Title

Providers and Related Staff in Gender-Affirming Care: Training Objectives and Recommendations Following the AJUSTER Community Research Project.

Abstract

The community organization TransEstrie notes that, in the same line as the literature, transgender, non-binary, and questioning (TNBQ) individuals in the Estrie region face significant difficulties accessing gender-affirming care (GAC) in Québec (UETMISSS, 2023; UETMISSS, 2022; Cotton et al., 2022; Pullen Sansfaçon et al., 2020; SAVIE-LGBTQ, 2022b). In the organization's mixed-methods community research project titled AJUSTER: Access to Just, Unified and Safe Transaffirmative healthcare in Estrie and other Regions, the primary objective is to generate knowledge about access to gender-affirming care (GAC) in Québec, as well as to highlight existing issues regarding the quality of this care. To address these objectives, a detailed conceptual framework is employed: GAC as defined by the 2022 WPATH guidelines, gender affirmation, standards of care (Coleman et al., 2022), the transaffirmative approach (Pullen Sansfaçon et al., 2021), medical violence (Brisson, 2023), intersectionality (Sensoy et al., 2017; Collins, 2020), cultural safety (MSSS, 2021; First Nations Health Authority, 2020), and professional self-efficacy (Gallagher, 2012). Using Braun and Clarke's reflexive thematic analysis (2006; 2019) and Baribeau's method for analyzing focus group data (2009), the results of three of the research methods made it possible to identify training priorities and recommendations for GAC providers and related staff: (1) semi-structured interviews with 8 GAC providers working in peripheral regions[1], (2) semi-structured interviews with 9 gender-diverse people who live in peripheral regions that experienced discomfort while accessing or attempting to access GAC , and (3) semi-structured interviews in 4 groups organized around common GAC, involving a total of 19 gender-diverse participants. The key training objectives and recommendations that emerge are: normalizing trans identity; raising awareness about misgendering and deadnaming; adapting IT[2] systems to include correct first name and pronouns; focusing on empathy and active listening; understanding culturally safe care; acquiring general knowledge about GAC; developing expertise in prescribing replacement hormone therapy; the role of peer support among GAC providers, learning about the sexual health of TNBQ individuals, ensuring the presence and improvement of informed consent practices, providing accommodations in the delivery of care, and facilitating referrals to GAC providers when requested or necessary.

Keywords: trans, non-binary, transgender, gender-affirming care, healthcare, care, professional, health, training, medical, Québec.

[1] Regions outside Montréal and Québec City.

[2] IT: **I**nformation **T**echnology, computer systems/programs.

1. Introduction

TransEstrie, a community organization active since 2019, is dedicated to supporting, assisting, and representing transgender, non-binary, and questioning (TNBQ) people in the Estrie region. In line with the literature, the organization is concerned about the lack of access to gender-affirming care (GAC) in the Estrie region and throughout the province of Québec (UETMISSS, 2023; UETMISSS, 2022; Cotton et al., 2022; Pullen Sansfaçon et al., 2020; SAVIE-LGBTQ, 2022b). Furthermore, organizations serving TNBQ individuals are troubled by the rise in transphobic rhetoric in Canada (Justice Trans, 2022). Seeking to better understand access to gender-affirming care in Québec as well as the experiences of violence faced by their TNBQ service users, TransEstrie launched the AJUSTER community research project in 2023: Access to Just, Unified and Safe Transaffirmative healthcare in Estrie and other Regions, funded by Women And Gender Equality Canada as part of the funding application for the project titled "Medical Violence Experienced by Trans and Non-Binary People." This article is part of that community-based research project and draws on data collected through AJUSTER.

1.1 An Overview of the Literature on Medical Violence Experienced by Trans and Non-Binary People

Among transgender and non-binary people (TNBQ), recent studies show an alarming rate of psychological distress. The 2019 TransPulse Canada survey reports that 56% of its 2,873 respondents rated their mental health as average or poor, and that 31% had considered suicide in the past year (Scheim et al., 2021). A recognized protective factor for mental health among TNBQ individuals is access to desired transition procedures (Amiot et al., 2024; Pullen Sansfaçon and Medico, 2021). A Québec study shows that TNBQ participants least affected by depressive symptoms and expressing greater life satisfaction are those who considered their transition processes to be complete (Cotton et al., 2021). However, access to GAC remains difficult in Canada (Weisdorf et al., 2023; Comeau et al., 2023). Only 26% of TransPulse participants in 2019 felt they had received all the necessary GAC for their transition (Scheim et al., 2021). In Québec, most GAC do not have a clear and specific pathway for access (Amiot et al., 2024; Cotton et al., 2022; Pullen Sansfaçon et al., 2020; SAVIE-LGBTQ, 2022). Certain issues that make access more difficult or impossible have been highlighted in the literature and by community organizations serving TNBQ individuals. One systemic issue identified is that general practitioners often refuse provide a desired GAC and/or refuse to refer their patient to another provider (whether or not that care provider specializes in GAC) on the pretext that the patient might change their mind (Justice Trans, 2022; Weisdorf et al., 2023). Issues more specific to certain lived experiences have been identified: TNBQ youth face a lack of consensus and clarity regarding the minimum age required for access to GAC in Québec according to some providers; trans women are more likely to have to pay for GAC because the desired services are less covered by Québec's public insurance, non-binary people are less likely to have their correct first names and pronouns used by their care providers, and experiences of fatphobia and racism making access to GAC more difficult or even

impossible (Justice Trans, 2022; Brisson, 2023). The process of obtaining and maintaining informed consent during GAC has been highlighted as crucial by TNBQ individuals, according to several authors (Ashley, 2020; Puckett et al., 2022; Mayer et al., 2023; MacKinnon et al., 2021; Gerritse et al., 2023).

Among healthcare providers in Québec, a 2023 analysis of scientific journals by Brisson highlights that the lack of resources available to caregivers in Québec is linked to an increase in their emotional distress. This emotional distress is believed to be one of the factors contributing to an increase in incidents of violence against service users (Brisson, 2023; Côté, 2023; Lapointe, 2022). Brisson (2023) also notes that applying the principles of benevolence to all healthcare providers in Québec across the board may hinder the recognition and reporting of discriminative behaviours committed by these providers. Experiences of discrimination or transphobia toward TNBQ people by healthcare providers are particularly prevalent in rural areas or communities where access to a trans-affirmative family doctor is even more difficult (Justice Trans, 2022). This can force people to travel to access trans-affirmative healthcare (Justice Trans, 2022; Weisdorf et al., 2023).

