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SYSTEMATIC REVIEW **Open Access**

Analysing the scientific literature on transgender and gender diverse persons' experiences with sexual and reproductive health care services from an intersectional perspective

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Abstract

Transgender and gender diverse (TGD) persons face considerable challenges accessing sexual and reproductive health care (SRHC), often resulting in poor health outcomes when compared to cisgender persons. Aetiological research predominantly explains these health disparities through a single axis explanation reducing them to factors related to gender identity. Yet, a one-dimensional representation of TGD persons fails to recognize the multiple experiences of systemic oppression that may contribute to poor sexual and reproductive health (SRH) experiences and outcomes. This scoping review was conducted to locate, analyse and synthesise contemporary scientific research exploring TGD persons' experiences with SRHC services, from an intersectional perspective. Searches were conducted in PsycINFO, APA Psychinfo, Ovid MEDLINE®, SCOPUS, and CINAHL. Studies were included if they were in English, conducted in OECD countries, published between 2012 to 2022 in peer-reviewed journals, based upon empirical research, involving human participants and presenting disaggregated data for TGD populations. To be included, studies also had to contain TGD individuals who had accessed SRHC services and data that pertained to forms of oppression, disadvantage, social determinants of health or aspects of identity that intersected with their gender identities. 1290 records were identified and entered into Endnote software X9, with 413 removed before screening. A total of 877 records were screened by the author and a research assistant independently who examined titles and abstracts and selected 27 for in-depth analysis. Included studies were uploaded to NVivo 12 and subjected to in-depth review, coding, and synthesis using descriptive statistics and thematic analysis. The review found that efforts to understand TGD persons' experiences of multiple marginalisation in SRHC settings are hampered by methodological challenges relating to adopted sampling techniques, measures used, the use of small and non-representative samples, and geographic location. The review found multiple intersecting systems of oppression including cissexism, heterosexism, racism, classism, geographical disadvantage and ageism, that challenged TGD persons' access to quality care within SRHC settings. Best practices were identified including affirming, person-centred care, collaboration, trauma-informed care and leveraging informal support networks, which provide hope for improved service provision and design.

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Introduction

Transgender and gender diverse (TGD) persons face considerable challenges accessing sexual and reproductive health care (SRHC) [1], often resulting in poor health outcomes when compared to cisgender persons [2] (see Table 1 for definitions of terms). Aetiological research predominantly explains these health disparities through a single axis explanation reducing them to factors related to gender identity [3, 4]. Yet, a one-dimensional representation of TGD persons fails to recognize the multiple experiences of systemic oppression that may contribute to poor SRHC experiences and outcomes. Limited attention has been paid to considerations of how interlocking systems of oppression may intersect with stigmatization associated with one's gender identity within a cis-normative and heteronormative SRHC system [4]. Agenor et al.'s [5] comprehensive scoping review of the scientific literature on reproductive health among TGD people identified this gap in the literature and argued that future research in this area must be guided by an intersectional perspective. This paper contributes to efforts to address this gap to develop more inclusive SRHC systems.

It is prudent to firstly define key concepts used within the context of this article. SRH is conceptualized as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes" [11](p.1). Moreover, Spielberg [12] argues that SRH encompasses a quality and safe sex life, the opportunity to reproduce, and the autonomy to decide if, when, and how to pursue reproduction.

Intersectionality provides a theoretical framework for analysing and understanding the multidimensional, interconnected, and complex nature of oppression. Originating within women of color resistance movements during the nineteenth and twentieth centuries, including Black and Indigenous theory and practice challenging exclusion from white feminism [13–15], and first coined by Crenshaw [16], intersectionality prosecutes the argument that the social categories of race and gender multiply marginalize people. Scholars and researchers from various disciplines including gender studies, health and social sciences have subsequently adopted intersectionality to recognise that social oppression, discrimination, and marginalization do not occur in a vacuum but rather in the context of interdependent power relations that originate and are reinforced in past and present systems of oppression. Positioned within multiple marginalised social locations, individuals can be constrained by mutually constituted and intersecting systems of oppression, including but not limited to cisgenderism, heteronormativity, white supremacy and colonialism [4, 9].

Intersectionality facilitates a nuanced analysis of how multi-dimensional systems of oppression may intersect to exacerbate challenges experienced by TGD people within the context of the SRHC system. Wesp et al [4] argue that adopting an intersectional approach to researching TGD persons' experiences within health care systems should attend to examining discourses and other practices that (re)produce, (re)enforce and internalize gender norms. Adopting an intersectional approach, can lead to a more nuanced understanding of the complexity of people's lived experiences as they are mediated within a complex and reinforcing "matrix of domination." [15].

This scoping review maps the scientific literature to consider what is known and not known about TGD persons' experiences with SRHC in OECD countries from an intersectional perspective. By mapping, analysing, and synthesising the scientific literature in relation to multiple interlocking forms of oppression, this paper argues for SRHC approaches that attend to diversity, recognise positionality and are responsive to TGD persons. Such approaches must consider how TGD persons' experiences with SRHC system are mediated through structural systems of oppression. By adopting an intersectional approach this study considered how multiple and

Table 1 Definitions of terms

Transgender and gender diverse persons– Transgender and gender diverse (TGD) persons was used in this study as an umbrella term for people whose gender identity or expression differs from the culturally-bound gender associated with the sex assigned to them at birth [6]. TGD was used because it best aligned with language in current literature, and with that used by key advisors in the field in the location the study was conducted (Such as [blinded for review]). However, the authors acknowledge the problematic nature of the term as it defines a person by one aspect of their being rather than acknowledging TGD identity as one of the many elements which make up who they are.

