care to two major groups: (a) transgender and gender-nonconforming people who are not generally perceived as the gender with which they identify and (b) transgender and gender-nonconforming people of color. These gaps in skill set and knowledge are disturbing; the likely result is that less marginalized transgender and gender-nonconforming individuals will benefit from providers' new skills and knowledge, whereas more marginalized members of these communities will remain underserved and will continue to experience barriers to quality care. This situation has the potential to perpetuate and exacerbate already existing inequalities and disparities within these communities.

Concerned with these gaps in training participants' understanding, we discussed some of the reasons why participants failed to come away with a broader understanding of the variations in appearance, expression, identity, and experience that are present in transgender and gender-nonconforming communities.

Misinterpretations of terminology may have been one reason for this failure to grasp the vast range of gender expressions associated with transgender or gender-nonconforming identity or experience. These misinterpretations may have been attributable to the training's focus on individuals who pursue hormones and surgeries; to the use of specific, bounded definitions; or to participants' previously held beliefs, stereotypes, or assumptions. We thought that the creation of a shared language and understanding via training was important, and interview participants responded to this strategy positively. However, this strategy could also have led providers to understand definitions as bounded and exclusive when, in fact, the language that transgender and gender-nonconforming communities use to describe themselves varies greatly and changes frequently.

Lack of comprehension regarding racial and ethnic variation within transgender and gender-nonconforming communities may have stemmed from a lack of effectiveness in the training's synthesis of this information or with participants' implicit assumptions about race and ethnicity. The vast majority of training participants identified as White; we surmised that participants' assumptions about race and ethnicity could have been a function of racial privilege and an assumed universality of Whiteness.

Transgender and gender-nonconforming individuals who are not readily perceived to be the gender with which they identify or who display a less conventional gender expression may have particularly profound difficulties in gaining access to services or care that recognizes and affirms their gender identities. Some of these individuals are not able to get cost-prohibitive medical treatment even though they desire it, whereas others simply do not want to pursue it for a variety of reasons. Providers who are able to offer competent care only to those who *pass* (individuals who are generally perceived to have been assigned the gender at birth with which they currently identify) or to people who present a relatively conventional gender identity are not providing competent care to the diverse population of transgender and gender-nonconforming patients and clients. The participant who differentiated between a male dressed as a female and a transgender individual demonstrated not only that she conflated transgender with passing but also that she most likely would treat individuals not generally perceived as the gender with which they identify differently than other transgender individuals.

Transgender and gender-nonconforming people experience varying degrees of *transphobia* (the systematic oppression of transgender and gender-nonconforming individuals). Within transgender and gender-nonconforming communities, some individuals also experience intersecting forms of oppression that further marginalize them both within and outside of these communities. Health disparities in communities of color in general have been well documented (Institute of Medicine, 2002). Transgender people of color who simultaneously experience transphobia and racism (as well as classism and sexism, in some cases) therefore experience an even greater challenge in gaining access to quality health care than do transgender and gender-nonconforming individuals who do not encounter these additional barriers. Health disparities in transgender and gender-nonconforming communities of color show that rates of negative health outcomes and of being uninsured are extremely high (Boston Public Health Commission, LGBT Health, 2002). Participants in the trainings made assumptions about the universality of Whiteness in the context of institutionalized racism (Jones, 2000), which centralizes dominant cultures and renders marginalized groups invisible (Pharr, 1988). Participants demonstrated that they had not necessarily considered the implications of racial and ethnic variation among transgender and gender-nonconforming people; therefore, these providers would not be likely to consider additional barriers that such individuals may face.

Despite the importance of cultural competence in delivery of care, some scholars in this field (Taylor, 2003b)

have cautioned against trainings that reduce culture to a recipe, perpetuate stereotypes, or describe culture as static and unchanging. An evaluation of a training on Aboriginal people in Australia (Copeman, 1989) found that when students received specific cultural information about this group, they were more likely to believe that Aboriginal people were all alike. Based on our results, it is difficult to ascertain whether participants in the training we evaluated came away with the mistaken assumption that all transgender and gender-nonconforming people are the same. However, some qualitative data indicated that participants saw the trainer as an example of "who we're talking about." Although we feel that community participation in trainings and community contact for providers was generally positive, we also believe that it is important for such trainings to discuss and represent the range and variance of identities, experiences, and needs of different members of transgender and gender-nonconforming communities.