In an empirical study conducted by Justice Trans in 2022, TNBQ participants felt that legal processes were too difficult to initiate and are potentially traumatic. Participants cited feelings of powerlessness and helplessness when it came to accessing justice for issues of discrimination and harassment they had experienced (Justice Trans, 2022). Out of the sample, 43% reported having faced a problem related to medical treatment, such as: a lack of appropriate care, a general lack of expertise and knowledge regarding trans health, being turned away by general practitioners who claim not being specialized even though the requested services are primary care, transphobia from providers and staff, being deadnamed (use of the wrong first name) and misgendered (use of the wrong pronouns) sometimes in a targeted, intentional and malicious way or sometimes caused by systemic failures, or the refusal to prescribe hormone therapy if a mental health referral letter has not been provided, even though this is not a requirement for accessing this GAC (Justice Trans, 2022). It is important to understand the intersectional realities faced by TNBQ people, such as Black and Indigenous people who report having been denied access to gender-affirming care because of their identity (Justice Trans, 2022). It remains difficult for people with intersectional identities to confidently identify which vectors of oppression have led to discrimination against them (Justice Trans, 2022). It is important to note that TNBQ individuals who had access to respectful care settings were then more likely to seek health care (Justice Trans, 2022).

Since the literature and community organizations that support TNBQ individuals highlight the difficult, and sometimes even impossible, access to GAC in Québec, this article aims to present research findings from the AJUSTER project to offer training suggestions and recommendations for GAC providers and related staff. Related staff are defined as workers who support the work of GAC providers in their workplace by being in direct contact with patients: medical secretaries, security guards, receptionists, pharmacists, pharmacy technicians, etc. Mental health providers are excluded from this category in the context of this article, as their role in accessing GAC is considered distinct from that of support staff due to their work, which focuses on the mental health of TNBQ individuals who may wish to access mental health services.

1.2 Research Objectives

The main objective of the AJUSTER project: Access to Just, Unified and Safe Transaffirmative healthcare in Estrie and other Regions is to make knowledge available about access to gender-affirming care (GAC) in Québec, as well as to highlight existing problems regarding the quality of this care.

For the purposes of this article, results from three research methods of the AJUSTER project's were selected: (1) semi-structured interviews with GAC providers, (2) semi-structured interviews with TNBQ individuals who have experienced forms of discomfort while accessing or attempting to access gender-affirming care, and (3) focus group interviews with TNBQ individuals who have accessed the same type of GAC.

For these three research methods, two common objectives are (1) to identify incidents or experiences of gendered medical violence, conversion therapy, human rights violations, and failure to comply with WPATH standards of care in the context of access to GAC in Québec, and (2) to examine the realities faced by GAC providers practicing in peripheral areas. By achieving these objectives, the findings from the various components of the AJUSTER project will enable the identification of specific training needs and help address certain systemic barriers to improve the quality of gender-affirming care in Québec.

2. Conceptual Framework

In this project, the goal is to use various concepts to examine the complexity of the issues surrounding access to GAC in Estrie, and in Québec as a whole.

First, certain broader concepts must be considered within the AJUSTER project. As a starting point, it is essential to understand GAC as defined by the World Professional Association for Trans Health (WPATH). In the context of this project, GAC refers to the process of connecting a care provider with TNBQ individuals to address their needs holistically (social, mental, and medical health and well-being), while respectfully affirming the person's gender identity (Coleman et al., 2022). GAC includes interventions such as puberty blockers, hormone therapy, gender-affirming surgeries, and other care identified as gender-affirming. Gender affirmation refers to the act of recognizing and affirming a person's gender identity across social, psychological, medical, and legal contexts (Coleman et al., 2022). This understanding of gender-affirming care helps clearly define what type of care should be considered when access to GAC is discussed.

Next, the trans-affirmative approach should be viewed as a holistic and systemic approach (Pullen Sansfaçon et al., 2021). It is important to emphasize that medical transition is neither central to nor necessary for a transition, and that a transition can take social or legal forms. The trans-affirmative approach holds that the various forms of transition desired by a gender diverse individual allow them to live as consistently and comfortably as possible in alignment with their affirmed gender (Pullen Sansfaçon et al., 2021). This concept makes it possible to accurately assess the quality of care provided to gender diverse individuals and to document the presence or absence of a trans-affirmative approach in Québec.

The third concept used is the WPATH Standards of Care (2022). These standards aim to provide clinical guidance to providers to support them in their work with gender diverse individuals. The WPATH seeks to help these professionals provide these populations access to safe and effective care so that they can achieve a lasting sense of personal well-being (2022). The WPATH aims to ensure that these TNBQ populations see improvements in and maximization of their physical health, psychological well-being, and sense of self-fulfillment (Coleman et al., 2022). It is important to establish a clear framework for understanding standards of care to evaluate the quality of the identified GAC, but also to clearly identify where improvements are needed.

In this project, we will examine service users' experiences of discomfort and medical violence. To gain an understanding of medical violence, we will draw on Brisson's conceptualization of the phenomenon, as presented in her 2023 master's thesis. In their critical interpretive review of the literature, Brisson emphasizes that medical violence is taboo and ambiguous, making it difficult to identify despite its omnipresence. Due to this phenomenon of invisibility, it tends to be ignored or unacknowledged, which in itself makes it violent. Another form of this violence, according to the author, lies in the tendency to infantilize or adopt paternalistic attitudes toward those who speak out against it, which reinforces the position of authority held by healthcare providers. Medical violence is also associated with a perception of a lack of empathy and disrespect on the part of healthcare providers (Brisson, 2023). This understanding of medical violence allows for a better comprehension and definition of the discomfort experienced by gender diverse people within the context of GAC.

The concept of intersectionality is central to this study. It proposes that each person simultaneously occupies multiple social positions, and that these positions do not cancel each other out but rather interact in complex ways (Sensoy et al., 2017). These social positions may include "race, social class, gender, sexuality, nationality, ethnicity, ability, age, and similar markers of power, which are interdependent and mutually constructed" (Collins, 2020). In this project, it will be important for us to adopt an intersectional understanding of access to GAC, since every individual should be able to access quality care regardless of the multiple social positions they simultaneously occupy. We must remain attentive to the specific issues arising from different intersections.

Another important concept in the context of this article is cultural safety. This approach initially focused on recognizing the power imbalances observed between healthcare providers and all First Nations and Inuit patients (First Nations Health Authority, 2020). Later, the definition was expanded to encompass all forms of oppression, with the aim of addressing the power imbalances observed between healthcare providers and all patients or groups experiencing some form of oppression, whether due to their gender identity or expression, age, culture, beliefs, sexual orientation, or ability (MSSS, 2021). This concept is used, among others, by the Collège des Médecins du Québec in its training program "Basic Training in Culturally Safe Healthcare" (2026).

Finally, a key concept in setting training goals is the sense of professional self-efficacy. Gallagher (2012) defines it as people's perception of their ability to perform the actions necessary to achieve a desired goal. It is a personal assessment of one's ability to carry out the necessary actions. Five mechanisms of self-efficacy have been identified: mastery experiences, modeling/by proxy experiences, imagined experiences, social persuasion, and somatic/emotional cues (Gallagher,

2012). It has been observed that individuals with higher levels of self-efficacy perceive new challenges as learning opportunities rather than situations to be avoided (Gallagher, 2012). The concept of a sense of professional competence allows for the assessment of its presence among providers in the context of GAC.