Cisgender persons – "A person whose gender identity is the same as their sex assigned at birth" [7].

Cisgenderism/Cissexism – "Cisgenderism refers to the cultural and systemic ideology that denies, denigrates, or pathologizes self-identified gender identities that do not align with assigned gender at birth as well as resulting behavior, expression, and community. This ideology endorses and perpetuates the belief that cisgender identities and expression are to be valued more than transgender identities and expression and creates an inherent system of associated power and privilege" ([8]p.63).

Cisnormativity – "The sociocultural assumptions and expectations that all people are cisgender and/or have a cisgender body" [3].

Heterosexism – "Sexual orientation-related bias, prejudice, and discrimination towards LGBQ and other sexual minority individuals" ([9]p.124).

Heteronormativity – "The presumption and privileging of heterosexuality" (Pollitt et al., 2021) ([10]p.1).

interlocking systems of oppression experienced by TGD individuals combine within the cis-normative SRHC system to result in TGD people suffering poorer health outcomes in comparison to their cisgender peers.

Method

Research Context

Author 1 was engaged by [government organisation blinded for review]'s statewide Women's Health Network to survey the scholarly landscape in relation to what is known about TGD persons' experiences with SRHC services from an intersectional perspective. The purpose of the review was to identify implementable practice change opportunities to enable the delivery of improved SRHC to TGD people in women's health services in [location blinded for review, Australia].

The research and the researchers were guided by an Advisory Group comprised of SRHC experts including TGD SRHC service users and TGD and cis-gendered SRHC policy makers, service managers, practitioners, and researchers. The researcher team was made up of researchers with diverse backgrounds, however, all researchers identify as cis-gender women. Author 1 is a cisgender social work professor teaching, researching and advocating from a critical, anti-oppressive framework concerned with ensuring socially just practice. Author 2 is a cisgender, biracial Asian and Middle Eastern woman. She is an early career academic who conducts social justice-focused research and has previously taught health profession students about diversity and cultural safety. Author 3 is a queer woman of Anglo-Saxon-heritage employed within a publicly funded health service. She has extensive experience in designing and delivering health services with an equity lens, including SRH programs for the LGBTIQ+community. Her work is underpinned by principles of social justice, person-centred, trauma-informed care, and the mandate of the Ottawa Charter (1986), 'health for all'.

Design

The research question guiding this inquiry was: What is known and not known in the scientific literature about the experiences of TGD persons when they access SRHC services from an intersectional perspective? A scoping review was chosen as an appropriate and rigorous type of evidence synthesis given the current study sought to: "inform the development of a systematic review, identify the types of available evidence in a given field, identify key concepts in the literature, examine how research is conducted on a topic, and report key characteristics or factors relating to a topic." [17] The nine-step JBI approach for scoping reviews [18] was used to guide this research. The protocol template from the JBI Manual for Evidence Synthesis [18] was used in the initial stage of the research (Stage one), although a scoping review protocol was not registered. Consultation with a social work and social sciences research librarian who played a vital role in defining the search strategy and relevant databases was undertaken in Stages One and Two. Discussions/consultations with the Advisory Group also occurred in Stage Two to refine key concepts and terms. In Stage Three, the research question was refined after consultations with the Advisory Group during Stage Two. The PCC format (*Population, Concept and Context*) was used to develop the research question and to refine concepts for investigation.

The eligibility criteria determined in Stages Four and Five is listed in Table 2. Studies were included if they were in English, OECD countries, published from 2012 to 2022 in peer-reviewed journals, based upon empirical research and included disaggregated data for TGD populations. To be included, studies also had to pertain to TGD individuals who had accessed SRHC services and data that pertained to multiply marginalising forms of oppression that intersected with their gender identities including sexuality, race, age, ability, socio-economic status and geographic location. In order to identify practice change opportunities relevant to TGD people accessing services delivered by the Women's Health Network, studies that focused primarily on HIV prevention were excluded. The Advisory Group recommended reducing the scope to exclude articles pertaining specifically to HIV prevention and treatment. The Advisory Group made this recommendation given that (anonymous agency) provides a range of publicly funded sexual health services that provide specifically tailored programs targeting HIV prevention and treatment that sit outside of the remit of the women's health network. Additionally, the review was restricted to comparable countries to Australia. OECD membership was deemed an acceptable point of determining comparability. Given the research question and aims, grey literature was also excluded, although the collection of grey literature is acceptable and appropriate practice for scoping reviews.

Data collection

In Stage Six, a multi-phased search for the evidence occurred. Initially, a preliminary search occurred in two databases to pilot the protocol. Searches were then conducted in PsycINFO, APA Psychinfo, Ovid MEDLINE®, SCOPUS, and CINAHL. The final search of the five databases occurred on 12/07/2022. A combination of controlled (Medical Subject Headings or MeSH terms) and unstructured terms were used to search the databases, which are evidenced in Appendix 1.