The participant who expressed a desire to see more manifestations of the range of transgender and gender-nonconforming identities also expressed a reluctance to have this desire perceived as comparable to looking at "animals in a zoo." Here, she articulated the tension between the need for context and community connection and the danger of indulging excessive curiosity. We echoed this concern, believing that it touched on the importance of offering enough information and context in trainings to benefit providers without reinforcing an increased scrutiny of transgender and gender-nonconforming bodies and experiences.

A number of scholars and practitioners in the field of cultural competence (Betancourt et al., 2003; Cross et al., 1989) have argued that competence trainings do little to affect behavioral change if they are not met with structural and systems-based change. Despite the lack of concrete evaluations demonstrating this conclusion, the argument in favor of a system-wide approach makes logical sense: Developing ways to administer quality care to diverse populations is most effective using such an approach because interactions with multiple individuals and agencies is characteristic of health care service provision. Policies set the stage for changes to be implemented rather than simply considered and formation of policies to integrate transgender and gender-nonconforming inclusive and supportive care delivery is then primarily the responsibility of health agencies and organizations. Trainings were focused in the domain of provider-patient clinical encounters. We felt that in addition to cultivating skills and knowledge associated with provider-patient interaction, a set of well-guided policies could better integrate the availability of accessible quality health care across the board.

The authors therefore propose a number of recommendations to develop policies that will facilitate integration of trainings at all levels of agency operation, including provider-client interaction. However, we first consider the ways in which trainings lend themselves to agency-wide or organization-wide integration because curriculum developers and trainers must exercise some degree of foresight in terms of how information can be used and integrated by providers and the agencies and organizations in which they work. Therefore, we also propose recommendations to those charged with developing Transgender 101–style curricula.

Policy Recommendations

Based on the limited scope of our research and the incompleteness of information about other training curricula, our policy recommendations are necessarily preliminary. At the same time, Transgender 101–style trainings, along with cultural competence trainings in general, share a theoretical assumption that educational trainings have a direct relationship to provider behavior change and increased quality of care. Transgender 101–style trainings also overlap to a greater or lesser degree in structure and content. Therefore, our research, in combination with recent scholarship on cultural competence in general, may be relevant in considering the policy implications of developing and integrating provider trainings in a range of contexts.

We will discuss policy with regard to trainings at two levels: (a) with regard to training curriculum development and dissemination and (b) with regard to organizational implementation of knowledge gained from trainings. This article will not discuss policy issues at a broader level, such as whether and how such trainings should be incorporated in health professional school curriculum.

Curriculum Development

A number of aspects of curriculum development should be considered in designing trainings with the aim of improving quality of care for transgender and gender-nonconforming patients and clients. We based these considerations in part on research in the field of cultural competence education (Chrisman, 2007; Cross et al., 1989; Shiu-Thornton, 2003) and also on ideas the community research team in our evaluation project generated about aspects of provider knowledge vital to a positive clinical encounter. These include:

1. Developing a set of learning objectives or goals that providers will gain in the course of the training

2. Offering information that is relevant to providers for maximizing their clinical competence (e.g., who needs mammograms and when)

3. Providing information about barriers to care (both structural, such as lack of insurance coverage, and organizational, such as front desk staff who are not trained to interact with transgender or gender-nonconforming patients)

4. Giving providers tools to prepare them for interaction with a wide variety of gender-nonconforming individuals (including those who may not outwardly appear to be the gender with which they identify)

5. Offering information about the medical and health care system's role in legal policy (e.g., how medical diagnoses with regard to transgender identity may be related to acquisition of legal identification)

6. Providing information about resources and community connections that providers can use in their professional development and in clinical interaction with patients or clients

