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## Healthcare Experiences of Transgender Adults Who Are African American

LaCole Cole  
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# Walden University

College of Psychology and Community Services

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LaCole Cole

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Walden University  
2024

Abstract

Healthcare Experiences of Transgender Adults Who Are African American

by

LaCole Cole

MA, Walden University, 2016

BS, Bowie State University, 1997

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services

Walden University

May 2024

## Abstract

African Americans struggle to access healthcare because of a combination of overt racism, implicit bias from providers, and the effects of systemic racism. As a result, researchers have studied the challenges of this specific adult population. Less research has been centered on those individuals who are both African American and transgender. The purpose of this generic qualitative study was to explore the experiences of this population. Guided by intersectionality theory, the study's research question asked about the experiences of African American transgender adults and their efforts to obtain necessary healthcare services to manage optimal health. Semi-structured interviews were conducted with eight African American transgender adults in the Mid-Atlantic region of the United States. Thematic analysis yielded the following themes: (a) experiences of gender- and race-based inequalities in healthcare settings, (b) African American transgender adults' practices of overcoming the barriers to accessing healthcare services, (c) healthcare needs of African American transgender adults that are unheard and not addressed by healthcare workers, and (d) difficulties with paperwork and health insurance claims. Gender-based discrimination by health care workers was manifested through denial of treatment, disrespect, and bias. The participants' gender-based needs were not taken seriously and were not addressed by health care workers. Race-based discrimination included unfair treatment. The results from this study may lead to positive social change through an increase in opportunities for improved education and gender affirmation training for health care providers to remove the barriers that prevent this population from receiving optimal care.

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## Dedication

Thank God for divine favor and an abundance of blessings bestowed upon me. During the darkest of nights, You illuminated my path with Your divine light. Lord, thank You for providing me with clarity, confidence, and peace.

I dedicate this dissertation to my loving parents, James and Shirley Brown. Mom and Dad, thank you for your ability to see beyond the surface to give me a deeper understanding of the world around me. Although you're in heaven, Mom, thank you for giving me the vision and insight to pursue a doctoral degree. To my devoted Dad who instilled my work ethics and determination to complete every assignment and to encapsulate academic research, thank you. To my dynamic loving daughter, JaNae, who was resilient during this rigorous process and who inspired me to continue through the difficult moments, I give you my thanks. To my unwavering and loving husband, James, thank you for challenging me to commit to the process, for the motivation and inspiration to complete the dissertation, and for presenting me with the one question that started me toward academia. To the Brown, Cole, and DeVille families, thank you for the support needed to endure the daunting tasks and for understanding my lack of presence during my academic journey. Lastly, I dedicate this dissertation to the triumphant individuals who identify as transgender and endure the pivotal challenges of navigating life in a world in which social change is being transformed.

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## Chapter 1: Introduction to the Study

Healthcare is an essential resource for all of society, especially its most vulnerable people. Unfortunately, those vulnerable members often struggle the most to access healthcare resources (Seelman et al., 2021). Even a single marginalized identity, such as being African American or transgender, is enough to limit healthcare access (Hall & Heath, 2021). For those with multiple intersecting marginalizations, such as transgender African American adults, the barriers they face to obtaining healthcare are multiplied (Cicero et al., 2019). However, although these intersectional barriers are evident, their specific nature of how they experience the healthcare system has not yet been adequately explored for the specific context of transgender African American adults. This gap gave rise to the need for the present study.

This chapter introduces the study and provides an overview of key components. The chapter begins with the background of the study, including its research gap. Second, is the problem statement, which establishes the study's central focus. Third is then the purpose of the study, which explicitly states the intention of the research. The purpose of the study then naturally leads to the critical research question guiding the study. Supporting the research question is a discussion of intersectionality theory, the conceptual framework for the study. After the framework, the key methodological aspects of the study are presented in brief, followed by several key definitions. Following the definition section are the assumptions, delimitations, and limitations. The introduction concludes with a discussion of the study's significance and a summary.

## **Background**

Racial discrimination and disparity in healthcare are widely researched topics (e.g., Hall & Heath, 2021; Muvuka et al., 2020). African Americans struggle to access healthcare because of a combination of overt racism, implicit bias from providers, and the effects of systemic racism (Parlier-Ahmad et al., 2022). These struggles often include disrespect everyday racism (Muvuka et al., 2020). In this context, everyday racism reflects the experience of low-level racism on an everyday basis, such as inconsideration, stereotyping, and microaggressions, that do not rise to the level of being overtly racist in the way most would identify as such (Muvuka et al., 2020).

Racism can also prevent individuals from trusting the healthcare system enough to seek care. For example, because of past healthcare injustices (especially the Tuskegee syphilis trials), many African Americans are implicitly distrustful of healthcare (Barrett, 2019). In addition, healthcare access is limited by cultural and religious beliefs, bias and discriminatory practices from providers, socioeconomic status, disparities in healthcare costs based on race, and a lack of knowledge about healthcare (Chandler et al., 2021; Muvuka et al., 2020). Some of these issues are specific to African Americans, while others are shared with other racial minority groups. These factors significantly hinder equitable healthcare (Muvuka et al., 2020).

Transgender adults of all races also face health disparities; a large body of research reflects the barriers to healthcare access faced by transgender adults (Kcomt et al., 2020; Romaneli & Lindsey, 2020; Seelman et al., 2021). For example, healthcare providers who do not feel favorably about transgender status may deny care, choose not

to prescribe the desired gender-affirming care, or provoke transgender people to feel unsafe and uncomfortable in receiving care (Sevelius et al., 2021). Although there is much literature, the topic is quickly evolving, especially with the rise of transgender issues as a significant political flashpoint (Tishelman et al., 2019). Transgender issues are also inherently more complicated because they are intrinsically bound up in healthcare, with gender-affirming care being considered an important or essential part of being transgender (Reback et al., 2018). At the same time, the medical dimension of transgender status can complicate other aspects of care, such as fertility treatment (Chen et al., 2019).

Less well-understood are the barriers facing those who are both African American and transgender (Howard et al., 2019). These individuals face all the barriers of African American and transgender people (Kcomt et al., 2020). However, those from such intersectional marginalized groups experience barriers unique to their intersectionality (Crenshaw, 1990). There was a significant and relevant research gap in terms of understanding those intersectional barriers in the healthcare context, specifically, how healthcare is experienced by transgender people (Cicero et al., 2019; Kcomt et al., 2020) and transgender people of color, such as African Americans (Howard et al., 2019). This research gap was vital given the essential nature of healthcare to anyone, especially vulnerable groups such as African Americans and transgender people.

### **Problem Statement**

The research problem guiding the study was that African American transgender adults face significant barriers to obtaining desired and necessary healthcare services to

manage optimal health (Howard et al., 2019; Seelman et al., 2021). Healthcare for marginalized communities is often present with biases and discriminatory practices that impede high-quality care (Loo et al., 2021). Such barriers take many forms, such as refusal to prescribe gender-affirming care or everyday racism that is defined as the experience of a pervasive, low-level form of racism in the medical context (Hobster & McLuskey, 2020). Because of the importance of healthcare, when barriers prevent access for an already vulnerable community, such as transgender people, there is a profoundly detrimental effect on the members of that community (Milner et al., 2019).

Discrimination and refusal to provide care can create significant hardships or even trauma for transgender and African American people (Hobster & McLuskey, 2020). The experiences of African American transgender adults needed to be examined and understood to meet better their underserved medical needs (Cicero et al., 2019).

Many transgender individuals experience inequality in healthcare (Seelman et al., 2021). The experience of this population is significant in creating increased transgender affirmative care and inclusive healthcare services (Daly & Champion, 2021). This finding is true generally but more so for transgender people from racial/ethnic minorities (Seelman et al., 2021). In particular, Alizaga et al. (2021) found that African American transgender individuals encounter discrimination based on race, ethnicity, and gender within the healthcare system. These individuals are at the intersection of multiple marginalized identities and face intersectional challenges and discrimination (Kattari et al., 2020). The experience of compounded marginalization for a second characteristic can cause significant negative effects and cause African American transgender people to

avoid care altogether (Goldenberg et al., 2021). This double discrimination is especially significant because African American transgender people could benefit in multiple ways from improved gender-affirming care because of those same intersectionalities (Sevelius et al., 2021).

Although the research regarding African American transgender adults facing significant barriers to obtaining desired and necessary healthcare services to manage optimal health illuminates essential findings, I had found no research that examined the barriers to obtaining healthcare services to manage optimal health among African American transgender adults. Given such, further research was warranted that could examine the barriers to healthcare experiences of African American transgender adults in an effort to address the documented problem of African American transgender adults facing significant barriers to obtaining desired and necessary healthcare services to manage optimal health (Howard et al., 2019).

### **Purpose of the Study**

The purpose of the generic qualitative study was to explore the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health. The central phenomenon of interest for the study was the barriers to healthcare faced by African American transgender adults. These barriers arise not only from individual identities but from the intersectionality of two marginalized identities, transgender identity and African American identity. This study may help healthcare navigators provide preventative and remedial services to incorporate inclusivity among transgender adults who are African American with healthcare needs.



### **Research Question**

The research question was: “What are the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health?”

### **Conceptual Framework**

The study was guided by the conceptual framework of the intersectionality theory (Crenshaw, 1990), particularly through a focus on the problems arising from the intersection of being African American and transgender. Crenshaw introduced intersectionality in 1989 as a way of understanding situations in which more than one marginalized identity overlaps (Carastathis, 2016). Crenshaw developed intersectionality using key concepts from critical race theory (Meer, 2014). The theory's original concept explored the interaction of gender and African American women and the lack of understanding of the intersectional marginalized African American women's experiences (Meer, 2014). In particular, Crenshaw (1990) observed that Black women faced issues specific to being Black women, not just a combination of issues that arose from being Black or female. The researcher noted that most feminist groups at the time focused on the problems experienced by White women while ignoring those of African American women. These unique issues arising from the intersection of two different marginalized identities required a new framework; intersectionality theory was that framework and has since been applied to a much wider group of intersectional identities (Carastathis, 2016).

In this study, intersectionality theory was an appropriate conceptual framework because of this study's focus on an intersectional population, African American transgender adults. An intersectionality perspective helped with understanding the dually

marginalized population's barriers to healthcare by exploring how African American transgender individuals respond to discrimination and how privilege is received. African American transgender individuals encounter discrimination from healthcare professionals who have core values and free will to align with social stigmas that discriminate against race and sexual minorities (Hobster & McLuskey, 2020). Intersectionality theory guided the research by helping to understand systemic barriers to healthcare at the intersection of African American transgender individuals and oppression. In addition, prior researchers have applied intersectionality to transgender people who intersect with other communities (e.g., Goldenberg et al., 2019; Mog & Swarr, 2008), giving precedent to its use. The study expanded on intersectionality theory by applying it to a new intersectional population that had not been adequately researched in the existing literature.