Table 2 Study inclusion and exclusion criteria (*N* = 27)

Inclusion Criteria	Exclusion Criteria
English Language	Non-English Language
Human Studies	Animal Studies
Published from 2012 to 2022	Published prior to 2012
Peer-reviewed journal articles	Non peer-reviewed journal articles
Empirical research study (quantitative or qualitative methodology)	Non-empirical research study (includes case reports, editorials, newspaper or other media article, literature or systematic review, report, committee opinions, clinical guidelines, letters to the editor)
Study pertains to one or more of the following services: sexual health, reproductive health, contraception, family planning, abortion, reproduction, STDs, cervical cancer prevention, IVF, perinatal care, postnatal care, fertility	Study does not pertain to sexual or reproductive health services. Study primarily pertains to HIV prevention
Study disaggregates data for transgender and gender diverse individuals	Study does not disaggregate data for transgender and gender diverse individuals
Study pertains to transgender and gender diverse individuals sexual and reproductive health experiences, preferences, perspectives, concerns, needs or priorities	Study does not pertain to transgender and gender diverse individuals sexual and reproductive health experiences, preferences, perspectives, concerns, needs or priorities
Study pertains to forms of oppression, disadvantage, social determinants of health, aspects of identity that intersect with an individual's identity as transgender or gender diverse	Study does not pertain to forms of oppression, disadvantage, social determinants of health, aspects of identity that intersect with an individual's identity as transgender or gender diverse
Research conducted in OECD country	Research not conducted in OECD country

All identified records were imported into an EndNote® X9 [19] library. Duplicate records were removed in EndNote® X9 then exported to a Microsoft® Excel® [20] spreadsheet, where they were screened by two researchers who independently examined titles and abstracts. The screening of titles/abstracts is an accepted practice in the first stage of the screening process. The reviewers met regularly to compare their screening decisions. A third reviewer was available to resolve conflicts but was not needed as differences in perspective between the two reviewers were openly discussed and agreement was reached through dialogue. A two-part data extraction form was developed that drew upon the work of Agenor et al's [5] scoping review of reproductive health among TGD people. Specifically, an adapted version of the researchers' template for the collection of data about the study characteristics (part one) and sample characteristics (part two) was used. A Microsoft® Excel® spreadsheet was used to synthesize data collected from the data extraction forms and results were synthesized into tables and charts, which are in the Results section of this paper.

Data analysis

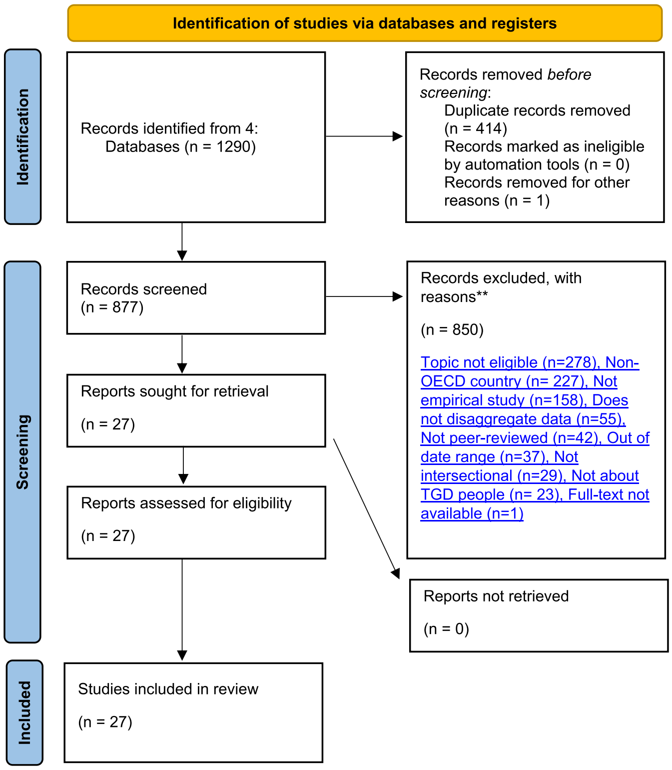
Descriptive statistical analysis was used to analyse the data collected from the two-part data extraction tool. Braun and Clarke's [21] six-phase process for thematic analysis was used to analyse the qualitative data collected. This included familiarisation with the data; actively reading and rereading the data; discovering themes; reviewing themes; defining and naming themes; and reporting the findings. This process drew upon a hybridized approach using both inductive and deductive methods. Inductively, NVivo12 [22] was used to help code the manuscripts line by line according to themes identified from the 'bottom-up'. In this initial phase, all manuscripts were read, reread and coded independently by two researchers. Later, the researchers compared and discussed their initial codes and synthesized them. In the next stage, these codes were used in a more deductive or 'top down' approach to code key concepts and sub-concepts. Specifically, the researchers compared initial codes and synthesized the data into overarching themes or 'parent nodes' and sub-themes or 'child nodes'. This process resulted in the development of twelve parent nodes and 20 child nodes. Most relevantly for this article are the data sets analysed within the following three nodes: 1) 'intersecting forms of oppression/marginalization', 2) 'barriers to quality SRHC', and 3) 'facilitators to quality SRHC.' The data sets were then reviewed and refined for reporting with reference to Wesp et al.'s [4] conceptual framework.

Ethical considerations

Given the nature of this scoping review, which relied upon the analysis of publicly available data, no ethical approval was required for this research.

Results

A total of 1290 records were initially identified, with 414 duplicates removed in EndNote X9 before screening. The remaining 877 records were screened and 850 were



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

Fig. 1 PRISMA 2020 flow diagram for new systematic reviews which included searches of databases and registers only

excluded for not meeting the inclusion criteria A total of 27 articles matched the inclusion criteria and were included for full text review and in-depth analysis (see appendix 2). The PRISMA flowchart contained in Fig. 1 summarises this data diagrammatically. The results are reported in two sections: the first reports findings of the analysis of data extracted from the data extraction tool and the second from the thematic analysis of qualitative data coded on NVivo™12 [22].