7. Developing expectations or action steps designed to facilitate organizational integration of knowledge gained in training

The training we evaluated had an implicit goal of increasing providers' clinical and cultural competence in delivering health care to transgender and gender-nonconforming individuals. Our results indicated that this goal was effectively reached in some ways, but that significant gaps remained. We thought the training could be improved by developing a set of specific learning objectives that participants were expected to gain over the course of the training. These objectives should be made explicit at the beginning of the training and should be addressed again at the conclusion of the training. Developing a specific set of learning objectives would also help ensure that the curriculum adequately addresses the concepts that the trainer wishes to get across to participants.

Curriculum developers should have a good understanding of what clinical information providers need most (and whether it may vary by audience) and should ensure that the training adequately covers these areas. Despite a general lack of research about transgender primary health care, guidelines are becoming available (Feldman & Goldberg, 2006) and these can be used as resources and as reference material. Finding out what clinical information providers need most is necessarily an iterative process, one that involves finding out about providers' gaps in knowledge and how these gaps might vary by region, type of provider, or other factors.

Cross et al. (1989) introduced the term *cultural competence* and defined it as involving a system-wide approach. Training curricula, even if focused on direct provision of health care and the patient-provider interaction, should always incorporate information about structural and agency-wide barriers. It is vital that providers understand the barriers transgender and gender-nonconforming people encounter in gaining access to health care, both because such understanding provides context in the clinical encounter and because health care providers currently play a major gatekeeping role for these communities.

Curriculum developers and trainers can play a central role in ensuring that providers are well equipped to deliver quality care to more marginalized members of transgender and gender-nonconforming communities. A variety of tools can be used to this end. Drawing from educational theories of praxis, curriculum developers can incorporate role playing and interaction into trainings, modeling these on actual or probable scenarios (Freire, 2000; Knowles, 1980). By centralizing and discussing the barriers to care that more marginalized members of transgender and gender-nonconforming communities experience, curriculum developers can anticipate and address some of the gaps in comprehension that may otherwise occur.

Providers' depth of knowledge about health care provision in transgender and gender-nonconforming communities should align with the extent to which they plan to provide care for these communities. For example, an endocrinologist who wants to provide primary hormone treatment for transgender or gender-nonconforming individuals who are pursuing it will need to be deeply familiar with standards of care, dosing requirements, and the specific barriers associated with gaining access to such care. A family practice physician who does not specialize in transgender care may require less specific knowledge but nonetheless should understand some of the basic clinical needs and barriers to care (Feldman & Goldberg, 2006). Curriculum developers should consider these factors in training design to provide information that corresponds with the extent and the degree to which providers will deliver care to transgender patients or clients. At minimum, all providers should have basic knowledge of clinical information with regard to primary care, as well as information about health disparities and the reasons for these disparities, the current role of providers as gatekeepers, and barriers to care.

Resources are an important component of training curricula because they not only offer participants an opportunity to further increase their knowledge and skills

but also give them information to pass on to patients and clients. Providers may choose to build relationships with agencies or community organizations that can provide ongoing information or guidance. Curriculum developers should ensure that the resources they provide are relevant, current, and accessible.

Curriculum developers should be explicit in developing trainings as a component, rather than an endpoint, of integrating cultural competence. They should include specific expectations, guidance, or recommendations about how clinics, agencies, and organizations can strengthen cultural competence at a system-wide level. They should also offer specific suggestions for providers about roles they can take in advocating for broader systematic integration of cultural competence in health care delivery for transgender and gender-nonconforming individuals.

Community involvement in training development. Cross et al. (1989) discussed the importance of involving community members in the development of cultural competence at an agency or organizational level. One notable feature of Transgender 101 trainings is that a great many of them have been developed by or in cooperation with transgender or gender-nonconforming individuals—and often trainers are themselves transgender or gender-nonconforming. In some ways, these features can be considered unique strengths.