### **Nature of the Study**

The study used a qualitative methodology and a generic research design. The qualitative methodology is a descriptive and exploratory research type used to research the subjective human experience (Merriam & Tisdell, 2015). The present study was focused on the subjective experiences of adult African American transgender people, aligning with the qualitative method. Qualitative research is also open-ended in nature, guided by research questions of what, how, or why (Yin, 2017). Such open-endedness makes qualitative inquiry ideal for exploring new topics (Merriam & Tisdell, 2015). The intersectionality of African American experiences and adult transgender experiences in healthcare represents a topic remains underdeveloped in the literature and, therefore, needs open-ended exploration.

Qualitative descriptive research was well-suited to the study. Descriptive research is also known as generic qualitative research because a descriptive qualitative design aligns closely with the general nature of qualitative inquiry (Thorne, 2016). In a descriptive study, the focus is on describing the central research phenomenon (Percy et al., 2015). A descriptive study offers greater flexibility than other qualitative research designs because it does not focus on a single aspect of the phenomenon but rather on the phenomenon as a whole (Thorne, 2016). This made a descriptive design ideal for looking at a qualitative phenomenon to which no other specific design applies. As mentioned above, the study is well-suited to a qualitative methodology. However, the study was intended to describe the central phenomenon as a whole rather than specific aspects. In addition, the flexibility of a qualitative descriptive design afforded more latitude to navigate the complex emotional issues surrounding this study's central phenomenon and research topic.

Data for the study were collected using qualitative, semi-structured interviews and open-ended questions. Interviews allow participants to give data that contains extensive information to express their experiences (Bevan, 2014). An interview guide with the preliminary questions was prepared and validated to ensure that the appropriate data points are collected. Each in-depth semi-structured interview (Kallio et al., 2016) was conducted via Zoom and lasted 60–90 minutes. The results were audio and video recorded to ensure all data points were captured accurately. Thematic analysis was utilized in analyzing the participants' interviews to generate codes, categories, and themes. Thematic analysis is the process of coding and categorizing raw data (Clarke et

al., 2015). Thematic analysis was appropriate for conducting a generic qualitative study and firsthand data on the lived experiences of individuals (Clarke et al., 2015).

Qualitative thematic analysis was relevant because it provides ontological and epistemological features (Ayre & McCaffery, 2022; Sundler et al., 2019). The research methods for the study are presented in greater detail in the research method chapter.

### **Definitions**

The following key terms are essential for the study:

#### **African American**

African Americans are defined as a racial category in alignment with the U.S. census definition; consequently, African American status is typically self-reported by members of the group and represents a marginalized social identity (Cicero et al., 2019). As discussed below under “Black,” the terms African American and Black are used interchangeable herein.

#### **Barriers**

In this study, barriers to healthcare are defined as pervasive factors that act to limit or remove the ability of individuals to access healthcare, such as discrimination and racism on the part of healthcare providers (Loo et al., 2021).

#### **Black**

Black is a term used to describe race for those who do not identify as being from Africa but are still a minority (Cicero et al., 2019). The terms Black and African American are used throughout this study somewhat interchangeably, in part because there is no clear standard in the existing literature for applying one term or the other, especially

given the changing connotations of the two terms over time and the inherent fluidity of language.

### **Intersectionality**

Intersectionality, in this study, refers to the intersection of two or more marginalized identities (Crenshaw, 1990). The present study focused on the intersectional group of transgender African American adults (Crenshaw, 1990).

### **Transgender**

Transgender people are defined as those whose self-determined gender identity does not match their biological sex at birth (Hobster & McLuskey, 2020).

### **Assumptions**

Assumptions are foundational aspects of a study that cannot be verified (Merriam & Tisdell, 2015). Hence, assumptions must be assumed to hold true. Assumptions are present in all research, including the study. One key assumption for this study was that the participants would respond accurately, honestly, and completely to the interview questions. A second related assumption was that members of a twice-marginalized group would be willing to participate in the research and engage with the researcher on potentially sensitive topics. This assumption was needed because no other population could speak to the barriers subjectively experienced by transgender African Americans. Finally, it was assumed that adult transgender African Americans would have some insight into the factors that have prevent them from receiving care. This assumption was grounded in the fact that only they would have experienced any limitation or prevention of care and was self-evident.

### **Scope and Delimitations**

Delimitations are boundaries in the research (Merriam & Tisdell, 2015).

Delimitations are typically imposed to focus the study and ensure it is feasible (Yin, 2017). There were several delimitations in this study. Firstly, the study was delimited to the experiences of transgender African Americans in alignment with the identified research gap. Secondly, the study was delimited to adults, as the existing research has already focused more on transgender African American children and adolescents. Thirdly, the study was delimited to specific recruitment sites to help facilitate the researcher's access to the target population. Lastly, the study was delimited to barriers in alignment with the practical problem the study addresses. The study was focused only on barriers to healthcare because of the particular importance of healthcare and because research indicates the existence of a problem in the healthcare context.

### **Limitations**

Limitations are weaknesses of a study (Merriam & Tisdell, 2015). Limitations are inherent in the research and can only be mitigated in most cases (Yin, 2017). There were several limitations to this study. First, utilizing qualitative research presents limitations by yielding no statistical data and hence results that cannot be generalized; instead, it incorporates realities and subjectivity (Rahman, 2017). The researcher participated in an external audit to examine the study's process, interpretations, and findings to help ameliorate this weakness. The audit involved an external reviewer with accredited expertise reviewing the study procedures to ensure they were sound and adequate for addressing the research questions. Additionally, the generic qualitative research design

involves only one source of data. Therefore, the study was limited in that it could not include multiple sources of data for the purposes of triangulation, offering no way to verify the results. A final limitation of particular importance was that recruitment could have been problematic because the study addresses a twice-marginalized population (Marks et al., 2017). African American transgender people are a twice-marginalized group who may be distrustful of the research and its intentions, which had the potential to create a limitation concerning the recruitment of participants. Moreover, the study addresses potentially sensitive experiences of discrimination. Therefore, measures were taken to ensure that recruitment was feasible, such as building a rapport with prospective participants.

### **Significance**

This study is significant because it helped fill the gap in understanding the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health and have faced significant barriers. The study provided much-needed insight into African American transgender adults' experiences of healthcare barriers from the African American transgender adults' viewpoint. The key players that could benefit from this research are African American transgender adults of Maryland, healthcare navigators and allies of Chase Brexton Healthcare, Pro Bono Counseling Project of Maryland, Maryland Health Connection, HealthCare Access Maryland, Johns Hopkins Hospital, Planned Parenthood of Maryland, and organizations advocating for racial and gender equality in healthcare such as World Professional Association for Transgender Health, Rainbow Alliance, and Trans Maryland. Understanding the

phenomenon from African American transgender adults' perspectives was essential because the information could impact patient care coordination, referral services, and treatment plans. The knowledge gained could help inform healthcare professionals and navigators of the need to advocate for and provide racial and gender equality and make trans-informed decisions. This study is significant to social change as the study provides a basis for those wanting to provide assistance to African American transgender adults and remove barriers that prevent racial and gender equality in healthcare.

The research gap the study addressed is built from three calls for further research found in the existing literature. Firstly, Cicero et al. (2019) conducted an integrative literature review on the healthcare barriers faced by transgender people. They concluded that further research is needed regarding the individual experience of those barriers, a call for research that this study addressed by exploring the experiences of African American transgender people with healthcare (Cicero et al., 2019). Secondly, Howard et al. (2019) conducted a study on the healthcare experiences of transgender people of color. Although they addressed the issue, they also argued in favor of more research on the topic, which this study addressed through an in-depth exploration. Finally, Kcomt et al. (2020) studied healthcare avoidance on the part of transgender people. They called for more in-depth qualitative research on the experiences of transgender people with healthcare (Howard et al., 2019), which this study addressed due to its qualitative nature.

In addition, the results of the study could hold practical significance because they address a timely practical problem. Per Sevelius et al. (2021), transgender African Americans would significantly benefit from gender-affirming care to help reduce the



burden of marginalization. However, researchers such as Alizaga et al. (2021) and Seelman et al. (2021) found that these individuals are likely to face more barriers than other transgender people. Therefore, understanding those barriers so they can be overcome has significance from both a professional and broader societal standpoint. The study's practical significance may lead to insights that can improve the healthcare provision experienced by transgender African American adults. In this way, the study contributes to positive social change.

### **Summary**

In summation, the research problem guiding the study was that African American transgender adults face significant barriers to obtaining desired and necessary healthcare services to manage optimal health (Howard et al., 2019; Seelman et al., 2021). To address this problem, the purpose of the generic qualitative study was to explore the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health. This purpose was actualized through a single overarching qualitative research question: What are the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health? The study was guided by the conceptual framework of the intersectionality theory (Crenshaw, 1990), particularly through a focus on the problems arising from the intersection of being African American and transgender. The study has significance in addressing a research gap and a timely practical problem as identified in the literature (e.g., Cicero et al., 2019; Kcomt et al., 2020; Seelman et al., 2021). This chapter has provided an introduction and

overview of the study. In the next chapter, the background and theoretical framework sections of this chapter are further developed into a full review of the relevant literature.

## Chapter 2: Literature Review

African American transgender adults face significant barriers to obtaining desired and necessary healthcare services to manage optimal Health (Howard et al., 2019). Healthcare professionals who treat marginalized communities present with biases and discriminatory practices (Loo et al., 2021). Healthcare is a multifaceted, complex human service profession where barriers create hardship for those who lack access (Milner et al., 2019). Discrimination and refusal to provide care can create significant hardships or even trauma for transgender people (Hobster & McLuskey, 2020). Although the research illuminates important findings regarding African American transgender adults facing significant barriers to desired and necessary healthcare services to manage optimal health, I found no research about the barriers to obtaining healthcare services to manage optimal Health among African American transgender adults. The experiences of African American transgender adults needed to be examined and understood to meet their underserved medical needs (Cicero et al., 2019). Therefore, the purpose of this qualitative generic design study was to explore the lived experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health.

Current literature has shown the problem of transgender and minority people facing discrimination and a lack of knowledge when seeking healthcare services (Alizaga et al., 2021; Cicero et al., 2019; Howard et al., 2019). Some have identified possible ways to advert such negative outcomes, such as having high levels of resilience due to gender affirmation and healthcare empowerment (Goldenberg et al., 2021; Sevelius et al., 2021). Other researchers approached the issue through participants who were care providers to

transgender people, expecting that increased education would enhance providers' transgender healthcare knowledge. However, Stoumsa et al. (2019) found no correlation between increased education and enhanced knowledge, meaning that extra education did not change providers' practices in the field. These studies' attempts to show the issue as prevalent, suggest ways to mitigate that issue, and increase education about the same issues have shown the need for increased research into not only transgender people's barriers to healthcare but also people of color's issues with discrimination and accessing care.