Data extraction findings

The study characteristics of included studies are contained in Table 3. They were published between 2014 and 2022 with most (n=16, 59.2%) articles published between 2016 and 2019. Just over half of the studies were conducted in North America (n=14, 51.8%) including in Canada (n=7, 25.9%) and the United States (n=7, 25.9%).The other half were conducted in Australia (n=5, 18.5%), Sweden (n=5, 18.5%), United Kingdom (n=2, 7.4%) and Greece (n=1, 3.64%). All studies employed an observational design and the majority used convenience/purposive sampling techniques. Most studies used qualitative methods (n=19, 70.4%) followed by those that used a quantitative (n=6, 22.2%), mixed methods (n=2, 7.4%) or participatory design (n=1, 3.7%).

Sample characteristics are largely reported at a study-level and summarised in Table 4. Most samples (n=20, 74.1%) included data collected from TGD participants, two (7.4%) only included data collected from HCPs and five included data collected from both TGD persons and HCPS (18.5%). Most studies contained small sample sizes of between 1 and 24 participants (n=12, 44.4%), though eight (29.6%) studies contained samples of over 125 participants. Most samples (n=13, 48.1%) included both people assigned female at birth (AFAB) and assigned male at birth (AMAB) whilst almost a quarter (n=6, 22.2%) of samples pertained only to people AFAB and none pertaining only to people AMAB. Most samples (n=20, 74.1%) included both transgender and gender diverse people, with six (21.4%) pertaining only to transgender people and one (3.7%) including gender diverse but not transgender people.

There was significant variation in whether and how studies reported demographic information of their

Table 3 Study characteristics of included articles ($N=27$)

Characteristic	*n*	%
Publication Year		
2014	2	7.4
2016	3	11.1
2017	4	14.8
2018	4	14.8
2019	5	18.5
2020	2	7.4
2021	5	18.5
2022	2	7.4
Country		
Australia	5	18.5
Canada	7	25.9
Greece	1	3.7
Sweden	5	18.5
United Kingdom	2	7.4
USA	7	25.9
Study design		
Observational	27	100
Methodology[a]		
Qualitative	19	70.4
Quantitative	6	22.2
Mixed Methods	2	7.4
Participatory	1	3.7
Methods[a]		
Chart review	1	3.7
Cross-sectional survey	3	11.1
Survey	2	7.4
Semi-structured in-depth interviews	16	59.2
Focus groups	2	7.4
Retrospective cohort analysis	1	3.7
Discourse analysis	1	3.7
Administrative data analysis	1	3.7
Binary logistic regressions	1	3.7
Sampling[a]		
Convenience/purposive	26	96.2
Snowball sampling	4	14.8

[a] Categories are not mutually exclusive hence the percentages do not add up to 100%

Table 4 Sample characteristics of included studies

Characteristic	*n*	%
Sample group		
TGD peoples	20	74.1
HCPs	2	7.4
Both	5	18.5
Sample size[a]		
1–24	12	44.4
25- 49	3	11.1
50–74	4	14.8
75–99	0	0
100–124	0	0
> 125	8	29.6
Sex assigned at birth		
Assigned female at birth (AFAB) only	6	22.2
Assigned male at birth (AMAB) only	0	0
Both AFAB and AMAB	14	51.9
Not recorded	7	5.9
Gender identity		
Transgender only	5	18.5
Gender diverse only	1	3.7
Both transgender and gender diverse	19	70.3
Aggregated		
Disaggregated		
Not recorded	3	11.1
Sexual orientation		
Queer	12	44.4
Lesbian	11	40.7
Gay	12	44.4
Bisexual	8	29.6
Pansexual	10	37
Other non-monosexual identities	9	33.3
Heterosexual/straight	9	33.3
Not recorded	13	48
Race/Ethnicity		
White (% participants)		
< 49	5	18.5
50–74	7	25.9
75–100	3	11.1
Not recorded	12	44.4
Racial/ethnic minorities recorded		
Indigenous/Aboriginal/First Nations	11	40.7
Black/African/Caribbean	7	25.9
Latinx/Hispanic	6	22.2
Other racial/ethnic minorities	11	40.7
Age		
Adolescents (< 18) only	0	0
Young adults (18–29) only	2	7.4
Both adolescents and young adults	1	3.7
Older adults (29 +) only	1	3.7
Both young adults and older adults	12	44.4

sample in relation to sexual orientation, racial/ethnic/cultural background, age, educational attainment, income, employment status, residential location, and disability. Sexual orientation was only reported in about half ($n=14$, 51.9%) of the articles reviewed. Likewise, only about half specified their sample's racial/ethnic ($n=15$, 55.6%) composition and only 5 (18.5%) had samples that were comprised mostly of people from non-White backgrounds. Most studies had samples comprised of only adults ($n=15$, 55.5%) and no studies contained only

Table 4 (continued)

Characteristic	*n*	%
All age groups (< 18–25 +)	6	22
Not recorded	5	18.5
Educational attainment		
Some college/university or more (% participants)		
< 25	1	3.7
25–49	0	0
50–74	3	11.1
75–100	8	29.6
Not recorded	15	55.5
Socio-economic indicators		
Employed % (participants)		
< 25	0	0
25–49	0	0
50–74	3	11.1
75–100	7	25.9
Not recorded	17	62.9
Income or financial status/strain	7	25.9
Private health insurance status	2	7.4
Home ownership status	1	3.7
Homelessness status	1	3.7
No socio-economic indicators recorded	8	29.6
Geographic location		
Urban	5	18.5
Rural/remote	3	11.1
Both	12	44.4
Not recorded	8	29.6
Disability		
Recorded	3	11.1
Not recorded	24	88.9

Sample characteristics are provided at a study-level rather than participant-level in most instances unless indicated with (% participants). The lack of uniformity by which participant demographics were collected and recorded, as well as the inclusion of studies with only HCP participants meant it was not always possible to provide accurate or meaningful data summarising participant composition across demographic categories. Additionally, percentages may not add to 100% due to rounding error

[a] Refers to the entire sample of the study, not number of TGD participants only. Samples included other types of participants such as SRHC services, HCPs or community leaders

participants who were adolescents aged under 18 years old. The majority of studies did not record their sample's employment status ($n = 17$, 62.9%) or educational composition ($n = 15$, 55.5%) but those that did had samples that consisted of mostly employed ($n = 10$, 37%) and tertiary educated ($n = 11$, 40.7%) participants. Most studies were conducted in both urban and regional/remote locations ($n = 12$, 44.4%). Disability was only recorded in three (11.1%) studies.