3. Methodology

The AJUSTER project is a mixed-methods study, comprising of four research methods which combines quantitative and qualitative approaches. For the purposes of this article, the three qualitative methods were selected to identify training objectives.

1. Semi-structured interviews with GAC providers who practice in peripheral regions.

2. Semi-structured interviews with gender-diverse people who have experienced discomfort while accessing or attempting to access GAC in peripheral regions.

3. Semi-structured group interviews organized around a common GAC received by gender-diverse participants in Québec.

The project was overseen by two paid committees of experts: an advisory committee composed of four gender diverse individuals, and a scientific committee composed of four professionals specializing in trans health research in Québec. These individuals reviewed and provided feedback on the various research tools, research methods, analytical approaches used to produce results, and our final reports.

The interviewers were trained internally, using online training materials and through a consultation with Lyanna Després, a research professional specializing in research interviews, to ensure high-quality interviews. One member of the AJUSTER research team has training in counseling as part of a bachelor's degree in sexology, as well as a master's degree in sexology research and intervention.

When transcribing the interviews, the research project leaders modified or removed any information that could identify the participants. The interview recordings were also securely deleted after transcription. No publication or communication regarding the research contains or will contain any information that could identify the participants. Braun and Clarke's (2019; 2006) reflexive thematic analysis was used for the three qualitative methods.

3.1 Qualitative section: Individual interviews with GAC providers who Practice in Peripheral Regions

The semi-structured interviews with GAC providers who practice in peripheral regions are intended to address two specific secondary objectives:

1. To identify gender-based medical violence, conversion therapy, human rights violations, and non-compliance with WPATH standards of care in the context of access to gender-affirming care in Québec;

2. To examine the realities faced by healthcare providers in Estrie in the context of gender-affirming care.

Given their unique position as they work and practice in peripheral areas, this qualitative method proved to be an effective way to accurately capture the observations of gender-affirming care providers.

3.1.1 Inclusion Criteria

For the semi-structured interviews with professionals, the study population consists of GAC providers who practice in peripheral regions, such as pediatricians, endocrinologists, family physicians, medical specialists, surgeons, nurses, specialized nurse practitioners, speech-language pathologists, estheticians, physical therapists, and any other providers providing GAC in peripheral areas. Participants could speak in French, English or a mix of both during the interview.

Initially, it was planned that healthcare providers providing access to GAC would be located only in the Estrie region. Despite recruitment efforts spanning more than six months to reach a sample size of more than six participants, we had to expand this selection criterion to include all peripheral areas of Québec. This solution had already been anticipated as an alternative in our ethics approval. We were then able to reach a sample size of 8 GAC providers from different regions across the province of Québec.

3.1.2 Recruitment and Data Collection Process

For the semi-structured interviews with GAC providers, recruitment posters and announcements were posted on TransEstrie's social media accounts, as well as on two independent Facebook groups with the administrators' approval. We contacted about 20 different organizations to ask them to share our recruitment posters on their networks. During some events TransEstrie attended, posters were displayed along with a QR code leading to a page where people could sign up for an interview. We also used a snowball effect approach through word of mouth, where, following their interview, participants were invited to reach out to people in their networks who met the selection criteria.

To favour accessibility, the interview was offered in person, via videoconference, or by phone. A sociodemographic form was completed either independently or with the interviewer's assistance prior to the interview. The interview framework was divided into four themes: professional practice; experiences and situations encountered while providing GAC; pathways to trans-affirmative care; and final reflections. Participants were offered compensation in the form of a carefully personalized selected set of trans-affirmative resources valued at $20, available in either print or digital format.

3.2 Qualitative section: Individual interviews with gender-diverse individuals from peripheral regions who experienced various forms of discomfort while accessing GAC

The second method chosen for this article is semi-structured interviews with gender diverse individuals from peripheral regions who have experienced various forms of discomfort while accessing or attempting to access GAC. The purpose of these semi-structured interviews is to more specifically address a secondary objective of the project: identifying gendered medical violence, conversion therapy, human rights violations, and non-compliance with WPATH standards of care in the context of accessing gender-affirming care in Québec.

3.2.1 Inclusion Criteria

The study population was defined as individuals living in Estrie who had experienced some form of unpleasant event while accessing or attempting to access GAC, and who were 14 years of age or older. The target sample size was 6 to 15 participants. Since it was not possible to reach the minimum sample size despite recruitment efforts spanning more than 6 months to reach a sample size of more than 6 participants, we had to expand this selection criterion to include all peripheral regions of Québec. This solution had already been anticipated as an alternative in our ethics approval. It was then possible to recruit a sample of 9 gender-diverse participants across the peripheral regions who had experienced various forms of discomfort while accessing or attempting to access GAC, with more than half located in the Estrie region.

3.2.2 Recruitment and Data Collection Process

Posters and recruitment announcements were posted on TransEstrie's social media accounts, as well as on TransEstrie's Facebook page and other independent groups with the administrators' approval. More than 125 organizations, groups, student gender-diversity associations, research chairs, CIUSSSs, CISSSs, LGBTQIA+ influencers, committees, services for TNBQ individuals, 2SLGBTQIA+ groups, and TransEstrie collaborators were contacted to share our recruitment posters on/in their networks. During certain events TransEstrie attended, posters were distributed along with a QR code leading to a page where people could sign up for interviews. We also used a snowball effect approach through word of mouth, where, following their interview, participants were invited to reach out to people in their networks who met the selection criteria.

To favour accessibility, the interview was available in person, via videoconference, or by phone. A sociodemographic form was completed either independently or with the interviewer's assistance before to the interview. The interview framework was divided into four themes: an introduction to the person's journey, gender-affirming care, standards of care, and final reflections. The list of resources was reviewed at the end of the interview. A social worker was available for consultation following the interview, if needed. A compensation of $25 was offered for participation, whether the interview was completed in full or not. After the interview, a research head emailed participants to send them their gift card via one of three available delivery methods (email, mail, in-person pick-up).

3.3 Qualitative section: Semi-structured group interviews with shared received GAC

The final method to be presented is semi-structured group interviews with gender-diverse people in Québec grouped according to a common GAC. These semi-structured interviews specifically address two secondary objectives of the project:

1. To document instances in which TNBQ individuals, due to their unique characteristics, systematically encounter barriers that prevent them from accessing the procedures they need;

2. To Identify instances of gender-based medical violence, conversion therapy, human rights violations, and non-compliance with WPATH standards of care in the context of accessing gender-affirming care in Québec.

This qualitative method proved to be an effective way to better understand and compare the different experiences of participants based on their respective GAC.