The first section of this chapter covers the strategy used to find research relevant to the topic, followed by a discussion of the conceptual framework, such as the intersectionality theory (Crenshaw, 1990). This literature review shows research on African Americans and transgender adults seeking and obtaining healthcare. For example, researchers have discussed the barriers to both minority populations as including discrimination, cultural characteristics, and lack of knowledge (e.g., Bleich et al., 2019; Cheatham et al., 2008; Duque, 2021; Harb et al., 2019; Parlier-Ahmad et al., 2022; Rees et al., 2021; Sacks, 2018; Tishelman et al., 2019; Wheeler et al., 2007; Vermeir et al., 2018). Thus, the first section of the literature review covers barriers to care faced by African Americans, followed by the second section's discussion of barriers faced by transgender adults. Furthermore, some researchers, then the previous topics have studied transgender ethnic/racial minorities accessing healthcare (e.g., Carter et al., 2020; da Silva, 2020; Goldenberg et al., 2020; Teti et al., 2021); thus, the third section and literature review theme concerns transgender ethnic/racial minorities and healthcare.

Research has also shown possible ways to mitigate transgender or racial/ethnic minorities choosing not to obtain healthcare due to discrimination (e.g., Butkus et al., 2020; Oliphant et al., 2018; Snow et al., 2022; Strully et al., 2021). The fourth section of the literature review covers research about preventative and remedial services to barriers to healthcare. Before continuing to the research method section, the literature review ends with a summary and conclusions section.

### **Literature Search Strategy**

The literature reviewed for this study was sought through resources found in the Walden University Library and Google Scholar. The databases that contained the research included the following: ProQuest databases, EBSCO, ERIC, APA PsycArticles, APA PsyInfo, PubMed, SAGE Journals, Science Direct, and Google Scholar. The key search terms and combinations of search terms used to find literature related to the subject include the following: *African American barriers to healthcare, Black adults and healthcare, healthcare barriers, transgender adult barriers to healthcare, transgender people and healthcare, minorities and healthcare, racial/ethnic minorities and healthcare, transgender racial/ethnic minorities and healthcare, preventative services to barriers in healthcare, and solutions to barriers in healthcare.*

Most searches came back with several pages of results, such as searches regarding African American/Black adults and healthcare barriers. There was a plethora of research on this subject. There were also several research pages on transgender adults facing barriers to healthcare. Despite the prevalence of articles about African American adults facing barriers to healthcare and transgender adults facing barriers to healthcare, the

minority characteristics were mostly discussed separately, with articles focusing on Black people or transgender adults only without identifying racial characteristics. The researcher found only nine articles that combined the subjects of transgender adults and ethnic/racial minorities into a single study focusing on barriers to accessing healthcare. Of those nine articles, only one discusses Black transgender adults and healthcare. The low prevalence of research covering both subjects and the issue of accessing healthcare represents a gap in the literature and shows the need for the current study.

Research in this literature review is mostly from the years 2018 to 2022. Some seminal research from 1990 to current is presented to support the new research. Over 85% of the research is from the past five years. The following section contains a discussion of the conceptual framework.

### **Conceptual Foundation**

The theory and concepts that ground this study include the conceptual framework of the intersectionality theory (Crenshaw, 1990), particularly focusing on problems arising from the intersection of being African American and transgender. In 1989, Crenshaw introduced intersectionality developed from the critical race theory (Carastathis, 2016; Meer, 2014). The theory's concept exhibits the interaction of gender and African American women and the lack of understanding of the intersectional marginalized African American women's experiences (Meer, 2014). Initially, Crenshaw revealed that intersectionality was a concept used to theorize how the law responded to issues about race and gender discrimination (Meer, 2014), with future research taking the intersectionality concept further (e.g., Goldenberg et al., 2019).

Crenshaw (1990) created the intersectionality theory to understand how individuals perceive oppression. Therefore, intersectionality theory is being used to address the uniquely intersectional needs of African American transgender people. Those needs and experiences are expected to go beyond the individual issues experienced by African Americans and those experienced by transgender people. For example, African Americans are a religious demographic and have cultural opinions about identity (Holt et al., 2014). However, transgender African American people may experience additional issues navigating that religious identity under religious conservatism and cultural beliefs.

The logical connections between the framework presented and the nature of my study include the study's focus on an intersectional population. Crenshaw (1990) originally developed intersectionality theory to explore the unique barriers experienced by African American women; however, the theory can be expanded to minorities other than African Americans and genders other than women. Although the prior approach explored the obstacles facing African Americans and women separately, Crenshaw (1990) used the intersectionality theory to show the unique barriers facing African American women. For example, during the 1990s, most feminist groups focused on problems experienced by White women, ignoring those of African American women (Mog & Swarr, 2008), showing the need for the current study to expand the use of intersectionality in research.

Other researchers have used intersectionality to study issues of transgender rights and healthcare barriers. For example, Mog and Swarr (2008) conducted a systematic literature review in seminal research. The researchers used the intersectionality theory to

study common threads of transgender and disability studies, finding that race and gender bias intersected in commonalities because of social desirability constructs, meaning societal expectations negatively or positively influences individuals accessing healthcare if they were transgender as well. The authors also found that bias and discrimination influenced individuals accessing healthcare, highlighting the intersectionality theory as a possible lens to view such issues, just as Goldenberg et al. (2019) found in their study of gender affirmation, healthcare use, and stigma among African American transgender peoples who were young still. The authors confirmed that gender affirmation would aid such a population to garner resilience, helping them gain strength to access healthcare despite discrimination. The authors discovered this finding based on an intersectional view, just as the current proposal study, confirming the applicability of the intersectionality theory to populations beyond the original intention of African American women (Crenshaw, 1990).

Further studies applied intersectionality research and concepts to transgender health. For instance, Wesp et al. (2019) used the intersectionality theory combined with social justice constructs to develop a new theoretical framework for future use (similar to the current study's use of intersectionality) to create Intersectionality Research for Transgender Health Justice (IRTHJ). The authors found that social constructs intersected with social marginalization, with transgender people disproportionately influenced by health issues and inequities while being disproportionately affected by health inequities for transgender health justice: Wesp et al. encouraged future research, such as the current study, to use IRTHJ as a tool for future research, suggesting using it to create, implement,



and interpret health research for transgender populations, agreeing with Goldie and Chatterjee (2021).

Goldie and Chatterjee (2021) also showed the applicability of intersectionality to transgender populations, expressing that few studies examined intersectionality among gender identification and race, with none studying power structures, such as the prison industry (a subject not studied in the current research). Unlike other studies examining intersectionality, the authors focused on COVID-19 and transgender populations experiencing oppression when obtaining healthcare. The authors encouraged cisgender advocates to support the transgender population in dismantling negatively impactful systems, and they expressed the need for further research, supporting Abreu et al. (2022) and the need for the current study's use of intersectionality.

Abreu et al. (2022) used intersectionality to view the findings of Latina transgender women's experiences in healthcare. The researchers also asked for future research to explore ways to combat discrimination against transgender people, further supporting the research above and that of Maroney and Horne (2022). Like the current study, Maroney and Horne similarly used intersectionality to understand transgender populations but focused on the intersection of autism with gender identity instead of race. Despite their study differing slightly from the current study, which focused on the need for culturally responsive mental health, the authors expressed the need to continue studying healthcare issues and gender identity. They also showed that culture would influence decisions to obtain healthcare, aligning with the belief in the current study that

African American cultural and religious beliefs might influence accessing healthcare for transgender individuals more than transgender people identifying as White.

Based on researchers' requests for further study of intersectionality among transgender populations (Abreu et al., 2022; Goldie & Chatterjee, 2021; Maroney & Horne, 2022; Mog & Swarr, 2008), I used intersectionality to understand the dually marginalized population's barriers to healthcare. I explored how African American transgender peoples respond to discrimination and how privilege is received. African American transgender individuals encounter discrimination from healthcare professionals who have core values and free will to align with social stigmas that discriminate against race and sexual minorities (Goldenberg et al., 2019). Therefore, the intersectionality theory guided the research by helping to understand systemic barriers to healthcare at the intersection of African American transgender individuals and oppression. The following section presents the literature related to key variables and concepts of the subject studied.

### **Literature Review**

Healthcare should be accessible for all individuals; however, African American transgender adults face significant barriers to obtaining desired healthcare services to manage optimal Health (Howard et al., 2019). African Americans alone, without the added minority status of gender identification, face significant barriers to healthcare that have continued from the past (Cheatham et al., 2008; Hammond et al., 2010; Wheeler et al., 2007). These barriers include cultural and religious beliefs among their population, bias and discriminatory practices, socioeconomic status, disparities in healthcare costs based on race, and a lack of knowledge (Ali et al., 2018; Chandler et al., 2021; Charron-

Chénier & Mueller, 2018; Muvuka et al., 2020; Planey et al., 2019; Sacks, 2018). When racial inequities are combined for an individual with other minority characteristics, such as variances in gender identity, the problem of barriers to accessing healthcare increases (Carter et al., 2020; da Silva, 2020; Salerno et al., 2020; Teti et al., 2021).

Healthcare professionals who treat marginalized communities also present with biases and discriminatory practices, furthering the issue of discriminatory practices in healthcare (Loo et al., 2021). Healthcare is a multifaceted, complex human service profession where barriers create hardship for those who lack access (Milner et al., 2019). Discrimination and refusal to provide care can create significant hardships or even trauma for transgender people (Hobster & McLuskey, 2020). Therefore, African American transgender adults' experiences need to be examined and understood to meet better their underserved medical needs (Cicero et al., 2019).

The current literature review in this section contains the following themes: barriers faced by African Americans obtaining healthcare, barriers faced by transgender adults obtaining healthcare, transgender ethnic/racial minorities and healthcare, and preventative, remedial services to such barriers. African American barriers to healthcare are first discussed with seminal research (e.g., Cheatham et al., 2008; Wheeler et al., 2007) to show that the issue has roots in historical and societal issues well before modern research joined the study of marginalized populations facing barriers to healthcare. The barriers faced by the African Americans section then continues to newer research from the past five years to show that the issue remains prevalent and requires further study. The following section discussing transgender barriers to healthcare contains newer

research than the African American barriers section. Transgender studies have primarily been developed in recent times with the further acknowledgment of the population increasing from issues discussed through social media and the Internet (Cicero et al., 2019). The third section combining the minority characteristics of transgender identity with racial/ethnic populations presents the newest research, with the oldest dating to 2019 (e.g., Howard et al., 2019), as such research is limited.