Table 5 Sexual and reproductive health topic of included articles ($N = 27$)

Topic	*n*	%
Contraception	7	25.9%
STIs and HIV	7	25.9%
Sexual health care experiences (general)	7	25.9%
Sexual and reproductive health care experiences (general)	4	14.8%
Cervical cancer prevention/screening	2	7.4%
Fertility	2	7.4%
Pregnancy	2	7.4%
Birth	2	7.4%
Lactation and chestfeeding	2	7.4%
Perinatal care	2	7.4%
Abortion care	1	3.7%

Categories are not mutually exclusive hence the percentages do not add up to 100%

Additionally, we found that the articles included in the review addressed a variety of sexual and reproductive health topics, the most frequent being contraception ($n = 7$, 25.9%), STIs and HIV ($n = 7$, 25.9%), and sexual health care experiences generally ($n = 7$, 25.9%), as summarised in Table 5.

Thematic data analysis findings

The results of the thematic data analysis are presented in two parts: 1) Barriers to quality SRHC – multiple and intersecting systems of oppression 2) Facilitators of affirming, quality SRHC and best practices. Themes identified are summarised in Table 6.

1) Barriers to quality SRHC—Multiple and intersecting systems of oppression Many studies, particularly those utilising qualitative methodologies, highlighted how multiple and interlocking systems of oppression combined to contribute to poor SRHC experiences and outcomes for TGD persons. The most widely discussed systems of oppression included: cissexism, heterosexism, racism, classism, geographical disadvantage and ageism.

Table 6 Themes

Multiple and intersecting systems of oppression in SRHC (barriers)	*Best practices for safe and affirming SRHC (facilitators)*
Cissexism	**Person-centred care**
Heterosexism	**Collaboration**
Racism	**Trauma-informed practice**
Classism	**Informal support networks**
Ageism	

Cissexism

Gender identity-related stigma and discrimination within the SRHC system is a leading explanation for the health disparities that exist between TGD and cisgender people [23]. Most studies found that gender-identity related stigma and discrimination negatively impacted on TGD persons' access to and experiences with the SRHC.. A quantitative study found a significant association between recognizability as TGD and experiencing discrimination [24]. Healthcare providers (HCPs) were described as routinely stigmatising TGD patients through engaging in cissexist practices ranging from subtle comments and gestures to more overt displays of gender-identity related discrimination. Instances of cissexist practices of HCPs included misgendering individuals, making assumptions about TGD people and their body parts and even refusing to treat TGD people due to their so called 'moral values' [25]. For example, a TGD individual in Agenor et al.'s[9p.125] study noted: "She would misgender me every time I went in for surgery stuff or like check-up stuff. And I never felt comfortable correcting her because I was always half naked with my foot in the stirrups.", highlighting how experiences of cissexism can exacerbate vulnerability for TGD people given the sensitive nature of SRHC.

Many studies reported on how the deleterious impacts of cissexism reduce the overall wellbeing of TGD people, heighten feelings of fear and apprehension towards HCPs and may lead to avoiding and delaying SRHC. Fears and prior traumatic experiences of cissexism was reported as a barrier to accessing important preventive health services including but not limited to undertaking routine check-ups and disease screening, obtaining prescriptions for contraception and attending consultations about safe sex practices. A TGD individual in MacDonald et al.'s ([26]p.15) study, for example, reported avoiding visiting the emergency department "because of previous negative experiences … due to their transgender status", highlighting the magnitude of distrust held by some TGD people towards HCPs. A quantitative study of over 1600 TGD people in Australia [27] found that the vast majority had experienced cisgenderism and transphobia while accessing sexual healthcare, and that such experiences were associated with a lower likelihood of and less frequent HIV/STI testing. Several HCP participants in Forsberg & Eliason's ([28]p.363) study highlighted how a TGD person's previous traumatic experiences of cissexism in their personal lives and/or in health care settings could explain why they avoided discussions about pregnancy prevention. The studies demonstrate the impact of cissexism on the prevention, detection and treatment of SRH conditions for TGD people.

On a systemic level, cisnormativity contributes to a lack of clinical knowledge of HCPs pertaining to the unique needs of TGD peopleaccessing SRHC, including the provision of contraception and abortion care [29]. Parameshwaran et al.'s ([30]p.371) study was illustrative of this trend, revealing that "84.9% of the participating HCPs strongly disagreed that they had received LGBTQ specific health care training. Similarly, 68.1% were very unconfident knowing where to look to find information about LGBTQ specific health care, and 72.9% felt very unconfident deciding in which ward transgender patients should be nursed." In Heng et al.'s [31] study, clinicians reported feeling more confident and knowledgeable after formal education. Many articles suggest that this knowledge gap is a result of TGD medical information being largely absent from the medical education curricula at the University level leaving HCPs to gain experience through informal means such as personal experience or through their patients educating them. However, Hoffkling [32] argues this latter method is undesirable as it places a heavy burden upon TGD people and results in patients incurring extra time and resources when utilising the healthcare system.