3.3.1 // Inclusion Criteria

For the focus group interviews, the study population consists of gender-diverse individuals in Québec who have had access to GAC. Initially, the goal was to form six groups of six people living in the Estrie region, grouped by received GAC. Since it was not possible to reach a satisfactory minimum number of participants despite recruitment efforts spanning more than 4 months, the inclusion criteria had to be modified. The selection criterion of living in Estrie was changed to living in the province of Québec. This change allowed the research team to form 4 focus groups with a satisfactory number of participants: a group of 3 people for GAC procedures not covered by public insurance, a group of 5 people that have taken hormone blockers or are taking hormone therapy, a group of 5 people that have had a genital or reproductive system surgery, and a group of 6 people that have had a mastectomy or breast reduction. This brings the total to 19 gender-diverse people living in Québec who received GAC who participated in a focus group interview.

In addition to using Braun and Clarke's (2019; 2006) reflexive thematic analysis, Baribeau's (2009) method for analyzing focus group data was also employed.

3.3.2 Recruitment and Data Collection Process

Posters and recruitment announcements were posted on TransEstrie's social media accounts, as well as on TransEstrie's Facebook groups and other independent groups with the administrators' approval. More than 125 organizations, groups, student gender-diversity associations, Chairs, CIUSSSs, CISSSs, LGBTQIA+ influencers, committees, services for TNBQ individuals, 2SLGBTQIA+ groups, and TransEstrie collaborators were contacted to share our recruitment posters on their networks. During certain events where TransEstrie was present, posters were distributed along with a QR code leading to a page where people could sign up for interviews. We also used a snowball effect approach through word of mouth, where, following their interview, participants were invited to reach out to people in their networks who met the selection criteria.

To favour accessibility, the interview was available in person, via videoconference, or by phone. A sociodemographic form was completed either independently or with the interviewer's assistance prior to the interview. The interview framework consisted of 13 closed-ended questions with follow-up questions as needed: icebreaker, timing of the GAC procedure, ease or difficulty of access, barriers to access, services aimed at accepting the gender assigned at birth, informed consent, staff training, lack of understanding from providers, experiences of discomfort, funds spent on GAC, travel for GAC, level of satisfaction with GAC results, and knowledge of the *transitionner.info* website. A reminder of the resource list made for participants of this project was done at the end of the interview. A social worker was available for consultation following the interview, if needed. A compensation of $25 was offered for participation, whether the interview was completed in full or not. After the interview, a research head emailed the participants to send them their gift card via one of three available methods.

3.4 Ethical Consideration

As part of this project, ethical approval was obtained from the Research Ethics Committee for Education and Social Sciences at the University of Sherbrooke. This was made possible through collaboration with Professor Julie-Christine Cotton, director of the *Laboratoire inclusif de recherche et de développement* (LIRD), who has access to this ethics IT resource through her research activities at the University of Sherbrooke. The two individuals responsible for the AJUSTER project have both earned their EPTC 2: FER-2022 certification, a training program in research ethics.

4. Results

The results of the three research methods selected for this article have been divided into three main themes to present the training objectives and recommendations. The first, identity and respect, consists of recommendations addressing the normalization of trans identity, misgendering, deadnaming, the adaptation of IT systems, the presence of empathy, active listening, and cultural safety. The second major theme is knowledge and resources, which highlights general knowledge regarding GAC, prescription of hormone therapy, the importance of collaboration among GAC providers, and knowledge about sexual health for TNBQ individuals. The final major theme of training objectives and recommendations is providing higher quality GAC. It presents key points regarding informed consent, possible accommodations in the delivery of care, and referrals to other GAC providers.

4.1 Identity and Respect

Across the three interview methods, several training objectives and recommendations that were brought up focused on how TNBQ individuals seeking GAC felt like they were perceived, treated, and understood by GAC providers or related staff. The theme of identity and respect encompasses five subthemes within the context of GAC: the normalization of trans identity, issues surrounding misgendering and deadnaming, the adaptation of IT systems, the presence of empathy and active listening, and cultural safety.

4.1.1 Normalization of Trans Identity

In the context of their interactions with GAC providers, the 9 gender-diverse individuals from peripheral regions who experienced various forms of discomfort while accessing GAC identified the normalization of trans identity as a training priority. More specifically, they recommended that TNBQ individuals be recognized and treated with the same level of acknowledgment and respect as cisgender[3] individuals. This recommendation applies to GAC providers, with a particular focus on family physicians and general practitioners, whom all participants mentioned as needing this training . In the following interview quote, Patrice draws on their[4] own experience to explain how ignorance and a lack of understanding among GAC providers regarding trans identity can lead to uncomfortable experiences for trans patients:

[3] Cisgender: people whose gender aligns with the sex assigned to them at birth.

[4] Since pronouns were asked only in French, the pronouns **they/them** will be used for all participants as to not assume pronouns used in English.

> That time, I basically did my coming out to her: “Hey, I’m trans. I don’t want testosterone right away, but maybe eventually.” And clearly, [my family doctor] didn’t understand at all. It was as if she’d never met a trans person in her life, and she asked questions… [laughs] Like, for example: “Are you still with your husband?” She asked me, “Is this a relationship thing?” So, you know, just… no. [literal translation] (Patrice)

The quote presents real-life examples of inappropriate questions asked by a healthcare professional who demonstrates a lack of understanding of what it means to be a transgender person. This same training priority was mentioned by six gender-diverse individuals from peripheral regions who had experienced various forms of discomfort while accessing GAC. During interviews with providers in regions providing access to GAC services, all of them recommended raising awareness among GAC providers and related staff who do not believe in the existence of TNBQ individuals. Normalizing trans identity therefore appears to be a fundamental training method to enable respectful interactions with TNBQ patients.

4.1.2 Misgendering and Deadnaming

Experiences of misgendering (incorrect use of pronouns) and deadnaming (use of deadnames, someone’s former first name·s) were frequently raised in the context of the three research methods selected. These experiences occurred with GAC providers or related staff. In interviews with gender-diverse individuals from peripheral regions who had experienced discomfort while accessing GAC services, 6 participants directly identified the following as a training objective: improving the use of correct pronouns and first names by GAC providers. Nurses were the GAC providers most frequently mentioned as needing this training. The following quote from the interview with Sapphire is a concrete example of the difficulty of having one’s chosen first name·s and pronouns respected:

> One time I went to the emergency and [the nurses] accepted to use the name that I want. I’ve changed my name legally but there’s a lot of trauma associated with it so I always want people to use another name. One time, at the emergency, [the nurses] accepted to do that, but most of the time they tell me that they can’t do that, which is a bit weird [chuckles]. (Sapphire)

Sapphire clearly illustrates, through various scenarios, how respecting the correct pronouns and first name·s depends on the willingness of care providers. During interviews with GAC providers that practice in peripheral regions, five of them also mentioned misgendering and deadnaming as a training objective for all GAC providers. Some took the time to mention the importance of asking and reconfirming during appointments with TNBQ patients which pronouns to use to avoid misgendering. Raising awareness about misgendering and deadnaming, as well as implementing measures to reduce their likelihood, therefore appear to be training priorities to encourage respectful interactions with TNBQ patients.