This gap in research shows why the current study is necessary, as the issue of transgender minorities struggling to access healthcare is prevalent in U.S. society but highly understudied (Teti et al., 2021). To further show the current study's need and some solutions to the problem, the remedial services section shows possible ways to mitigate the issue (e.g., Snow et al., 2022). I aim to find that some research may align with the solutions mentioned by participants in the current study.

### **Barriers Faced by African Americans Obtaining Healthcare**

African American/Black people have experienced marginalization, bias, and discriminatory practices throughout U.S. history (Hall & Heath, 2021; Wheeler et al., 2007). Because of the prevalence of this issue, many studies have been conducted to show the reasons behind such inequalities and find solutions to the problem of racial stigmatization by enhancing knowledge of the issue while heightening awareness (Cheatham et al., 2008; Parlier-Ahmad et al., 2022). Although this population has faced broad inequalities in the United States, the issue of accessing healthcare may be one of the worst influences, as it affects African Americans' abilities to stay healthy (Hall & Heath, 2021).

Issues in healthcare that influence an entire population may increase healthcare costs for healthcare organizations as African Americans may not continue care properly, such as following medication adherence and attending follow-up appointments (Hall & Heath, 2021). These issues increase the risk for additional healthcare problems, placing further strain on an already strained medical system in the United States due to COVID-19 and a lack of health insurance or knowledge of ways to receive care despite socioeconomic issues (e.g., Chandler et al., 2021; Charron-Chénier & Mueller, 2018; Duque, 2021). Because of the prevalence of research into African Americans facing bias and discrimination when seeking healthcare, as well as their own population's opinions based on culture and religion, this section of the study presents seminal research to show the issue's historical weight that continues into today.

### ***Foundational Research on Issues With Seeking Care***

Much seminal research has discussed the issue of African Americans facing barriers when seeking healthcare. Discriminatory practices developed throughout history, starting with African Americans facing slavery in the 1800s and continuing beyond the end of slavery in June 1866 (Wheeler et al., 2007). Because of this negative background, African American people have developed an overall mistrust of structured systems, and something later called systemic racism, especially regarding healthcare institutions (Hammond et al., 2010). This mistrust caused most African Americans to avoid seeking care altogether or not adhere to medical recommendations when seeking care. The mistrust also caused them to lack awareness of preventative healthcare services available to them despite socioeconomic challenges, further exacerbating the issue of high costs in

the healthcare industry and the heightened risk of illness among the population (Hammond et al., 2010; Wheeler et al., 2007). Foundational research has further shown that issues of masculinity and cultural perceptions influenced African American individuals to avoid healthcare (Cheatham et al., 2008). These studies are discussed in more detail in this subsection.

In a foundational study, Wheeler et al., (2007) focused on diabetes care for African American patients following up after discharge from an urban hospital. Through surveys on in-hospital patients that then were discharged, the authors identified several barriers to this population's continuing care properly: age, gender, race, marital and employment statuses, level of education in school systems, the status of insured healthcare, admission, and diagnosis dates, blood sugar level at admission/discharge, and blood sugar level-raising drug at discharge. Wheeler et al. expressed the need for a future study to increase the knowledge of the issue and develop more solutions to the problem than existed in 2007.

Barriers to healthcare for the African American population continued after Wheeler et al.'s (2007) study. Cheatham et al. (2008) found the same barriers in a similar study. Although their study researched barriers to African Americans seeking healthcare, the researchers instead focused on African American men seeking healthcare in general, without focusing on a specific ailment. Just as Wheeler et al. (2007) identified a barrier such as sex, Cheatham et al. (2008) found that concepts of masculinity among African Americans acted as a barrier to seeking care. The researchers also identified religious beliefs and influences of peers as barriers to seeking healthcare, supporting that the lack

of healthcare among this population may go beyond discrimination, as cultural/religious beliefs add two-fold issues to an already difficult situation.

Research has shown that peer support can encourage African Americans to obtain care; thus, it is important to increase the knowledge of family members in the community to mitigate the opposite (Cheatham et al., 2008). In another foundational study, Hammond et al. (2010) agreed with Cheatham et al. (2008) that African American beliefs about masculinity added to the medical mistrust that had developed historically from their marginalized past. These issues caused African American men to avoid seeking preventative healthcare, which might have caused increased costs for themselves and healthcare institutions that must care for patients who lack health insurance and have not taken measures to avoid getting sicker (Hammond et al., 2010).

Hammond et al. (2010) conducted a cross-sectional analysis of 610 Black men to develop this conclusion by focusing on their likeliness to obtain blood pressure and cholesterol screenings. The researchers showed that those with increased medical mistrust would be more likely to delay care or not obtain care than those with higher self-reliance characteristics, who were identified as most likely to obtain care from the variables studied. The variables included advocacy of traditional masculinity norms in relation to independence, the importance of traditional masculinity norms, and medical mistrust and self-reported delay in health services considered preventative (Hammond et al., 2010). The researchers indicated the need to acknowledge masculinity as a barrier to African American men seeking care, suggesting that healthcare leaders proceed to care for such patients with this knowledge.

In agreement with prior studies but with a focus on reproductive health services in African American women (not men), Golden (2014) expressed that low income was a barrier for African American women seeking healthcare beyond discrimination faced in the community. The researcher used a specific setting based on ecology to show that low-income women in the African American community of a small urban setting struggled with a lack of income and knowledge, negatively influencing their desire or ability to obtain health care. Although there may have been provisions to assist low-income people with obtaining reproductive healthcare, the participants seemed to need to learn how to access such care. Thus, Golden expressed the need for more research into the issue of African Americans facing barriers to obtaining proper healthcare, supporting the opinions of prior researchers discussed in this section (e.g., Cheatham et al., 2008; Hammond et al., 2010; Wheeler et al., 2007).

Cheatham et al. (2008), Hammond et al. (2010), Wheeler et al. (2007), and Golden (2014) all suggested and requested future researchers to continue studying the barriers that African Americans face when obtaining healthcare. The researchers conducted foundational studies explored in this section to show the historical prevalence of this racial issue. In answer to such requests and the issue remaining in U.S. society well into 2022, researchers continued to address this call for future research, as discussed in the following subsection.

### ***Latest Research on Seeking Care***

The issues noted in the foundational research above have continued into modern times. Research from the past five years shows the issue is prevalent and the need for



future research to continue studying an old problem that has yet to be resolved entirely. Thus, because foundational research addressed the problem up to the most recent five years, researchers were able to continue work on the issue by conducting newer and similar studies to support the findings of seminal research further (e.g., Cheatham et al., 2008; Hammond et al., 2010; Wheeler et al., 2007). For example, Charron-Chénier and Mueller (2018) studied racial disparities in medical spending in White and Black households from 2013 to 2015 through a synthesized literature review study. Their research supported earlier researchers' assertions in the above subsection concerning the high costs associated with African Americans avoiding healthcare or not adhering to medication and follow-up practices (e.g., Golden, 2014). Black households were found to be less likely to spend money on healthcare costs compared to White households. The research did not show the reason for such a discrepancy but opined that this issue showed healthcare inequalities between the two races, indicating the need for more research. Thus, Sacks (2018) continued such a study into Black Americans facing barriers to accessing healthcare; however, the researcher focused on a participant sample of middle-class women who were also Black. The author identified that most research from the past, such as that of Charron-Chénier and Mueller (2018), focused on comparing Black and White populations; thus, Sacks (2018) chose to focus on the Black population only. The author found that discriminatory practices throughout history continued into the modern era, causing Black people to lack proper medical care. The author found that race, class, and gender may add increased barriers to healthcare, depending on how much money an individual can access or if they face cultural assumptions due to being a different gender,

such as masculinity values expressed by prior research as a barrier (Cheatham et al., 2008; Hammond et al., 2010). The specific issues related to barriers to healthcare for African American adults are discussed in the following subsections.

***Lack of Knowledge and Awareness From Cultural/Religious and Socioeconomic Differences***

Black people from poor socioeconomic conditions may lack awareness of the need for healthcare or ways to obtain it despite their lack of monetary resources (Sacks, 2018). Black people from middle-class families were more likely to access healthcare than those of lower-class families who had less money or the ability to obtain information (Ali et al., 2018; Sacks, 2018). In corroboration of the findings of Sacks (2018), Ali et al. (2018) conducted a qualitative study (similar to the current proposal) focusing on Black people from urban areas and the literacy gaps regarding health insurance. Just as foundational research showed a lack of trust in healthcare practices as a barrier (e.g., Cheatham et al., 2008; Hammond et al., 2010; Wheeler et al., 2007), Ali et al. (2018) showed that this mistrust also aided increased misunderstandings of the need for preventative care through conducting 12 focus groups on a Black sample of individuals from Kentucky. The authors noted the need for better information delivery to African American communities about health insurance options despite their socioeconomic situations.

The lack of health insurance knowledge negatively influences access to preventative care and harms advance care planning for African Americans entering older ages, as suggested by Magwood et al. (2019) and Sanders et al. (2019). They further

supported Ali et al.'s (2018) findings. These findings were corroborated by Campbell and Egede (2020). They studied 1,183 articles in a systematic literature review to identify barriers faced by African Americans with Type 2 diabetes residing in an inner-city environment. The researchers confirmed other findings before them (e.g., Ali et al., 2018; Sacks, 2018; Wheeler et al., 2007) that the population lacked awareness and knowledge, causing them to avoid seeking healthcare. Campbell and Egede (2020) suggested that mistrust might have led to this issue, which had developed from systemic racism faced when seeking access to healthcare. Muvuka et al. (2020) agreed with Campbell and Egede (2020) that the Black population lacked awareness about seeking care. Muvuka et al. (2020) suggested that this issue stemmed from a lack of health literacy or education among communities in low socioeconomic conditions. Without knowledge, mistrust was bound to develop among the Black community (Campbell & Egede, 2020; Muvuka et al., 2020). This concept of mistrust was prevalent in the literature studied; thus, the following subsection discusses research that has found similar results about mistrust acting as a barrier to care.