Importantly, several studies found SRHC to be framed and/or labelled as 'women's healthcare' [9, 32, 33] and tied to notions of femaleness with the effect of marginalising, othering, erasing and excluding TGD persons, significantly transmasculine AFAB people. This was particularly the case in relation to obstetrics and gynaecological care where TGD people reported a lack of HCP knowledge of transgender health in reproductive health services resulting in HCP approaches to care that narrowly focus on sex assigned at birth rather than a person's gender identity [9, 32, 33]. Pregnancy was reported in these studies as being synonymous with femaleness and incompatible with masculine gender. As one transmasculine person put it: "They could not make sense of the concept at that time of being male and pregnant" ([32] p.11). As a result, HCPs are often underprepared to provide gender-affirming information and care related to aspects of reproductive health such as birth and lactation [33].

Heterosexism

In conjunction with cissexism, many articles illustrated how TGD people experienced heterosexism or sexual orientation-related stigmatisation when accessing SRHC. Heterosexism often manifested through HCPs making assumptions about TGD patients grounded in myths and stereotypes pertaining to TGD people's sexual orientations and practices. For example, in Flanders et al.'s ([34] p.107) study, a bisexual patient was profiled by their HCP as being a "vector for sexually transmitted infections and a conduit for unwanted pregnancy" due to the erroneous assumption that the patient engaged in group sex. Participants in other studies reported feeling that their sexual practices were 'exotified' [25, 32], by HCPs who asked voyeuristic questions. These experiences were perceived by some TGD persons as 'microaggressions' [33] or signs of disrespect or discrimination [35] that increased patient apprehension and avoidance, precluding the provision of relevant SRHC.

These studies drew attention to how cissexism and heterosexism intersect to multiply marginalize TGD people. HCPs were reported as making 'automatic assumptions' [36] regarding TGD persons' gender, sexual orientation and sexual practices, including "around body parts and preferences... which are just not true" ([37]p.375). These assumptions extended to the sexual partners of TGD people. Such assumptions hinder the ability of HCPs to deliver quality and patient-centred SRHC because they may unduly limit the provision of relevant information, treatment options or lead to significant oversights such as whether an individual could be at risk of falling pregnant or contracting a sexually transmitted infection.

Racism

Many of the articles [9, 27, 29, 37] reported that racism intersects with TGD persons' experiences of gender identity-related stigmatization to multiply marginalize them within the SRHC. Agenor et al., ([9]p.129) in the context of the United States, mapped the "long history of racism within medicine, including gynaecological and reproductive abuse and coercion targeting Black cisgender women and other AFAB individuals since slavery" and enduring to this day. Within this context, racism manifests itself in a range of forms including subjecting racially and gender diverse people to "medical experimentation, abuse, control and coercion resulting in TGD people's reproductive capacity, bodily autonomy, and self-determination being undermined." Similarly, studies conducted in colonised countries often drew attention to how SRHC behaviours and outcomes for Indigenous TGD persons were shaped by historical processes of colonisation and ongoing structures of colonialism [36–39]. For instance, in a study focusing on the experiences of Indigenous transgender Australians, racism was argued to be a distinct and unique fact of their lived experiences that intersected with experiences of cissexism to socially isolate them from both queer communities and wider Australian communities and in turn, exacerbate SRH disparities [37].

In some studies, TGD people reported experiences where HCPs' racist attitudes converged with assumptions about the sexual practices of TGD persons. For example, in Agenor et al.'s [9] study, black and Latina TGD people reported that their HCPs routinely hypersexualised them – making assumptions about their sexual practices, asking irrelevant questions that implied they were highly sexualised, drug users. Little awareness of the intersections between racism and cissexism among HCPs was evident throughout the studies, however in one study, an HCP participant explained that they would consider the person's race and ethnicity in addition to their gender identity when referring a TGD AFAB person to abortion care services "because I know that some of the facilities have better reputations with serving people of color than others" ([29]p.2687).

There was recognition of the need to further investigate the intersections between cissexism and racism for TGD people in SRHC in some studies (Aegenor et al., 2022) [9, 36, 38, 39]. For example, the predominance of white researchers and participants was acknowledged as "limiting our understanding of differences of experiences based on Indigenous and/or racialized identities" ([39] p.1874).

Classism

Many articles discussed the impact of poverty and socioeconomic disadvantage as an intersecting factor exacerbating poor SRH experiences and contributing to health disparities. This disparity is indicative of a broader pattern of TGD people experiencing economic marginalisation and discrimination across several facets of life including within educational settings and the workplac [39, 40].Classist stigmatization was also reported among TGD people, with one quantitative study finding a significant association between sex work and "street economies" such as drug sales and experiences of discrimination [24]. Manifestations of economic marginalization, including higher levels of poverty, unemployment and homelessness, are compounding factors that limit SRHC access and choice [9, 23, 34, 40]. In conjunction with this, affordability of SRHC for TGD people is greatly influenced by structural healthcare system factors such as national and state healthcare policies and laws to protect against gender identity-based discrimination in healthcare contexts.

Issues with health insurance coverage were commonly discussed including difficulties maintaining coverage, affording premiums or co-payments and gaps in coverage for SRHC treatments and procedures, though experiences varied by country. For example, in the USA where health insurance is not provided by the government, a TGD person explained, "It's hard to keep consistent insurance, for one. A lot of it is because it's hard to keep consistent employment and those are usually linked" ([29] p.2689). Difficulties accessing pap smears and contraception for transgender men assigned female at birth with a male gender marker on their insurance policy were also reported [29]. In Australia where the government provides universal health insurance, there are limited clinics that do not add an additional service fee, limiting choice in service and clinician for TGD people [42].