4.1.3 Changing First Name·s and Pronouns in an IT System

One factor that can affect respect for a person’s first name·s and pronouns is the computer system used by GAC providers and related administrative staff. Of the 9 gender-diverse individuals from

peripheral regions who experienced some form of discomfort while accessing GAC who were interviewed, 4 mentioned training aimed at improving staff's ability to change first name·s or add pronouns in the internal IT system as a priority. In the following quote, Orion recounts their experience of discomfort at having to constantly correct medical staff about their pronouns and name due to the impossibility (or said impossibility) to change or add them in the IT system.

> For example, I had an appointment […] recently, and the nurse called me "Miss." At that point, I thought, "Well, OK, this is off to a great start." After that, she said to me, and I'm quoting here, "Are you a healthy woman?" […] By the third time she called me "Miss," I said, " Listen, I'm a trans person, and I'd like you to note in my file that I don't want to be called 'Miss' because I find it really uncomfortable when that happens." Then she kind of got it, and she told me straight out, "I'll make a note of it, but I don't have a place to write that information down." I was like, "OK, so is there really no one in the IT system capable of doing their job to add a checkbox? So I'm going to have to deal with being misgendered every time I make a call? And multiple times during the same call?" You know, I'm not necessarily physically or mentally able to correct the person every single time. Sometimes I just don't feel like it. Sometimes I don't have the energy, or sometimes it's just not possible, but I shouldn't have to put up with that kind of treatment every time I get a call. It's a bit stressful. [literal translation] (Orion)

Orion highlights here how making it easier to change name·s and pronouns would help prevent instances of misgendering. They also explain how having to correct people is a mental burden that could be partially alleviated by making changes in the IT system. Among GAC providers in peripheral regions, two of them recommended being able to change first name·s and pronouns in the IT system to improve quality of care. The ability to modify the first name·s and pronouns of a TNBQ person in the IT system therefore seems to be a way to enable GAC providers and related staff to better respect the identity of TNBQ patients, as well as to incorporate this aspect into their GAC training.

4.1.4 Empathy and Active Listening

Gender-diverse individuals from peripheral regions who experienced some form of discomfort while accessing GAC that were interviewed mentioned that they wished for more empathy and understanding from GAC providers and related staff. The gender-diverse individuals from peripheral regions who experienced some form of discomfort while accessing GAC that were interviewed identified this training objective as important for all GAC providers, and more specifically for nurses. Among gender-diverse individuals from peripheral regions who experienced some form of discomfort while accessing GAC, 8 out of 9 people identified this training objective for GAC providers. During the focus group interviews with gender-diverse individuals from Québec grouped according to a shared specific GAC received, 2 people identified this training objective for GAC providers. In the following quote, Patrice, during a focus group interview, shares their perception of empathy from the medical staff in the context of GAC.

> It seems like there's sometimes a bit of a lack of empathy on the part of the staff. […] After the first week, the stitches […] started to really hurt. I contacted the GrS. It was hard to

> talk to someone [for the post-op follow-up], but I was able to. […] She said, "Everything looks great." But it really hurt. When I moved, I felt like I was being stabbed. But that's just how it is. I had to wait until the fluid level went down. […] Except that, after a week, I was still a few milliliters over . So I messaged back, "It's painful. I'm really close. Can I have it removed even if I'm just a little over right now?" The person replied, "You have to keep it even if it's uncomfortable." I found that fucking insulting. *[literal translation]* (Patrice)

Patrice takes the time to point out that, despite experiencing significant post-surgery pain and mentioning it to the medical staff, their response showed a lack of seriousness and empathy toward them. Five of the 8 GAC providers who practice in a peripheral region who were interviewed emphasized the importance of delivering GAC with empathy and treating patients as human beings, and that this must be reflected GAC training. Active listening and demonstrating empathy toward TNBQ patients therefore appear to be core professional skills and attitudes that should be targeted in training to maintain a relationship of trust based on respect for these patients.

4.1.5 Cultural Safety

In interviews with gender-diverse individuals from peripheral regions who experienced various forms of discomfort while accessing GAC, 4 out of 9 individuals identified different forms of oppression within GAC context, highlighting a need for education on cultural safety for GAC providers and related staff. In the following quote, Patrice recounts an experience of fatphobia they encountered while accessing GAC.

> After that, he sent me some questions by email. It seems like he took the time to think about it, and there was one in particular that went something like: "Are you still working with your nutritionist to make sure you're eating well?" To me, that implies, "Oh yeah, I'm fat, so I eat like crap, and it's important that I see my nutritionist to eat well." But, because of the GrS, I see my nutritionist to make sure I'm eating, period. I answered that question with something like, "Yeah, I still see my nutritionist," without really answering his question because I was kind of like, "Fuck you." [literal translation] (Patrice)

Patrice's experience highlights a lack of training regarding fatphobia in the context of medical care leading up to GAC. The lack of proficiency in cultural safety manifests as fatphobia on the part of a member of the medical staff. Cultural safety training would therefore be important in potentially reducing certain experiences of discomfort among patients, who are systematically discriminated against in the medical field. Furthermore, mastering the basics of cultural safety could help build trust with GAC providers and their support staff. Cultural safety in the context of GAC thus appears to be a fundamental training angle for developing appropriate interpersonal skills when working with TNBQ patients.

4.2 Knowledge and Resources

The training objectives grouped under this theme focus on knowledge related to the professional competencies of various types of GAC providers and associated staff. The selected results are divided into four subthemes: general knowledge of GAC, prescribing hormone replacement

therapy, the role of mutual support among GAC providers, and knowledge of sexual health of TNBQ individuals.