### ***Issues of Mistrust and Medication Adherence***

Among issues identified as barriers not discussed in research thus far (e.g., negative or positive moods about illness), the other findings showed a direct correlation with prior studies showing barriers due to a lack of medication adherence or issues with obtaining medication in general, resources being unobtainable or low, cultural beliefs, and religious expectations (Ali et al., 2018; Hall & Heath, 2021; Parlier-Ahmad et al., 2022; Sacks, 2018). In support of issues with medication adherence among African

American U.S. adults (Ali et al., 2018), Hall and Heath (2021) and Parlier-Ahmad et al. (2022) studied medication adherence or issues among Black adults. Hall and Heath (2021) explored medication adherence to show misconceptions about care for hypertension and diabetes and misconceptions and an increased interest in natural remedies. After finding 58 papers that matched the search criteria, Hall and Heath found that mistrust in healthcare providers might have led to misconceptions and an overreliance on home remedies to avoid going to the doctor. Parlier-Ahmad et al. (2022) found an issue with White and Black individuals opioid use individuals and how White adults had better outcomes than Black adults with the same issues. The systemic issues in the healthcare environment caused Black adults to struggle with seeking out help for addiction to opioids. Thus, the researchers conducted secondary data analysis using a cross-sectional survey and a review of medical records. Ninety-eight Black participants provided a urine test, most being treated for over one year. There were no differences among the gender of the participants, but the researchers showed that older age and whether they had used pills through injection correlated to improved outcomes. The researchers found that if the participants could access high-quality treatments, they had better outcomes for recovery; however, they faced stigma and discrimination when accessing care, so those barriers must be addressed to improve outcomes further. The researchers suggested the need to develop care that would be culturally informed to help with lowering mistrust in the community.

Parlier-Ahmad et al. and Hall and Heath (2021) identified medication adherence as an issue regarding mistrust among Black American adults. Participants in Parlier-

Ahmad et al. (2022) did not always obtain quality care. Such patients had relapses if they could not follow their medications prescribed to handle the symptoms of their addiction to opioids. At the same time, participants in Hall and Heath (2021) avoided medication adherence as well. Parlier-Ahmad et al. (2022) and Hall and Heath (2021) identified mistrust as the possible cause of a lack of medication adherence. This barrier extended beyond the racism or discrimination faced, although the lack of mistrust might have stemmed from such issues in the first place.

Sanders et al. (2019) similarly identified that barriers to healthcare extend beyond simple discrimination, influencing African Americans beyond their youth and well into their older ages. The authors conducted a qualitative study on five experts of health disparities experts, nine members of the community members, and 11 dangerously sick Black patients and those who provide them care (Sanders et al., 2019). These participants identified a pattern of discriminatory practices as extending throughout their lives. This issue caused them to avoid necessary healthcare during the healthy part of their lives as they did not obtain preventative services that might have supported better health later in their lives. Medical issues faced by the older adults in the African American population might have been avoided, reduced, or mitigated altogether if they had trust in medical providers and willingly sought care (Magwood et al., 2019; Sanders et al., 2019). The discrimination faced in healthcare caused them to avoid attending healthcare visits and to have insufficient medical knowledge of the need for preventative care (Sanders et al., 2019). Bleich et al. (2019) further acknowledged the issue of historical discrimination causing Black people to avoid preventative healthcare services. Thirty-two percent of

Black participants admitted to facing discrimination when attempting to get clinical aid. Another 22% avoided healthcare altogether for the same reason, as shown through the logistic regression of 802 Black people (Bleich et al., 2019). Although the study was quantitative, Bleich et al. (2019) were essential to research to show the issue's prevalence in current times, making the current study important to the field of healthcare and Black populations. Systemic racism added to the issue of discrimination, with Black people avoiding more than just the police, as they ignored healthcare issues to stay away from any possible discrimination also faced in healthcare institutions (Bleich et al., 2019).

Not only have researchers studied the issue of barriers to healthcare in adult African Americans, but some researchers have also identified Black youth facing significant barriers to care (Planey et al., 2019). Barriers to care faced in youth may make it more difficult for Black people to trust medical professionals after they have grown up. These barriers are particularly prevalent for Black youth seeking mental health care; thus, Planey et al. (2019) used a systematic review of this issue to show the barriers and possible facilitators to seeking care. The youths faced barriers from being young, factors associated with the therapy itself or the clinician, stigma and discrimination, spirituality and religion, and cost and availability of treatments. Despite the barriers, some facilitators have also identified: practitioners in child mental health as having a high level of care for young people, caregivers having experience with the youths, and the youths having support through good social networks, spirituality, and or religion (which was also a barrier), parents or caregivers offering mandated referrals, and geography. The facilitator of spirituality or religion was also a barrier, showing the need to understand

how such factors may act as both hindering and helping Black individuals who wish to seek mental healthcare. The findings showed that there still existed a need to reduce barriers for this population to care for as mental health is vital to a functioning society. Alang (2019) corroborated Planey et al.'s (2019) findings; however, Alang did not focus on Black youths' mental health and used a mixed-method study. Instead, Alang studied mental Health among U.S. Black adults. Like Planey et al. (2019), Alang (2019) found that racism hindered access to care. From a survey on drug use and health, 1,237 Black adults reported unmet needs regarding their mental health care.

Alang (2019) found that Black people who had higher educations or were currently enrolled in college had more fear of healthcare practitioners, with many reporting high levels of mistrust, a theme supported by much of the research reviewed (Magwood et al., 2019; Sanders et al., 2019). Alang (2019) expressed the difficulties Black adults have because of systemic racism, which has limited their desires or abilities to access care. The study was important to show the overwhelming data indicating that racism and discrimination have caused mistrust in healthcare practitioners, all acting as barriers to care for Black individuals.

### ***Issues Influencing Long-Term Care***

Because of systemic racism, most Black adults have faced discriminatory practices related to their healthcare throughout the entirety of their lives. Magwood et al. (2019), Rositch et al. (2019), and Mathews et al. (2020) all studied chronic conditions that Black adults had to face throughout their lives, such as HIV, stroke issues in older age, and cancer. The lack of health insurance mentioned by Ali et al. (2018) was found

by Magwood et al. (2019) also to harm advance care planning for African Americans entering older ages, as suggested by Sanders et al. (2019). They further supported Ali et al.'s (2018) findings. Magwood et al. (2019) suggested that increased stroke risk was prevalent for African Americans who faced discriminatory practices when seeking healthcare. The authors studied whistleblower interviews with ten healthcare providers, 20 focus groups of stroke patients, and 19 of their families or caregivers (Magwood et al., 2019). The study differed slightly from past studies as Magwood et al. (2019) included healthcare practitioners' opinions to show barriers to care, which still showed issues with a lack of awareness and knowledge. In corroboration of Magwood et al. (2019), Rositch et al. (2019) found that long-term care suffered for Black individuals with cancer, as they faced concepts of fear in their communities and the double issue of bias toward the illness and their minority race. The family could encourage patients to seek care; however, the families had preconditioned opinions about healthcare stemming from cultural and religious differences. Fear was one of the seven identified psychosocial factors that influenced Black participants to continue care properly throughout their lives for cancer, as identified through a thematic analysis of four focus groups with 40 participants and interviews with nine others. The other factors included "pride/dignity, selflessness/self-sacrifice, cancer fatalism, and distrust/skepticism of medical care" (Rositch et al., 2019, p. 1192). Because of familial mistrust and experience in the past with a history of family cancer, the participants reported low communication behaviors among family members who could have offered better guidance if they had not also developed a fear of the system.



Continuing to express the need to combat issues that would cause long-term care in chronically ill Black adults, Rositch et al. (2019) identified the need for increased communication to encourage members of this community to get cancer screenings to avoid increased costs later in life. This finding supported other researchers who had requested better information dissemination to Black communities about long-term illnesses and preventative healthcare services (e.g., Magwood et al., 2019; Mathews et al., 2020). Mathews et al. (2020) studied barriers to care for Black people with HIV, identifying the same factors as Rositch et al. (2019) and others (e.g., Bleich et al., 2019; Sanders et al., 2019). These factors that supported prior research in the above subsections stated that a lack of knowledge and trust in healthcare systems caused Black people with HIV to delay care, potentially causing the illness to spread to others or to evolve into a worse situation like AIDs. This mistrust also led Black American adults not to seek preventative testing services. Without preventative services, healthcare institutions face an influx of HIV-infected Black people in the future who may require long-term care, as Magwood et al. (2019) regarding stroke victims and Rositch et al. (2019) regarding patients with cancer. Beyond long-term care illnesses, there is one virus that has influenced all communities, but especially Black ones, COVID-19; thus, the following subsection contains some articles that focus on barriers to care for Black seeking help when infected with COVID-19.

### ***COVID-19 and Black Individuals' Barriers to Care***

Although COVID-19 influenced all populations in the United States, many fell ill during the outbreak. The virus negatively influenced Black individuals more than White

individuals (Duque, 2021). For example, Chandler et al. (2021) studied the impact of COVID-19 on Black women. The findings developed from interviews with 15 Black women participants. The goal was also to show the participants' knowledge rates about the virus, as public data had shown low rates of understanding among this population and about this subject. Interviews occurred with 15 African American women. These women were patients at a family-based center that served the community in which they lived. Most participants cited social media and online news platforms as sources of COVID-19 information. These findings were shown through a thematic analysis with MaxQDA software, with deductive/inductive coding. Seventy-nine percent of the women interviewed did not trust the information they had found on the virus; this same amount felt confused about the information they had received. These findings confirmed findings from other researchers regarding mistrust (e.g., Bleich et al., 2019; Sanders et al., 2019), but this mistrust could have longer-reaching consequences as COVID-19 remained in society. Duque (2021) agreed that Black people were more adversely affected by COVID-19 than other populations as Black people continued to face systemic racism in poverty and an inability to obtain quality homes in safe environments. The researcher used an action-oriented approach to study nonprofits using a mixed-method approach. The findings indicated that intergenerational poverty, possibly derived from systemic racism, was a barrier to COVID-19-related care. The study was essential to confirm that such racism had caused long-reaching consequences for this minority population, further confirming research by Wakeel and Njoku (2021). These researchers showed that issues of racism and stigma intersected with COVID-19 for Black Americans using the

Weathering Framework. This framework showed the ability of a particular community to weather issues placed in front of them despite racial obstacles. The researchers agreed with prior research (e.g., Bleich et al., 2019; Sanders et al., 2019) that mistrust was prevalent in the community, possibly leading to more infections than in other communities and higher mortality rates. In further agreement, prior research (e.g., Chandler et al., 2021; Duque, 2021), Wakeel and Njoku (2021) stressed the importance of further research into systemic barriers faced by Black people, as well as the need for interventions to combat misinformation found online and increase awareness in an untrusting African American population. Similar barriers are shown for transgender adults, as discussed in the following section.

### **Barriers Faced by Transgender Adults Obtaining Healthcare**

Many transgender individuals experience inequality in healthcare (Seelman et al., 2021). The experience of this population is significant in creating increased transgender affirmative care and inclusive healthcare services (Daly & Champion, 2021). For this reason, several researchers have studied transgender people's experiences with barriers to healthcare (e.g., Cicero et al., 2019; Kcomt et al., 2020; Romaneli & Lindsey, 2020; Seelman et al., 2021; Vermeir et al., 2018). Because research has shown that some awareness may have increased with time, this section is divided by years to show a possible change in outcomes over time. However, some changes seem minimal and further show the need for more research like the current study.