Although there is no way to control what providers may get or fail to get out of a training curriculum, trainers and curriculum developers have a responsibility to consider how information may be interpreted and must evaluate training programs to ensure that goals and objectives are being met. In addition, they must ensure that curricula are developed in collaboration with a broad set of transgender and gender-nonconforming individuals and communities.

Community collaboration in curriculum development should be used to develop a broad and deep analysis, as well as a set of examples, about different challenges that transgender and gender-nonconforming individuals experience. Barriers to care vary a great deal among these groups and between individuals, and care should be taken to represent the breadth of these barriers and the different forms they take.

Educational approach. We enumerated and described the central aspects of training curricula at the beginning of this section. These aspects were shaped in part by scholarship in cultural competence that argued for investing providers with tools they can use to interact cross-culturally rather than giving them formulas, scripts,

or recipes. Reducing cultures or communities to one specific experience can be tempting, but such an approach is harmful because each individual's experience of culture and identity (including gender identity) is unique and contextualized by countless other factors.

To adopt a cookbook approach is too reductive: Such an approach not only fails to meet patient or clients needs but also fails to cultivate their trust in a clinical encounter, exacerbating marginalization rather than countering it. Thus, trainings should focus on giving providers the tools to deal with a variety of clinical encounters with transgender and gender-nonconforming patients and clients. Members of the community research team suggested a number of ways—some of which are currently in use by some Transgender 101–style trainings—in which trainings could accomplish this goal. For example, trainers could introduce the concept of gender fluidity and the depth and breadth of gender-nonconforming experiences by asking participants about how they fit or do not fit gender stereotypes. Games, activities, or role plays that demonstrate the range of barriers encountered by different transgender and gender-nonconforming individuals could also be useful. Community research team members generally thought that focusing on barriers to care was a better strategy than focusing on transgender experiences. The former allows providers to focus on the role they can play in ensuring quality, accessible care for these communities. The latter is more likely to cause participants to come away from the training with a narrower understanding of supposedly prototypical transgender or gender-nonconforming individuals because it is impossible to truly represent the breadth of experience in these communities.

Qualitative data from the training evaluation revealed some of the unanticipated effects of using specific, bounded definitions in trainings and showed some of the unanticipated consequences of a transgender or gender-nonconforming individual leading trainings. Although we do not deem it necessary to eradicate these components from trainings, we certainly recommend that curriculum developers and trainers deeply consider the ways in which these factors may unintentionally undermine the overall goals and messages of the trainings. Curriculum developers must keep in mind that providers are building their skills not in order to identify and categorize transgender and gender-nonconforming patients and clients, but rather to learn how to create the space for those individuals to identify themselves in a supportive environment.

Data also revealed the ways in which racial privilege and assumptions grounded the ways in which providers interpreted training information. Consequently, trainings must specifically articulate that transgender and gender-nonconforming groups and communities include

people of color and that because of racism, these individuals may experience additional barriers to care.

If trainings successfully prepare providers to deliver quality care to the most marginalized members of transgender and gender-nonconforming groups and communities, they will have little difficulty delivering quality care to members of these groups and communities who are less marginalized. The reverse, however, is not true.

Organizational Implementation

Cultural competence trainings are not likely to lead to sustainable improvements in quality of care if they are not accompanied by organizational or agency-wide change and support. Although trainings are key in providing tools and information to staff and providers who interact with transgender and gender-nonconforming individuals, organizational and agency policies serve as the bridge to action and implementation. The key elements of implementation are as follows: (a) agency- or organization-wide focus on quality of care; (b) pretraining and posttraining needs assessment; (c) pretraining and posttraining collaboration with individuals, coalitions, or organizations in the community; (d) agency- or organization-wide prioritization of reducing or eliminating barriers to care; and (e) ongoing patient satisfaction and quality assurance measurements.

Agency- or organization-wide focus. Cross et al. (1989) asserted that it is necessary to assess and develop cultural competence at each level of agency structure: among administrative and clinical staff, boards, directors, and providers. Concrete policies with regard to quality assurance must apply to each of these levels, not just to providers having the tools and skills to deliver supportive and competent care to transgender and gender-nonconforming individuals. For example, front desk staff must be prepared to address patients or clients by chosen name rather than legal name, billing staff must be aware of issues with health care coverage, and directors and board members should have enough knowledge to inform decisions about agency or organization policy and community partnerships.