4.2.1 General Knowledge on GAC

The first training objective related to this topic is knowledge of GAC. Among people from peripheral regions who have experienced discomfort while accessing GAC, 8 out of 9 identified knowledge on GAC as a training objective for GAC providers. An interesting aspect of this training objective is that the goal is not to expect all healthcare providers to be able to provide access to GAC, but rather that they should first be familiar with them so that providers can inform patients about them. The next step would be for them to feel comfortable providing care to a TNBQ person or who is experiencing complications in the context of GAC. In the quote from the interview with Mangue, they explain why this training objective should be part of every healthcare professional's knowledge:

> "Being informed [is the role of providers], and then doing their job properly. […] And if they don't know, at least refer me to other providers who do. […] At the very least, take the time to get informed." [literal translation] (Mangue)

Mangue emphasizes here the importance of referring a client to another professional who can assist them in accessing GAC if the current professional thinks they lack the necessary knowledge to do so. As for the related staff providing GAC, 7 of the 9 gender-diverse individuals in peripheral regions who experienced some form of discomfort while accessing GAC mentioned knowledge of GAC as a training priority for them as well. Among these individuals, 3 specifically mentioned this for pharmacists. Here, Mangue goes on to explain why this training objective for pharmacists is important to ensure that hormone therapy is taken safely:

> I'd also mention the pharmacist who wasn't able to properly show me how inject myself. I don't know, that's definitely not something out-there, especially since he didn't give us any other resources and didn't talk to other people to show us how to do it correctly. […] If I do it too close to my belly button, I don't know what might happen, but I can't imagine injecting myself all wrong. It seems dangerous to me, doesn't it? [literal translation] (Mangue)

Mangue explains why it could be dangerous to the health of a person whose GAC involves hormone therapy via injection if they are not properly informed by their pharmacist. He also highlights how the lack of resources and staff with basic knowledge of GAC within their field of expertise prevents a TNBQ person from having alternative ways to access information in this situation.

All GAC providers from peripheral regions who were interviewed reported that they had received no training on GAC as part of their professional education, excluding residency training. Two methods of training in general knowledge of GAC were mentioned: 5 providers mentioned the ECHO training program at the Sainte-Justine hospital, and 4 providers mentioned that they had learned through support/ mentoring from colleagues. Five out of 8 providers also mentioned that understanding GAC in general is a training objective for all GAC providers and related staff. Half

of the providers interviewed also acknowledged the need to ask questions and seek clarification if something related to GAC is not understood. Regarding training itself, 3 of the providers mentioned the need to train GAC providers and their supporting staff while taking into consideration their existing level of knowledge on the subject—whatever that may be—and without judgment. In the following quote, Rose explains why broadening knowledge of GAC among all types of healthcare providers is important to improve access to care.

> The goal is for everyone to be trained to do this and then for everyone to do it correctly. Right now, that's not the case. Also, I think that to improve access to care, what's needed is for each department to train people who will make care accessible, so that it's easier to get hormones or referrals. (Rose, GAC provider practicing in a peripheral region)

During the interviews with the providers, they were asked to specify whether they had any training needs specifically for themselves. Since the participating providers already provide access to GAC, it is of interest to the project to better understand the training needs of providers in peripheral areas who are already equipped with knowledge regarding GAC. In this regard, two of the providers expressed a desire for more in-depth training on all forms of GAC to better understand all available options, their current availability, and gender-affirming products that could be useful for their patients. Finally, 4 GAC providers in peripheral regions expressed a desire to have access to a clinical guide on GAC in a Québecois context to provide guidance on various aspects. For example, how to initiate certain types of GAC with patients, the different types of gender-affirming surgeries and their procedures, or how to conduct pre- and post-operative follow-ups for GAC surgeries. Mastering knowledge of GAC therefore appears to be a key training objective to enable GAC providers to better support TNBQ individuals in meeting their medical needs.

4.2.2 Prescribing HRT[5]

Four gender-diverse individuals from peripheral regions who experienced various forms of discomfort while accessing GAC expressed the need for care providers to receive more training in prescribing HRT. They also mentioned that family doctors or general practitioners should be the primary recipients of this training. In the following quote, Patrice shares their opinion on a way to reduce the wait time to receive HRT:

> If you cut that wait time, you take some of the workload off endocrinologists who don't just treat trans people. There are plenty of people with complex cases who need to see them. But then you're adding delays for them too, because they have to help trans people since family doctors aren't doing it. It's a bummer for everyone; it negatively impacts everyone. I understand that they, too, face obstacles, like a lack of time that prevents them from taking all the training they'd like, I get that. But if, over the next few years, the majority of doctors could receive training on how to prescribe hormone therapy, I think we'd see things change pretty quickly. [literal translation] (Patrice)

As mentioned earlier in the previous section, half of the GAC providers in peripheral regions want a guide on GAC in a Québecois context to be written and distributed to all GAC providers and

[5] Hormone replacement therapy.

their supporting staff. These 4 providers also expressed a desire for a section specifically dedicated to prescribing HRT and monitoring its use, with the aim of facilitating the work of providers who wish to offer this type of GAC. Expertise in prescribing HRT therefore appears to be a key training objective to enable healthcare providers to directly offer this type of GAC to TNBQ individuals.

4.2.3 Mutual Support Among Providers

In interviews with GAC providers in peripheral regions, half of them mentioned the importance of creating networks for professional contact and mutual support among GAC providers. According to them, this would, among other things, help alleviate the sense of isolation they experience in their GAC practice and further the feeling of legitimization in the provision of these services. In addition, 5 out of 8 providers recommend, whenever possible, working as a team with other GAC providers when they feel the need for an outside opinion, and with support staff to assist with these tasks. The Sainte-Justine hospital's ECHO program, mentioned earlier, was also identified as an example of mutual support among providers, with 5 of the interviewed providers stating that they had benefited from the training and telementoring offered by this program. In the interview with Maxime, they took the time to address providers who do not yet provide access to GAC services.

> As soon as you have someone in front of you who tells you they're questioning their gender, start with an initial consultation, gather information, try to clarify their needs, and then reach out for support. There are plenty of us. All of us doctors who provide gender-affirming care are ready to support people who want to get involved, who want to give it a try, or who want to improve their skills. Surround yourself with communities of practice, ask us your questions, and we'll support you. There are plenty of people who'll be willing to see your patient once to conduct an assessment and make a set of recommendations, or to coach you so you can prescribe hormones yourself and do a good job. [literal translation] (Maxime, GAC provider in a peripheral region)

In this quote, Maxime emphasizes the importance of mutual support among GAC providers. They points out that these providers are prepared to assist those who wish to begin prescribing GAC and that reaching out to them would be an accessible and effective starting point. Promoting mutual support among GAC providers therefore appears to be an effective and useful recommendation within the context of GAC training.

4.2.4 Sexual Health

Of the 8 GAC providers from peripheral region, 5 identified knowledge related to the sexual health of TNBQ individuals as a training priority for all providers. For some, this also includes knowledge related to sexual violence. During interviews with GAC providers in peripheral regions, they were asked if they had any specific training needs for themselves. In response to this question, two of the providers mentioned that they would like more training for themselves on the sexual health of TNBQ individuals. In the following quote, Camille explains why this training objective is relevant to them.

> I think we don't know much about this, and I'm not sure how to help them develop a healthy relationship with sexuality throughout this whole process, which is quite complex. [literal translation] (Camille, GAC provider in a peripheral region)

Camille highlights the need for training in sexual health and how this could help her in her work with her TNBQ clients, given that they are already a professional providing access to GAC. Given that there are already GAC providers in Québec, it is important to focus on the areas that warrant further exploration based on the needs identified by these providers. Acquiring knowledge about sexual health therefore appears to be another key training objective to enable all providers to better support TNBQ patients.