### *Studies in 2018*

Recent research from 2018 showed that the problem existed five years ago and persists today (Hussaini & Nilsen, 2018; Lee et al., 2018; Reback et al., 2018; Vermeir et al., 2018). Houssayni and Nilsen (2018), Reback et al. (2018), and Vermeir et al. (2018) studied barriers to care for transgender people who identified as American, while Lee et al. (2018) showed similar issues in accessing care in Korean transgender participants. Unlike Americans, who had acknowledged that transgender beliefs did not constitute a disorder, Korean transgender people still faced the issue of practitioners believing they might be mentally ill, further hindering care (Lee et al., 2018). Some participants decided on different therapies over others; thus, the researchers included this question in the nationwide cross-sectional survey of 278 transgender Korean people (Lee et al., 2018). Most participants (91%) were diagnosed with the disorder just mentioned, with 88% choosing hormone therapies and about 42% getting sex change operations. The participants showed the following barriers: experiences with negative implications in healthcare settings, few specialized and knowledgeable practitioners available to the Rainbow Connection population, and social stigma. Most had reported going to the street for their hormone medications. The findings showed a lack of safe access to care for these individuals.

Such findings led to recommendations agreed with by other researchers. For example, Lee et al. (2018) suggested the need to improve such healthcare through intervention programs, agreeing with other researchers in 2018, such as Houssayni and Nilsen (2018), Reback et al. (2018), and Vermeir et al. (2018). All of these researchers

agreed that barriers included low access to health insurance and health disparities that negatively impacted transgender people's abilities to obtain primary care or access medications related to gender confirmation, such as hormone therapy. Barriers negatively influenced access to emergency healthcare (e.g., Vermeir et al., 2018). Reback et al. (2018) focused on transgender women, unlike the other studies that had included both gender identities (e.g., Lee et al., 2018; Vermeir et al., 2018). This focus helped to identify issues commonly faced with infertility developed from taking hormone therapies. Because of bias and preconditioned beliefs, transgender women were too scared to access care. Reback et al. (2018) suggested that heightened education about gender minorities might increase practitioners' cultural sensitivity when dealing with this population. Houssayni and Nilsen (2018), Reback et al. (2018), and Vermeir et al. (2018) suggested further research into the issue to heighten awareness of the need for more education and culturally-sensitive knowledge.

### ***Studies From 2019***

In 2019, research into transgender people attempting to access healthcare and barriers to seeking care continued in response to requests from prior research (Chen et al., 2019; Cicero et al., 2019). For example, Cicero et al. (2019) conducted an integrative literature review on transgender adults' healthcare experiences that included 23 studies selected for their relevance to contextualizing the experiences of transgender adults interfacing with healthcare, especially concerning the Healthy People 2020 report. Cicero et al. found that transgender adults experienced many issues, including barriers to access to health care, discrimination by health care professionals and clinicians, limitations on

health insurance benefits for essential care, and barriers to essential care, including cross-sex hormones and primary care and preventive medicine. These perceived barriers matched those found by Chen et al. (2019), who also studied practitioners with transgender patients and their ability to access healthcare, precisely fertility issues.

Gender-hormone medications can influence fertility, which helps transgender individuals transition to a gender-affirming aspect of their care (Chen et al., 2019; Reback et al., 2018; Tishelman et al., 2019). For example, because of discrimination, Tishelman et al. (2019) found that fertility care was complex for transgender individuals to access. Through a nationally-distributed survey, 110 participants expressed difficulties obtaining care from admission and expense problems; the necessity for gender-affirming therapy; patient ages or lack of knowledge to choose future goals; and provider-related issues regarding a lack of education and their roles as clinicians (Tishelman et al., 2019). Chen et al. (2019) continued such research and distributed a 46-item survey to 200 providers at conferences or listservs. The quantitative study showed a mean of 3.64 and a standard deviation of 1.61 for overall knowledge among the participants, indicating that a high amount of knowledge existed. Despite participants stating that they had patients who had no desire to delay care or treatment, the participants indicated they witnessed provider-related barriers to healthcare, with  $p < .001$ . These barriers also included bias and a lack of knowledge of culturally-sensitive care among providers, supporting other research (e.g., Lee et al., 2018; Vermeir et al., 2018). Cicero et al. (2019) conducted an integrated literature review of mixed methods to support such findings further to show that such themes were prevalent in past research. These themes included transgender

people facing bias, discrimination, and a lack of knowledge/culturally-sensitive care; moreover, the researchers identified a lack of a clear definition of transgender people as confusing practitioners and further harming the transgender community who face misconceptions about their characters.

These issues continued in schools in 2019, as well. For example, Goldberg et al. (2019) studied transgender students and their healthcare experiences. These students were younger than other populations studied, indicating they might not have as much resilience as older transgender individuals who have faced discriminatory practices for much longer. Goldberg et al.'s participants feared violence and negative interactions when seeking mental or physical healthcare. The participants expressed frustration with constantly facing misgendering by practitioners, which caused the participants to avoid care. Misgendering is when a person refuses to acknowledge the gender an individual identifies with in favor of the biological gender listed on their birth certificates (Harb et al., 2019). Misgendering was also expressed by Harb et al. (2019) and Kcomt (2019) as an issue causing transgender people to avoid seeking care. Participants reported that misgendering was offensive to them, and they would rather avoid experiencing it altogether by not accessing care (Harb et al., 2019). The researchers studied transgender individuals assigned to the female sex when born and how they feared accessing sexual health services because of misgendering. The study mainly included White transgender people ( $N = 17$ ). Most were unaware of HPV indicators and had not obtained Pap tests because of a lack of competent care, as supported by Kcomt (2019), who conducted a systematic review on the issue of healthcare discrimination. Other sexual minorities did

not seem as compromised when accessing care as transgender individuals, with a significant prevalence of discrimination cited in most reviewed studies ( $n = 8$ ).

Harb et al. (2019) requested awareness of structural inequities among healthcare practitioners to increase culturally-sensitive care among this population, also confirming the findings of Macdonald et al. (2019) and Tishelman et al. (2019). Macdonald et al. (2019) studied barriers to oral health care for transgender youth, including young adults. The participants reported wanting to be treated like an average person, feeling exhausted from constantly reminding practitioners of their identified gender, thus expressing misgendering as a barrier like other researchers (e.g., Chen et al., 2019; Cicero et al., 2019). The 36 participants were interviewed using a semi-structured guide, and they reported primarily positive results, with negative results occurring from misgendering that was corrected immediately by the oral practitioners. This improvement in knowledge compared to other studies (e.g., Chen et al., 2019; Cicero et al., 2019) may indicate awareness has increased among practitioners, or dentists may have better culturally-sensitive training, being more removed from the sphere of mental health where bias first developed, than other healthcare industries (Macdonald et al., 2019).

### ***Studies From 2020 to 2022***

Because these researchers called for more research, researchers from 2020 to today have continued to study the issue of barriers to care for transgender individuals (e.g., Bakko et al., 2021; Johnson et al., 2020; Kattari et al., 2020; Kcomt et al., 2020; Meyer et al., 2020; Rees et al., 2021). For example, Kcomt et al. (2020) continued the study of healthcare avoidance from anticipated discrimination among transgender people.



In particular, the researchers aimed to understand the factors that predicted transgender people's healthcare avoidance from a nationally representative sample of 19,157 transgender people ages 25 and older. The study found that nearly 25% of the sample had avoided healthcare. Transgender men were significantly more likely to avoid healthcare, especially if they were visually non-conforming. Health insurance status was also significant and interacted with gender identity. They argued for the importance of providers offering better trans-friendly care, supporting Cicero et al.'s (2019) assertion for better care for this community and Romaneli and Lindsey (2020). Romaneli and Lindsey studied multiple healthcare discrimination indicators to identify response patterns with transgender help-seekers. The researchers found patterns of health service discrimination among transgender individuals requesting healthcare. Specific subpopulations were at greater risk of experiencing various types of healthcare discrimination and receiving care from providers with little transgender competence. These results corroborated Seelman et al. (2021), who studied healthcare mistreatment among transgender individuals to understand if race or ethnicity played a role in the mistreatment of patients. Their quantitative study used data from a 2015 nationally representative transgender study. Seelman et al. (2021) found that (c) among transgender clients of minority statuses beyond gender choices, the psychosocial risk was consistently more important than characteristics based on socioeconomic issues in predicting abuse. In addition, however, gender identity incongruity with identifying documents was a major predictor of mistreatment, as supported by others (Johnson et al., 2020; Kattari et al., 2020; Kcomt et al., 2020; Meyer et al., 2020; Rees et al., 2021).

The lack of health insurance, persistent discrimination faced when obtaining care, high costs to care, and lack of sensitive care and knowledge among practitioners was consistently reported in research (e.g., Bakko et al., 2021; Johnson et al., 2020; Kattari et al., 2020; Kcomt et al., 2020; Meyer et al., 2020; Rees et al., 2021). For instance, Johnson et al. (2020) conducted a study due to the gap in research for transgender people in the Southeast United States. The researchers claimed that most research on transgender people and their access to healthcare is affected by barriers focused on those in northern U.S. cities; thus, the researchers aimed to show healthcare barriers for this population in that location, avoiding the most used locations, to gather data. Four focus groups were conducted that lasted 120 min to explore experiences of accessing healthcare with their identified genders. The researchers conducted a qualitative study that showed the following barriers to accessing healthcare: having fear or mistrust in the system, experiencing inconsistencies when seeking care, facing providers' disrespect, and experiencing mistreatment. These findings were also supported by Kattari et al. (2020) when studying healthcare denials among transgender populations. The barriers mirrored others, such as discrimination, lack of knowledge, and lower income, as found through a multivariate logistic regression (Kattari et al., 2020). Again, Kattari et al. (2020) suggested more education for practitioners, supporting assertions by Houssayni and Nilsen (2018), Reback et al. (2018), and Vermeir et al. (2018) and others (e.g., Bakko et al., 2021; Johnson et al., 2020; Kcomt et al., 2020; Meyer et al., 2020; Rees et al., 2021). Access to care poses an issue for transgender individuals. However, when combined with the individual being from an ethnic/racial minority, barriers to care increase. As discussed

in the following section, the combination of issues may cause heightened discriminatory practices.