Geographical disadvantage

Many articles discussed the myriad challenges inherent in accessing quality SRHC for people living in rural and remote areas, which are not wholly exclusive to TGD people. In rural communities there is increased potential for the public and private spheres to converge given the small population size. For example, in Logie et al.'s [36] study a TGD patient reported their HCP coming over for dinner after treating them. Within the TGD community, however the problems of scarce services and confidentiality breaches are further exacerbated because individuals may fear being 'outed' for their gender identities and/or sexual orientation. Indigenous TGD people were uniquely impacted by these issues, with Indigenous people representing high proportions of rural and remote populations [36–38]. Furthermore, there are far fewer TGD specific services and specialist HCPs in remote areas in comparison to metropolitan areas. Consequentially, TGD people must travel long distances to receive adequate health care, which again places additional time and resource burdens on the TGD community [27, 29, 31].

Ageism

Few studies specifically considered how ageism intersected with cissexism and how this may further compound the challenges inherent in navigating cisnormative SRHC systems. The few studies that examined this issue highlighted how adolescent and younger TGD persons are a particularly vulnerable TGD group in SRHC settings when compared to adults. Fix et al.'s [29] study drew attention to the intersections between cissexism, classism and ageism when pointing out that many TGD youth are still financially dependent on their parents and most likely within their parent's insurance scheme, impacting access to contraception. A lack of fertility counselling for TGD young people prior to the initiation of gender-affirming care was identified as a barrier to pursuing fertility preservation and/or assisted reproductive techniques [40, 41]. The articles highlighted the need for TGD youth to be provided with adequate information, support and opportunity to access SRHC services and make informed decisions about their SRH into the future.

2) Facilitators of TGD-inclusive SRHC and best practices This article will now summarise some examples of the facilitators of TGD-inclusive SRHC and best practices which were reported within the articles and affirmed by TGD people currently navigating the SRHC sphere. Many of the articles analysed qualitative data collected from both HCPs and TGD people regarding proactive actions, methods of communication, attitudes and forms of care that can be adopted by individuals to lead to a more positive healthcare experience for TGD people. The key themes that emerged included: affirming, person-centred care, collaboration, trauma-informed practice and leveraging informal support networks. It is important to firstly note though – as Hoffkling et al. ([32]p17) so concisely did—that the "positive experiences some participants described give reason for optimism". However, "at the same time, the surprise that accompanied these stories highlight how much more work is needed".

Affirming, person-centred care

Examples of best practice in SRHC were often characterised by TGD people as the provision of affirming, person-centred care by the HCP. TGD people reported that this involved treating their patients with respect and dignity by avoiding making assumptions about their gender, preferred pronouns and sexual orientations, instead asking the patient these important questions [35, 36]. TGD people value HCPs who are non-judgemental, make genuine attempts to honour correct pronouns, actively listen and know where to refer them. Making an effort to ensure TGD people have access to private spaces and that patient confidentiality and anonymity is upheld were also deemed crucial [38].

Overall, HCPs with TGD specific knowledge and trans-positive or affirming attitudes improved the individual's experience of SRHC..Participants in Ross et al.'s [43] study recommended that HCPs must have a sound understanding of LGBTQ+terminology to address health inequity and the authors provide a glossary of terms commonly used. Although it is desirable for HCPs to possess TGD specific clinical knowledge, ultimately most TGD people felt it was most important that the HCP treated them with respect and dignity, were open to learning and listened to their individual needs and concerns over and above possessing TGD specific knowledge.

Collaboration

Most articles highlighted the importance of collaboration between the HCP and patient, emphasizing how positive collaboration could empower both parties to be fully aware of relevant SRHC concerns and then make informed decisions pertaining to the best course forward. Partnerships between TGD patients and their HCPs were recommended [31]. Examples of best practice that were reported by TGD people were based upon collaboration between the HCP and the patient and the building of a positive relationship and space whereby open and non-judgemental communication could occur [37]. Importantly, one TGD respondent in Macdonald et al.'s [26] study insightfully explained that good quality SRHC can only be facilitated through the establishment of a two-way street between the HCP and TGD patient, with both individuals undertaking respective responsibilities that are owed to one another such as HCPs listening on the one hand, and TGD patients voicing one's needs on the other. While many articles pointed out how having to educate HCPs on TGD SRHC issues constituted an additional burden that TGD people experience equally important was that TGD people are afforded the space and feel comfortable to express their own unique, individual needs.

Moreover, there is a need for HCPs to become more confident in delivering quality, affirming SRHC care to TGD patients.For example, Forsberg & Eliason's [28] article illuminates this need whereby about half of the participants discussed their fears of offending TGD patients and experienced nervousness when treating them. Such fears can only hamper genuine efforts for collaboration between the patient and practitioner to occur and therefore should be minimised where appropriate.

Trauma-informed practice

Some articles highlighted how SRHC services are environments where previous experiences of trauma can resurface for TGD persons. Traumatic experiences – particularly sexualized violence and interpersonal abuse, intersected with cissexist stigmatization to exacerbate negative experiences within SRHC settings. [28]. Violence perpetrated against TGD individuals was also framed as encompassing "economic, legal, medical, psychological and physical violence" ([32] p.8). Given the sensitive nature of SRHC and that medical examinations and HCP's questions may touch on potentially distressing topics such as assault and a patient's sexual history, including abuse, it is recommended that HCPs practice trauma-informed care when engaging with TGD patients [28]. Trauma-informed approaches to SRHC for TGD patients can help to mitigate against experiences of re-traumatisation.