4.3 Providing high-quality GAC

Among gender-diverse individuals in peripheral regions who had experienced various forms of discomfort while accessing GAC, as well as in focus group interviews with gender-diverse individuals in Québec grouped according to a shared GAC procedure, the perception that GAC was difficult to access or of poor quality in the peripheral regions throughout Québec was strongly emphasized during the interviews. Certain training objectives to address these issues were mentioned by participants: improving the informed consent process, providing accommodations in the delivery of care, and facilitating referrals to GAC providers.

4.3.1 Informed Consent

For 7 of the gender-diverse individuals in peripheral regions who experienced some form of discomfort while accessing GAC, improving (or even simply ensuring) informed consent emerged as a key training objective throughout the interviews. In the following quote, Mara explains why informed consent is important in the context of a medical decision, in this case, GAC.

> We're in the best position to know who we are and what we need. Be there to inform us so we can make an informed choice, but don't stop us from doing certain things for X reason—unless there are medical reasons. [literal translation] (Mara)

Mara takes the time to emphasize the importance of self-determination in the transition process and how informed consent should be a tool to facilitate it. During interviews with GAC providers in peripheral regions, 4 of the 8 people interviewed emphasized the importance of self-determination through informed consent within GAC as a training priority for all GAC providers. The topic of informed consent also came up in focus group interviews with gender-diverse individuals in Québec grouped according to a shared GAC. During the focus group interview on mastectomy and breast reduction, Patrice pointed out what they perceived as gaps in informed consent when they accessed their GAC surgery.

> I know this was a new policy when I had my surgery. They made me sign an "informed consent" form that said, "If I ask not to have everything removed—or if it's just a reduction—I'm signing to say that I won't be able to have a complete mastectomy later." " […] Usually, consent has to be free and informed to be legitimate. I didn't feel free at all to say something like "Yes." No, what you're asking me doesn't make any sense. […] I just thought, "Fuck off, I'm going to ask them to remove everything because they made me

> sign that thing." But I felt pressured. I don't know if, in the end, I would have decided to have everything removed because I didn't give myself a chance to consider that option. [literal translation] (Patrice)

During interviews with gender-diverse individuals from peripheral regions who had experienced discomfort while accessing GAC, four of them highlighted a need for improvement in the accuracy and clarity of the GAC procedure. Two individuals specifically mentioned the need for targeted training for GrS GAC surgeons, particularly regarding postoperative care and follow-up. In the following excerpt, Orion explains how important it is for them to have information about recovery and potential complications from a procedure:

> "It's clear that not being informed—not knowing that my wounds could have opened up, in extreme cases—I feel that's a lack of information, and it caused me harm." [literal translation] (Orion)

Through their personal experience, Orion highlights the importance of receiving all information accurately and clearly to avoid unintended consequences following GAC.

Another component of improved informed consent mentioned by 5 of gender-diverse individuals from peripheral regions who experienced some form of discomfort while accessing GAC who were interviewed is taking patients' transition goals into account. Two of these individuals specifically pointed this training objective towards family doctors and general practitioners. Similarly, among GAC providers in peripheral regions, 5 out of 8 recommended working as a team with TNBQ patients. The implementation and improvement of informed consent practices within GAC therefore appear to be a central training objective for providing high-quality GAC.

4.3.2 Accommodations in Healthcare Administration

Three gender-diverse individuals from peripheral regions who had experienced discomfort while accessing GAC mentioned that adapting delivery of care should be a training objective for GAC providers. They noted that such adaptation must be tailored to the physiological, psychological, social, and/or geographic specificities of the patient population. In the following excerpt, Matt emphasizes the importance of adapting how GAC providers deliver care to prevent experiences of discomfort:

> Also, I was told that "If you tell [the surgeon] you don't use your anatomy in your sexuality, he can skip the preoperative pap test and just do a pelvic ultrasound. He'll look at what he needs to look at while you're asleep on the operating table," which really suited me. [literal translation] (Matt)

Matt presents a real-life example in which a GAC provider adapts their care procedure in certain cases, which in this instance resulted in an accommodation that was preferable for Matt. Of 3 gender-diverse individuals from peripheral regions who experienced various forms of discomfort while accessing GAC, 2 identified nurses as a group that could greatly benefit from this training. In the following excerpt, Mangue highlights some of the positive effects of accommodations made by a nurse within the context of GAC:

> Even when I needed to have blood drawn or I needed to get or my testosterone shots, the nurse would come to my workplace to administer them. I'm really, really lucky in that regard. [literal translation] (Mangue)

In Mangue's experience, adapting the care setting seems to be greatly appreciated and helpful to them. This type of adaptation appears to be a factor that improves the quality of the GAC received. Accommodations in the administration of care within GAC therefore seem to be a training focus that enables GAC providers to provide high-quality GAC.

4.3.3 Referrals in GAC

Another training objective aimed at improving the quality of GAC is to facilitate referrals to GAC providers. Among gender-diverse individuals in peripheral regions who have experienced discomfort while accessing GAC, 6 of them highlighted this need. For 3 of these individuals, this training objective would be most beneficial for family doctors and general practitioners who may not be sufficiently informed or equipped regarding GAC. In the following excerpt, Matt explains how, in their view, the referral process depends on the training and willingness of family doctors:

> That said, yeah, of course, if doctors could be a little more informed about trans health, I wouldn't say no—but just the fact that they know who to refer you to is already a big deal because… It's a problem. […] It's not normal that I have to convince a walk-in doctor to sign a fucking referral so I can see the specialist who'll actually be able to help me. I mean, come on—I'm not asking you to prescribe testosterone for me; I'm asking for a referral to see the endocrinologist who might be willing to prescribe it for me. It's complicated… [literal translation] (Matt)

Drawing on their own experience, Matt highlights the difficulty of obtaining referrals from family physicians for GAC. Facilitating referrals appears to be a simple and effective way to improve the quality of GAC. Facilitating referrals to GAC providers when requested or necessary therefore seems to be a key training objective to deliver high-quality GAC.

1. Discussion

The pooling of research findings as part of the AJUSTER community-based research project has identified training objectives and recommendations for GAC providers and related staff to address existing challenges and improve the quality of this type of care. The findings include some that are quite innovative and others that align with recommendations in the literature. The 5 main training priorities that emerged are (1) normalizing TNBQ patients, (2) the need for empathy and active listening in medical care, (3) mastery of basic information regarding GAC, (4) reemphasizing the importance of informed consent, and (5) raising awareness about misgendering and deadnaming.