### **Transgender Ethnic/Racial Minorities and Healthcare**

Because the current study was concerned with the intersection of race and gender identity and the effects of both on barriers to care, this section discusses the few studies found that included both minority statuses. Not many studies included ethnic/racial minorities and transgender people, showing the need for further research. Even fewer studies focused on African American transgender adults than the current study. One study was Alizaga et al. (2022), which studied the experiences of healthcare discrimination among transgender and gender non-conforming people of color. The researchers used a quantitative research methodology and conducted a latent class analysis to understand better the types of discrimination faced by transgender people of color. Many transgender people of color either experienced or anticipated discrimination and those who experienced it perceived worse or no healthcare service (Alizaga et al., 2022; Goldenberg et al., 2020, 2021). Salerno et al. (2020) also specifically studied Black transgender people, showing the discriminatory practices that influenced their access to quality care. Another such study by Goldenberg et al. (2020, 2021), included transgender youths of color and gender affirmation as a potential source of resilience for transgender youth of color. The researchers found that the youth reported more stigmatization associated with healthcare than anything, even when they had received affirming care. Those receiving gender-affirming care could still face stigmatization during the process of accessing that care, confirming the findings of Howard et al. (2019), who studied the healthcare

experiences of transgender people of color using a qualitative study with data from interviews with 22 participants and focus groups with 17 of those participants. The researchers found that all participants described negative experiences with healthcare providers because of biases against their race or gender identity.

Howard et al.'s (2019) participants who sought out expressly LGBTQ-friendly care still worried about experiencing racism there, confirming findings by Carter et al. (2020) and da Silva (2020), who both found fear of healthcare because of experiences with a lack of awareness and racism. Similarly, Kattari et al. (2020) confirmed the possibility of such continued bias when studying the intersecting experiences of healthcare denials among transgender and nonbinary patients. The researchers conducted a quantitative study with data from a nationally representative 2015 trans study with 27,715 participants. Around 8% had been denied trans-specific healthcare, while over 3% had been denied general healthcare (Kattari et al., 2020). Healthcare denial was most strongly predicted by older age, biracial or multiracial status, and lower-income status. Teti et al. (2021) found corroboration for Kattari et al.'s (2020) findings through a qualitative study. Thirty-five qualitative studies were included after a systematic search that included 1,607 participants. Most conducted focus groups and or interviews of their participants. The findings were mostly aligned with one another, with most research discussing the barriers and challenges faced by this population when seeking care for their gender-affirming or basic healthcare needs. The findings showed that most other research discussed the patients' needs and the strengths within the patients that helped them combat the barriers faced and seek care. The researchers encouraged more research

into this subject, especially racial/ethnic minorities, and possibly included methods to assess this issue. These results are relevant to informing the social problem that the study addresses while showing the gap in the research about African American transgender people and their barriers to care. Although few studies existed that combined both minority characteristics, some still were able to suggest possible solutions, which also mirrors the goal of the current study; thus, the following sections include some preventative and remedial services suggested by transgender researchers to increase access to care and lower discriminatory practices.

### **Preventative and Remedial Services to Barriers in Healthcare**

Most studies reviewed suggested the same possible solutions to decreasing barriers to care for sexual and racial/ethnic minorities. These solutions include the need for increased education among providers (Ali et al., 2018; Stoumsa et al., 2019), increased resources and healthcare empowerment provided to low socioeconomic communities (Sevelius et al., 2021), and the need for gender affirmation (possibly leading to heightened resilience levels; Butkus et al., 2020; Moseson et al., 2020; Oliphant et al., 2018; Snow et al., 2022). Some researchers even showed the need for more outreach work, specifically in minority communities, to increase awareness of healthcare needs for certain illnesses, such as hypertension in African Americans (Ferdinand et al., 2020) and COVID-19 for minority populations (Strully et al., 2021).

Some studies focused on minority populations, their barriers to seeking healthcare, and ways to mitigate these issues. Although not focusing on transgender people, these studies remain useful because they still reflect the issue of race (Ferdinand

et al., 2020; Strully et al., 2020), an intersecting issue discussed in conjunction with transgender populations that was studied within the current paper. Strully et al. (2020) indicated that outreach efforts were required regarding COVID-19 vaccination for minority populations because of misinformation and cultural beliefs concerning healthcare. Because of these issues, minority populations (i.e., specifically persons of color discussed by the author) were less likely to have heightened awareness of vaccines or to volunteer to be vaccinated; thus, Strully et al. suggested launching campaigns in low socioeconomic areas or where higher populations of minorities live to try and spread accurate information to those communities and combat the old belief system stemming from these populations being used to facing racial inequities and common misconceptions about their communities. The authors suggested creating self-reflective/adaptive campaigns while reassessing old strategies to empower these minority populations regarding seeking healthcare. Also specifically focusing on populations of persons of color regarding healthcare access, Ferdinand et al. (2020) studied why African Americans faced such high rates of cardiovascular diseases. The findings mirrored Strully et al.'s (2020) findings that suggested issues seeking healthcare stemmed from diagnosis/treatment racial inequities and few practitioners in these communities having the proper knowledge to apply care that was competent culturally. Ferdinand et al. (2020) also made similar suggestions to Strully et al.'s (2020) suggestions to help alleviate this global healthcare issue regarding minorities feeling safe enough to seek healthcare, no matter what they might face regarding illness. These suggestions included raising community awareness through outreach programs to educate patients in the community

while employing informed practitioners in these areas to ease the burden of discrimination. Unlike Strully et al. (2020), Ferdinand et al. (2020) went further in their findings to suggest that information technology might be a better way to reach younger generations of minorities to increase community engagement about the way to raise disease resistance.

Out of all the suggestions for ways to mitigate barriers for transgender people, the most prevalent involved practitioners using proper gender affirmation and patients being able to obtain treatments that suited the gender with which they identified. For example, Sevelius et al. (2021) studied the importance of gender affirmation in other healthcare outcomes. Their quantitative study included a sample of 858 transgender women of color. Their results yielded that affirming a person's gender and empowering healthcare choices significantly influenced the overall impact of sexual orientation-related intolerance on viral inhibition (Sevelius et al., 2021), meaning that these factors could reduce the harm caused by discrimination to general healthcare issues. Stoumsa et al. (2019) also conducted a quantitative study to determine whether formal education on transgender health forecasts knowledge about the care for transgender patients. The researchers found no correlation between increased hours of education and enhancement of the healthcare provider's knowledge of transgender healthcare, which was surprising as most researchers have insisted that increased education on the issue would allow practitioners to provide better quality care (Butkus et al., 2020; Moseson et al., 2020; Oliphant et al., 2018). Beyond solely educating practitioners of minority issues about accessing healthcare, researchers also mentioned the need to improve the overall quality of care by raising

social awareness and ending discrimination (Butkus et al., 2020). Butkus et al. (2020) specifically mentioned the lack of universal access to healthcare of high quality for the general population and the minority population, stating that ensuring coverage is not enough for minority populations. Minority populations still deserve high-quality healthcare when seeking help, not just lowered or free prices to access it (Butkus et al., 2020). Butkus et al. (2020) suggested lowering workforce shortages so that burnout does not influence practitioners to not take the time to understand minority issues, which would help them approach these vulnerable populations more gently than if practitioners were too overburdened with patients to provide personalized care. This research is relevant as the researchers have called for further investigation of interventions beneficial to providers' knowledge while improving transgender healthcare.

Some researchers focused on the idea of transgender people seeking healthcare for pregnancies, providing some methods to alleviate any issues with this vulnerable, minority population from seeking very basic medical needs for pregnancies and reproductive healthcare issues. Moseson et al. (2020) stated that most studies focused on heterosexual issues with reproductive health, mostly ignoring the population of transgender people who remain capable of carrying a full-term baby. Such people face a large amount of discrimination when presenting as a different gender, such as a man who is now pregnant, from what a practitioner expects. Much discrimination occurs in this situation, possibly causing the patient to avoid seeking help when their babies and own bodies require specific care. Thus, Moseson et al. suggested the need for inclusive healthcare practices, specifying that practitioners must learn to remain respectful, and



they should have enough knowledge about this population to avoid showing surprise and making the patient potentially uncomfortable enough to avoid coming back for necessary care. These populations still require care, and causing more discrimination regarding healthcare access may harm these patients mentally and physically.

Although most research expressed the need for gender affirmation to increase resilience among transgender people, only a few showed ways to mitigate issues with individuals who were both transgender and from an ethnic/racial minority. This lack of suggestions shows the need for current research, as the aim was to find more solutions to the problem by continuing the calls for research made by other researchers (e.g., Butkus et al., 2020; Moseson et al., 2020; Oliphant et al., 2018). The final section of the literature review follows and contains a summary and conclusions developed from the reviewed literature.

### **Summary and Conclusions**

The current literature review contained the following themes: barriers faced by African Americans obtaining healthcare, barriers faced by transgender adults obtaining healthcare, transgender ethnic/racial minorities and healthcare, and preventative, remedial services to such barriers. These themes led to the conclusion that healthcare should be accessible to all individuals despite perceived barriers. However, the research showed that African American transgender adults faced significant barriers to obtaining desired healthcare services to manage optimal health (Howard et al., 2019). African Americans alone, without the added minority status of gender identification, face significant barriers to healthcare that have continued from the past (Cheatham et al., 2008; Hammond et al.,

2010; Wheeler et al., 2007). These barriers include cultural and religious beliefs among their population, bias and discriminatory practices, socioeconomic status, disparities in healthcare costs based on race, and a lack of knowledge (Ali et al., 2018; Chandler et al., 2021; Charron-Chénier & Mueller, 2018; Muvuka et al., 2020; Planey et al., 2019; Sacks, 2018). When racial inequities are combined for an individual with other minority characteristics, such as variances in gender identity, the problem of barriers to accessing healthcare increases (Carter et al., 2020; da Silva, 2020; Salerno et al., 2020; Teti et al., 2021).

Because this study studied participants' sexual and racial minority characteristics, the intersectionality framework was used to view the results—this framework in the literature review was developed by Crenshaw (1990). The logical connections between the framework presented and the nature of this study include the study's focus on an intersectional population. Crenshaw originally developed intersectionality theory to explore the unique barriers experienced by African American women; however, the theory could be expanded to minorities other than African Americans and genders other than women.

The following chapter reviews the methods used to collect and analyze data. The next chapter, research method, also contains information about the participants, including the population, sample size, and ethical considerations when conducting the study. The methodology includes the study's results, followed by the results chapter, which disseminates the results with the research from the current chapter.

### Chapter 3: Research Method

The purpose of the generic qualitative study was to explore the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health. The previous chapter developed the theoretical foundations of the study and its background. This chapter addresses the research methods laid out in the nature of the study in the introduction, which is discussed in full. First, the research methodology and research design are more fully discussed and justified. Second, the role of the researcher in the research process is discussed. Third, the methodology is laid out, including the participants, the instrumentation, the data collection procedures, and the data analysis. Next are issues of trustworthiness, discussed in terms of its four dimensions. Finally, this chapter ends with research ethics and a summary.

#### **Research Design and Rationale**

The research problem guiding the study was that African American transgender adults face significant barriers to obtaining desired and necessary healthcare services to manage optimal health, and only limited research has examined (e.g., Salerno et al., 2020) the barriers to obtaining healthcare services to manage optimal health among African American transgender adults (Howard et al., 2019). This problem was addressed through a single, overarching research question: “What are the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health?”