Leveraging informal support networks

Finally, many of the articles recognised the importance of informal TGD support networks as being facilitators of positive health outcomes for TGD people. Such networks comprised of family and friends and groups on the internet utilising social media platforms [31]. These networks have helped facilitate communication amongst the TGD community regarding information on how to best navigate SRHC and information about where to seek the best TGD specific care [29, 33]. Furthermore, the sharing of anecdotal healthcare experiences – both positive and negative has helped reduce feelings of isolation amongst this marginalised group and increased trans-affirming social support and connection [29]. Significantly, groups who have utilised social media platforms and the internet to communicate and to access health information and services have enabled the sharing of important healthcare information to reach regional and rural communities who previously were unable to participate due to their geographic isolation [31]. As such, HCPs could support TGD patients to utilise their existing informal support networks and make referrals to peer-support groups to improve their SRHC experiences.

Discussion

This review highlighted how TGD people experience barriers to accessing quality SRHC stemming from multiple and interlocking systems of oppression including heterosexism, racism, classism, geographical disadvantage and ageism. Many articles highlighted how these systems of oppression combine to worsen health disparities amongst the TGD population, including poorer mental health, increased substance misuse or dependence and increased HIV and STI vulnerability [23, 30, 36]. Unsurprisingly such disparities are most prominently felt by TGD people who may find themselves at the junction of multiple intersections.

This review highlighted the crucial role that HCPs play in ensuring the health needs of TGD people are met and safe and non-judgemental spaces for open patient-practitioner dialogue are created. This is particularly so in the context of SRHC which may entail discussing intimate and potentially triggering topics for TGD individuals. The best practices identified can be utilized by HCPs to challenge the status quo of health injustice for TGD people and it is our intention that this review will assist in this endeavour. However, we acknowledge that the fulfilment of TGD health justice will require structural change at societal and institutional levels [4] in addition to interpersonal levels and that individuals working within healthcare systems are constrained by institutional policies and practices. As such, those who hold positions of power within SRHC system must prioritize structural change.

The limitations of this scoping review are that empirical studies were only included that were written in English, conducted in OECD countries, and published in peer reviewed journals between 2012 and 2022. Moreover, SRH topics that fall outside the inclusion criteria used to define SRH topics were not considered. Similarly, topics that fall outside the inclusion criteria used to define intersecting aspects of disadvantage/marginalization were not considered. Future research could be conducted that includes studies in non-OECD countries and written in languages other than English to enhance understandings of TGD people's SRHC experiences in non-Western contexts. SRH topics and disadvantage/marginalization could be operationalized in different/wider terms and grey literature included in future research.

This review highlighted many methodological limitations in the research base that hamper efforts to understand the diversity of TGD persons' experiences of multiple marginalization within the cis-gendered and heteronormative SRHC… This includes a lack of standardized definitions of key concepts associated with identity, and small and non-representative sample sizes. Moreover, the review found that inconsistent methods are used to collect and report data on important aspects of identity such as age, race, culture, disability, socio-economic indicators, educational status, and sexual orientation. For example, the haphazard way that race, ethnicity and/or culture are reported and frequently pooled together as one concept begets imprecise data that precludes attempts to understand multiply marginalizing experiences. Moreover, no consistent approach was identified in relation to capturing data about participants' socio-economic status and it is therefore difficult to gain an accurate reflection of how common economic marginalization is and how it impacts people's access to quality SRHC. The review also found that important aspects of identity such as whether a person lives with a disabilit(ies) is infrequently collected by researchers despite the significance of this aspect of identity and its association with ablism as an intersecting oppression. So too, many articles included in the review did not explicitly apply intersectional theory and it was more common for qualitative studies to explore one or more system(s) of oppression that intersected with gender identity-related discrimination in SRHC whether explicitly or not. Wesp et al. [4] provides a comprehensive conceptual framework to argue for increased research that draws upon intersectionality to theorize TGD health inequities and emphases the need for naming intersecting power relations in this framework. Future research is needed that considers how multiply marginalizing systems of oppression may converge with one's experiences of cissexism to (re)produce health disparities within SRHC.In particular, greater attention should be given to how racism, ageism and ableism intersect to multiply marginalize TGD people in SRHC settings. Such research must strive to address the abovementioned limitations currently evidenced by and within this scoping review.

Conclusion

Scoping reviews are an invaluable form of evidence synthesis to map foundational concepts, identify gaps in policy and practice and direct future research inquiries. This scoping review found that TGD people face multiple challenges accessing quality SRHC that are often the result of a complex interplay of factors at multiple levels and that are rooted within reinforcing systems of oppression including cissexism, heterosexism, racism, classism, geographic disadvantage and ageism. A range of facilitating best practices were identified that HCPs, policy actors, TGD allies and supporters identify as affecting positive change and which contribute to a more positive SRHC experience for TGD people. Limitations of the current research base were identified, and recommendations underexplored intersections were identified in order to guide future SRHC research pertaining to TGD people.

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

Authors' contributions

SHB completed the research and wrote the main manuscript text. SC and RL assisted with revisions.

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Data availability

Information about how to access datasets are contained in the appendices to this manuscript.

Declarations

Ethics approval and consent to participate

No ethical approval from an Ethics Committee was required for this study, as the study is a scoping review and thus all information was obtained from published sources.

Competing interests

The authors declare no competing interests.

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