4.1 Normalisation of a TNBQ Patient Population

The primary training objective is to normalize trans identity among GAC providers and related staff. For all gender diverse individuals from peripheral regions who experienced some form of discomfort while accessing GAC that were interviewed, respecting the identity and dignity of TNBQ individuals is a fundamental need and a basic standard (UETMISSS, 2022). The importance

of raising awareness among practitioners who do not believe in the existence or validity of trans and non-binary people—as highlighted by interviewed GAC providers from peripheral regions — aligns with the 2022 recommendations of UETMISSS. Given that, according to a 2022 SAVIE-LGBTQ study, 73% of non-binary people reported that healthcare providers had assumed they identified with a different gender identity, it seems essential to promote the normalization of trans identity and its presence among patients in Québec's healthcare system. Respectful recognition of the existence of TNBQ people could, on the one hand, improve the quality of care, but also restore confidence in some individuals to seek care in healthcare settings, where 53% of TNBQ participants in the TransPulse study felt somewhat or not at all comfortable discussing TNBQ health needs with their primary care provider (2021).

4.2 // The Need for Empathy and Active Listening in Medical Care

The second primary training objective is to promote empathetic medical care grounded in active listening. This need was mentioned by nearly all gender-diverse individuals from peripheral regions who experienced some form of discomfort while accessing GAC, as well as by two participants in the focus group interviews with gender-diverse individuals in Québec grouped according to a shared GAC. These professional skills and interpersonal competencies appear to be essential in the care of TNBQ individuals seeking access to GAC . However, in an article by Côté examining compassion fatigue in a capitalist and patriarchal society such as Québec's, she identifies a potential obstacle to the feasibility of this recommendation. The author argues that the current medical context forces healthcare providers to choose between efficiency and providing compassionate care to their patients (2023). The quality of care—and thus of GAC—is compromised as a result, since healthcare providers are forced to maintain a work pace that can lead to burnout, reinforcing a cycle that distances them from empathetic care and active listening (Côté, 2023).

4.3 Basic Information About GAC

The third most common training objective is to ensure a solid grasp of the fundamental knowledge in GAC. This training objective is cited by nearly all gender-diverse individuals from peripheral regions who have experienced some form of discomfort while accessing GAC. Clinical guidelines covering GAC developed in British Columbia and Ontario—which are considered excellent resources (Weisdorf et al., 2023)—serve as training tools to achieve this objective, while highlighting the need expressed by 4 of the GAC providers from peripheral regions who were interviewed; they emphasized the need for this type of clinical guideline, but in a Québecois context.

Regarding the finding that all GAC providers in peripheral regions reported having received no training on GAC as part of their professional or academic education—excluding residency training—our objective aligns with a WPATH recommendation:

> [Institutions] involved in the training of health care providers should develop competencies and learning objectives for the health of transgender and gender-diverse people within each area of expertise in their specialty. (Coleman et al., 2022)

In the same vein, the UETMISSS notes a need to deepen knowledge of GAC, particularly among primary care physicians (2022).

4.4 Restoring the Importance of Informed Consent

The fourth primary training objective is to ensure that informed consent is obtained in the context of GAC, including all of its essential elements. A majority (7) of gender-diverse individuals from peripheral regions who experienced some form of discomfort while accessing GAC cited various experiences and opinions to help document and improve the practice of informed consent within GAC. As several authors have argued, participants highlighted a need to improve the informed consent process, and for some, simply to ensure that it is in place (Puckett et al., 2022; Mayer et al., 2023; MacKinnon et al., 2021; Ashley 2020). It is important that informed consent for GAC follow a trans-affirmative approach by including and empowering TNBQ individuals (Puckett et al., 2022; Mayer et al., 2023; Pullen Sansfaçon et al., 2021). The training objective echoes criticisms regarding the informed consent capabilities of surgeons in GAC, where they are reportedly ill-equipped to convey useful information to TNBQ individuals (Ashley, 2020). In the studies by MacKinnon (et al., 2021) and Gerritse (et al., 2023), TNBQ individuals receiving GAC also emphasize the importance of being adequately informed, having transparent discussions, and participating in decisions affecting their bodies, which fosters a relationship of trust and honesty with the GAC provider. This training objective also aligns with the findings of Gerritse and colleagues, in which TNBQ participants identified three elements necessary for informed consent: the patient should lead the decision-making process; the decision-making process should strive as much as possible to prevent harm or adverse effects to the patient; and each decision-making process must be tailored to each individual patient (2023).

4.5 Raising Awareness About Misgendering and Deadnaming

The fifth primary training objective is to raise awareness of and address situations involving misgendering and deadnaming. This applies both to gender-diverse individuals in peripheral regions who experienced various forms of discomfort while accessing GAC—as reported in the interviews—and to the focus group interviews with gender-diverse individuals in Québec grouped according to shared GAC; a significant majority have experienced misgendering and deadnaming, just like the participants in the mixed-methods study by Justice Trans, “2STNBNCG Perspectives on Access to Justice” (2022). The UETMISSS aligns with this training objective, recommending that staff members be educated to prevent instances of misgendering (2022).

4.6 Methodological Limitations

Although the study uses a mixed-methods design—in this case, drawing on three methods from the AJUSTER research project—the sample sizes are small: 9 individuals, 8 providers, and 19

individuals, respectively. Since the samples have not reached saturation, they cannot fully reflect the experiences of all other affected individuals. Another limitation is the small number of participants who strictly identify as trans women. Despite our efforts to contact various types of groups, including trans women, and the extension of our recruitment periods, we must not overlook this population's loss of trust in previous research as well as their fatigue with participating in research projects (Bauer et al., 2019). To the best of our knowledge, the current literature does not allow us to determine with certainty the sociodemographic proportion of TNBQ individuals in Québec who have had access to GAC, nor the number of providers in Québec providing access to GAC services. It is therefore difficult to determine an appropriate sample size for each group to achieve saturation. However, some GAC providers interviewed confirmed that, to their knowledge, they were one of the few—or the only—professional·s in their entire region providing access to GAC.

2. Conclusion

The main objective of the AJUSTER community-based research project is to generate knowledge about access to GAC in Québec, as well as to highlight existing issues regarding the quality of that care. The purpose of this article is to propose training objectives and recommendations for GAC providers and related staff, identified using 3 of the AJUSTER project's research methods: (1) semi-structured interviews with 8 GAC providers practicing in peripheral regions, (2) semi-structured interviews with 9 gender-diverse individuals who live in peripheral regions who experienced discomfort while accessing or attempting to access GAC, and (3) semi-structured interviews conducted in 4 focus groups—each centered on specific GAC—involving a total of 19 gender-diverse participants. The results of this mixed-methods design enable the identification of training objectives aimed at addressing systemic barriers to access GAC as well as improving the quality of GAC in Québec. The 5 predominant training objectives, consistent with the literature, are (1) the normalization of trans identity, (2) the need for empathy and active listening in GAC (3) mastery of basic information regarding GAC, (4) reemphasizing the importance of informed consent, and (5) raising awareness about misgendering and deadnaming.

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Femmes et Égalité des genres Canada
Women and Gender Equality Canada

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