Needs assessment. Prior to seeking training, agencies or organizations would benefit from considering the educational needs of providers, staff, board members, and directors. A number of approaches can be used for conducting this type of needs assessment, including assessment instruments, interviews, analyses of patient satisfaction data, or external performance reviews. Ideally, such an assessment should take place in collaboration or on a contract basis with a health or community organization, agency, or coalition that has demonstrated success and experience in serving the needs of transgender and gender-nonconforming individuals.

Also prior to seeking training, agencies and organizations should establish the extent to which they are committed to increasing quality of care to transgender and gender-nonconforming patients and clients. At minimum, a specific vision and set of goals should be agreed upon, trainings should be offered to all organization or agency employees, and a set of concrete policies to facilitate implementation of changes should be instituted.

An important component of needs assessment involves examining the cultural assumptions and environment of the agency or organization itself. Often, health care delivery agencies and organizations assume that they are culture free (Taylor, 2003a) and that those who experience challenges in gaining access to care are somehow to blame. Cross et al. (1989) have pointed out that this approach serves to ignore cultural and community strengths and to encourage assimilation. Such an approach also ignores the ways in which a lack of organizational self-reflection contributes to maintaining or setting up barriers to quality care.

Community engagement. The most important move that agencies and organizations can make toward increasing quality of care for transgender and gender-nonconforming individuals is to create relationships, partnerships, and alliances with a wide variety of organizations, groups, and coalitions that centralize these groups and communities. Cultivating sustainable partnerships enables health agencies and organizations to build and maintain connections with groups and communities that already have experience with transgender and gender-nonconforming individuals, enables them to build trusting and mutually enriching relationships with such groups, and opens up an avenue of communication and collaboration. Of course, care should be taken to make these relationships equitable and mutually beneficial, not exploitative.

Cultivating such partnerships allows health agencies and organizations to view transgender and gender-nonconforming groups and communities in an asset-based framework. Recognition of communities' capacity to make recommendations and decisions enables health agencies and organizations to develop policy and engage in advocacy with a solid grounding in the self-determination of communities. This grounding facilitates ongoing exchanges rather than culture clashes, maximizing the ability of providers to deliver quality care and increasing the ability of transgender and gender-nonconforming individuals to gain access to competent care.

For such partnerships to be most effective, these connections must be with organizations, groups, and coalitions that represent a broad cross section of transgender and gender-nonconforming individuals. Such connections need not and, in fact, should not be limited to LGBTQ organizations. Seattle, for example, has a number of agencies, groups, and organizations that would be excellent candidates for consultation or partnership: an informal group of providers interested in the needs of the transgender community meets on a quarterly basis; the People of Color Against AIDS Network (n.d.) runs an HIV prevention, support, and discussion group targeting Latina and African American trans women; and a wide variety of community groups are organized to meet the needs of transgender and gender-nonconforming individuals.

Reduction and elimination of barriers to care. Although little research has explored health disparities among these groups, transgender and gender-nonconforming individuals are generally considered to be medically underserved (Dean et al., 2000; Feldman & Bockting, 2003). They experience a multilayered set of barriers to primary care, including a lack of legal protections leading to underemployment, homelessness, and lack of access to health care coverage.

In addition to these general barriers to care, they also encounter a number of specific, agency- and organization-related barriers to gaining access to health care. For example, the dearth of health agencies and organizations that deliver clinically and culturally competent care to transgender and gender-nonconforming individuals may contribute to underutilization. For those who seek a medically assisted transition, individuals may encounter a number of barriers ranging from excessive medical gatekeeping (Spade, 2003) to insurance coverage exclusion or prohibitive cost of surgeries or hormone prescriptions (Gay and Lesbian Medical Association, 2001). Even structural and environmental aspects of agencies or organizations can contribute to presenting barriers regarding access to care, including no provisions for usable restrooms, lack of training for front desk staff, and absence of discussion or protocol regarding medical charting for transgender or gender-nonconforming individuals.

Health agencies and organizations can play an important role in reducing or eliminating these barriers to care, both within the agency or organization and more broadly. At the least, agencies and organizations should commit to reducing all barriers to care that are within their control. Once these barriers have been identified in the course of a needs assessment, the agency or organization should develop a plan to address and eliminate each one.

Because medical providers are positioned at the helm of medical and legal gatekeeping regarding transgender and gender-nonconforming identities, they can play a major role in advocating for eliminating some of the large-scale barriers to care. For example, providers, agencies, or clinics may be able to effect change in insurance coverage policies, legal definitions of gender, and protocols regarding access to medically assisted transition. In this context, health care providers can play a large part in drastically reducing far-reaching barriers to care that not only can increase quality of care but also could improve quality of life for transgender and gender-nonconforming individuals. We highly recommend that any plan of action for advocacy be conducted in collaboration with a broad coalition of individuals, organizations, and groups that are familiar with all of the implications of such policy agendas.

Patient satisfaction and quality assurance. An agency or organization's level of cultural and clinical competence can be fully assessed only by those who use its services. Therefore, it is vital to integrate patient satisfaction measures into practice, including items that assess cultural and clinical competence in serving transgender and gender-nonconforming individuals.

Quality assurance should be ongoing. At minimum, it should involve meeting a minimum standard of patient satisfaction. Ideally, quality assurance should be regularly assessed both by patient satisfaction measures and by continuing needs assessments and reviews conducted in collaboration with community partners.

Models for Training and Implementation

One of the reasons that transgender and gender-nonconforming individuals fail to receive quality health care is that their needs have not been prioritized. Thus, few models have been proposed for integrating systems of quality care for these groups.

Some standards of care have been developed, which can in part be considered an indicator of providers responding to a set of needs. However, most of these standards are designed to serve a subgroup within transgender and gender-nonconforming groups—specifically, individuals who desire a medically assisted transition and who have existing access to services (e.g., psychiatric care, primary care).

Health agencies and organizations that choose to make a commitment to improving quality of care and health outcomes for all transgender and gender-nonconforming individuals (including but not limited to

those seeking medical transition) are in a position to set a precedent in health care practice. Our recommendations can help facilitate the process for agencies and organizations taking this step to implement supportive and affirming care.

Resources

TRANSCEND was a Canadian organization that provided outreach and education to address the social, economic, and political issues that affect transgender and intersex individuals. Prior to the organization's closure in 2006, it published a primary care training framework, *Moving Beyond Trans-Sensitivity: Developing Clinical Competence in Transgender Care (the Trans Care Project)* (Goldberg & Lindenberg, 2006), aimed at providers and including guidelines for implementation. Though largely focused on a clinical rather than an organizational perspective, this framework includes specific and detailed information about engaging in continued, sustained development toward delivering care that is inclusive and supportive of transgender and gender-nonconforming patients and clients.

The Transgender Law Center in San Francisco compiled a list of problems and policy-based recommendations with regard to transgender health care. This list is an excellent resource for helping agencies and organizations evaluate institutional barriers to care and formulate action steps to increase access (Marksamer & Vade, n.d.).

A variety of health clinics and organizations provide transgender-specific care. The Tom Waddell Health Center (2006) in San Francisco has developed its own standards of care for transgender and gender-nonconforming patients. The Callen-Lorde Community Health Center in New York City (http://www.callen-lorde.org/), the Mazzoni Center in Philadelphia (http://www.mazzonicenter.org/), and Fenway Community Health in Boston (http://www.fenwayhealth.org/site/PageServer) all offer health care and resources to transgender and gender-nonconforming individuals.

Although cultural and clinical competence trainings for providers should focus on issues of health care delivery, they should also consider factors that contextualize and affect health status for transgender and gender-nonconforming individuals. Regional, national, and international organizations—such as the Transgender Law and Policy Institute (http://www.transgenderlaw.org), the Sylvia Rivera Law Project (http://srlp.org), Transgender at Work (http://www.tgender.net/taw), Transgender Health Empowerment (http://www.theincdc.org), and the National Center for Transgender Equality (http://www.nctequality.org)-are working on issues affecting transgender and gender-nonconforming health, including incarceration, unemployment, lack of access to legal documents, immigration policies, and homelessness.

Overview of Recommendations

Recommendations for Trainers and Curriculum Developers

1. Consider limiting coverage of definitions and terminology or offer broad, abstract definitions rather than bounded ones. If terminology is considered a necessary component of trainings, spend the same amount of time discussing less conventional expressions of transgender or gender nonconformity (genderqueerness, multiplicity of genders, gender nonconformity) as discussing more conventional ones (female-to-male, male-to-female, transsexual individuals, and transgender men and women who seek hormone treatment or surgical interventions). Repeat definitions, use examples, and engage participants in discussions to ensure clarity. Emphasize that the use of terms varies and changes; stress that allowing patients and clients to describe and define their own identities is ideal.

2. Focus on teaching ways to improve quality of care rather than on acquainting providers with an abstract and narrative sense of the trans experience. To accomplish this goal, centralize discussions around the following four main topics: (a) what constitutes clinically competent care (give concrete clinical guidelines); (b) what constitutes culturally competent care (provide tools to help providers interact with trans or gender-nonconforming patients or clients in a positive, supportive way); (c) what are the main barriers to care and how can providers address them; and (d) how can providers cultivate mutually productive partnerships with community organizations, groups, and coalitions, and what can be gained from such partnerships.

3. Providers' desire to see or hear from transgender and gender-nonconforming individuals can be accomplished in a number of ways. For example, trainings can incorporate a film showing transgender and gender-nonconforming individuals discussing both positive and negative experiences in their interactions with health care providers. Alternatively, trainings can incorporate a panel of transgender individuals speaking about their experiences with health care providers. It is important that providers see many different manifestations

of transgender identity and gender nonconformity—in other words, inclusiveness in terms of race and ethnicity, choice to pursue hormone or surgical treatment, gender expression, sexual orientation, religion, size, gender, geographic area, and so on—so as to avoid leaving them with a picture of the typical transgender individual.

Recommendations for Clinics, Hospitals, and Health Organizations Seeking Training and Education

1. Prior to training, make connections with community groups, organizations, and coalitions that have experience with and centralize transgender and gender-nonconforming individuals and their needs.
2. Prior to training, conduct an agency- or organization-wide needs assessment with regard to competence in delivering quality care to transgender and gender-nonconforming individuals (ideally, in collaboration with partner organizations).
3. Prior to training, develop a vision and level of commitment for time and resources to improving quality of care to transgender and gender-nonconforming patients and clients.
4. After training, develop an agency- or organization-wide implementation plan to develop new policies to guide practice, build community connections and resources, and plan follow-up training or education programs, as well as consider additional action steps for local, statewide, or national policy advocacy.
5. Maintain partnerships and continue to deepen and expand community connections.
6. Include items specific to the experience of transgender and gender-nonconforming individuals in patient satisfaction measures and build mechanism of quality assurance.

Conclusion

Transgender and gender-nonconforming individuals currently face a number of barriers to getting quality health care. Cultural competence scholarship and limited research has demonstrated that cultural and clinical competence trainings may be one strategy for reducing barriers and increasing quality of care to these communities. For sustainable change to occur, however, trainings should be accompanied by system-wide changes. The authors' policy recommendations—for developers of training curriculum, as well as for organizations, agencies, and clinics—can guide the integration of sustainable provision of quality care for all transgender and gender-nonconforming individuals.

More research is required to demonstrate the most effective means of increasing access to quality care for individuals in these communities. In the meantime, data from existing research and scholarship can help improve existing models of cultural competence instruction and integrate them more broadly.

Acknowledgments

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