Underlying this research question, the central phenomenon of interest for the study was the barriers to healthcare that are faced by African American transgender

adults. These barriers arise not only from individual identities but from the intersectionality of two marginalized identities, that of transgender identity and that of African American identity. To address this phenomenon, a qualitative approach and a generic qualitative research design were adopted for the study.

The qualitative methodology was a descriptive and exploratory research type used to research the subjective human experience (Merriam & Tisdell, 2015). Qualitative research is descriptive in that it seeks to document the human experience using long-form, in-depth data collected from those who have firsthand experience with the central research phenomenon (Moen & Middelthon, 2015). Qualitative research is also open-ended in nature, guided by research questions of *what*, *how*, or *why* (Yin, 2017). The open-endedness of qualitative inquiry is not only expressed in the type of research questions it is used to answer but also in the way in which a qualitative researcher must seek to elicit all perspectives on the phenomenon, with a focus on documenting each perspective at least once rather than on analyzing the frequency of repetition (Moen & Middelthon, 2015). Such open-endedness makes qualitative inquiry ideal for exploring new topics (Merriam & Tisdell, 2015). Qualitative research is also contextual, capturing much of the context around the research topic through its open-ended exploration (Moen & Middelthon, 2015).

Qualitative research was appropriate for several reasons. The present study was focused on the subjective experiences of adult African American transgender people. This study's focus on subjective experiences aligned closely with a qualitative method. In addition, the intersectionality of African American experiences and adult transgender

experiences in healthcare represented a topic that was not yet well developed in the literature and, therefore, was in need of open-ended exploration. Furthermore, issues of intersectional discrimination are inherently contextual, as the nature of the intersectional effects depends upon the context in which they occur. Therefore, the main aspects of the study strongly aligned with qualitative research.

By contrast, quantitative research is closed-ended (Park & Park, 2016).

Quantitative studies are used to examine the relationships between closed-ended variables rather than open-endedly explore phenomena (Apuke, 2017). In addition, quantitative research's greatest strength is in large sample sizes (Park & Park, 2016). Large sample sizes are made feasible through the collection of closed-ended, short-form data. These data, however, cannot enable exploration of new ideas because of this closed-ended nature (Apuke, 2017). In addition, quantitative research is a poor choice for exploring new topics or ideas, as quantitative studies require a strong theoretical grounding (Park & Park, 2016).

A quantitative methodology would have been poorly aligned with the significant characteristics of the study. The study was intended to explore a broad phenomenon rather than focusing on specific variables or their relationships. Moreover, the population of interest for this study was difficult to access, which would have greatly hindered attempts to gather large-scale quantitative data. Additionally, the study addressed a new and poorly understood topic upon which the prevailing theory offered no clear hypotheses. Therefore, a quantitative research methodology would have been a poor choice.

Within the qualitative paradigm exist a multitude of research designs. For this study, the specific research design was a generic qualitative design, also known as interpretive description. Generic qualitative research is a descriptive qualitative design aligns closely with the general nature of the qualitative inquiry and lacks the more specific focus of other qualitative research designs (Thorne, 2016). Generic qualitative research focuses on describing the study's central phenomenon (Percy et al., 2015). The interpretive component is that such description must then be interpreted to derive meaning within the context of the research problem and corresponding societal problem (Thorne, 2016). A descriptive study offers greater flexibility than other qualitative research designs because it does not focus on a single aspect of the phenomenon but rather on the phenomenon as a whole (Percy et al., 2015). Hence, it is possible to adjust the research approach when necessary.

A descriptive research design was well-aligned with this study. As established previously, the study strongly aligned with an overall qualitative methodology. However, the study was intended to describe the central phenomenon of the barriers to healthcare faced by African American transgender adults as a whole rather than specific aspects, making it align with a generic qualitative design more than other, more specific qualitative designs. This phenomenon was expansive and in need of full exploration, given that the type and nature of these barriers was unknown. In addition, the study was descriptive and intended to describe the intersectional experiences of African American transgender adults in the healthcare system. In addition, the flexibility of a qualitative

descriptive design afforded more latitude to navigate the complex emotional issues surrounding this study's central phenomenon and research topic.

Other qualitative research designs would have been less appropriate. A case study (Yin, 2017) design focuses deeply on context. While context was an aspect of this research, it was not the central focus. A narrative approach to research focuses on understanding the narratives or stories of the participants (Murray, 2009). However, this study was focused on discrete experiences, not holistic narratives. A phenomenological design is used to study lived experiences in-depth (Moustakas, 1994). While this study was intended to study experiences, the depth of phenomenological description was more than was needed to obtain a general understanding of the phenomenon. A phenomenological design is also descriptive in nature, but it is more focused on the lived experiences of the participants in their own right. This study, by contrast, was intended to use the experiences of the participants in a more instrumental fashion. This use required less depth and the smaller sample sizes in phenomenological research even vis-à-vis other qualitative designs would not have suited this study's purpose given the desire to explore the phenomenon as fully as possible. Hence, interpretive description was appropriate because of the inappropriateness of alternate qualitative research designs.

### **Role of the Researcher**

In qualitative research, the role of the researcher is that of primary data collection instrument (Merriam & Tisdell, 2015). In this study, the researcher was positioned as an impartial observer. An impartial observer means that the researcher would not include any individuals who have a preexisting relationship with the researcher, with the

advantage being that the researcher could avoid power dynamics or conflicts of interest power dynamics or conflicts of interest.

However, a disadvantage was that the researcher had a stake in the research topic as a scholar of that topic with both personal and professional feelings regarding it; such a stake could lead to the introduction of bias without due care (Holmes, 2020). In particular, as the researcher, I care strongly about justice regarding both racial and transgender issues. These key issues that are reflected in my worldview were both present in this study and, indeed, were the main foci of the research. Additionally, I am a mental health counselor who specializes in services for the LGBTQ+ community. I have worked in various capacities in the Department of Social Services. I am aware that healthcare can be difficult to obtain for members of this community. Given the nature of my experience with the phenomenon, the study could have been subject to bias without care taken to prevent my experiences from compromising the integrity of the findings. Therefore, reflexivity was employed. Reflexivity entails identifying preconceptions due to a researcher's experiences and continuing to do so throughout the research, out of an awareness that positionality changes during a study (Holmes, 2020). I took care to remain aware of my biases, preconceptions, and expectations before and while conducting the research. These factors were set aside to the extent possible in order to minimize bias. No other ethical issues arose because of the researcher's positionality.



## **Methodology**

### **Participant Selection Logic**

The population of interest for the study was all African American transgender adults in the United States. Within this overall population, the target population was African American transgender adults in the Mid-Atlantic region of the United States. Localizing the population by the state is important because states have different cultures. In addition, many laws and healthcare practices are determined at the state level, meaning that African American transgender adults in the Mid-Atlantic region of the United States likely face different issues than those in other states. The inclusion criteria for the study was: (a) be African American, (b) identify as transgender, (c) have lived in the Mid-Atlantic region of the United States for at least one year, and (d) have accessed healthcare or attempted to access healthcare in the Mid-Atlantic region to ensure relevant experiences, and (e) be at least 18 years of age.

Sampling within this population was conducted through a combination of purposive sampling and snowball sampling. Purposive sampling involves approaching prospective participants specifically for their ability to answer the research questions (Etikan et al., 2016). Snowball sampling involves asking the first round of participants to suggest other potential participants (Parker et al., 2019). Snowball sampling is useful when the population of interest is difficult to access, which was expected to be the case in this study as African American transgender adults are a twice-marginalized population. Purposive sampling was conducted through social media platforms of Facebook, Twitter, Discord, and LinkedIn. A preliminary sample size of 8–10 participants was targeted. The

final sample size was determined by saturation or the point at which new participants no longer add new data (Hennink & Kaiser, 2021).

### **Instrumentation**

The primary instrument of data collection for the study consisted of qualitative, semi-structured interviews conducted by the researcher. The qualitative interview is the standard means of collecting qualitative data because interviews offer an in-depth understanding of participants' opinions and perceptions (Kallio et al., 2016). The interviews in this study were semi-structured. Semi-structured interviews offer a special combination of structure and adaptability (Adeoye-Olatunde et al., 2021). Semi-structured interviews are structured in that they are conducted with the use of an interview guide. This guide includes a list of the key topics the interview must address and a list of preliminary questions to guide the interview. However, the researcher is not constrained by these preliminary questions and may opt to ask probing, follow-up, and clarifying questions as long as all the topics in the guide are adequately addressed as well (Kallio et al., 2016).

The interview guide was key to the interviews. I developed the interview guide in advance with careful reference to the underlying literature reviewed in the literature review. A panel of three experts from the university was recruited to review the interview guide after it was developed (Appendix B). In addition to offering direct feedback on the validity and appropriateness of the guide, the experts each completed a mock interview using the guide. In this fashion, it was possible to ensure that the interview guide was adequate and appropriate for collecting the specific data necessary to answer the central

research question. Each interview was conducted virtually through Zoom and both audio and video recorded. Interviews were then transcribed to yield the final data necessary for the study. In addition, research notes were taken during the interviews to help recall any non-verbal data that would contribute significantly to meaning, such as body language or expressions.

### **Procedures for Recruitment, Participation, and Data Collection**

Prior to any data collection or recruiting any participants, the first step in the study was to secure Walden University's Institutional Review Board (IRB) approval to conduct the research. Any changes requested by the IRB were made to secure approval. In addition, the policies of the social media sites Facebook, Twitter, Discord and LinkedIn were reviewed, and site authorization were sought and obtained prior to recruiting participants via that platform as needed.

Prior to IRB approval, as part of the IRB application, a recruitment post was drafted (Appendix A). This post consisted of a description of the study, its purpose, and what would be required of participants. Prospective participants interested in the study were able to contact me by e-mail. The recruitment post was posted to a series of relevant social media groups identified through a careful review of the indicated social media platforms to find groups for transgender African American adults or groups for transgender people in general.

Prospective participants who contacted the researcher were asked to briefly verify that they met the inclusion criteria, namely that they (a) be African American, (b) identify as transgender, (c) have lived in the Mid-Atlantic region of the United States for at least 1

year, (d) have accessed healthcare or attempted to access healthcare in the Mid-Atlantic region to ensure relevant experiences, and (e) be at least 18 years of age. Then, if they met the criteria, they were sent a copy of the informed consent form. This form more thoroughly detailed the study, how the participants would be protected, how they could withdraw, and similar topics. Participants who accepted the informed consent were asked to sign the form using DocuSign. Once a participant agreed to informed consent, an interview was scheduled at a time of mutual convenience.

Interviews were carried out using a semi-structured interview protocol (Appendix B) and in a secure digital setting through password-protected Zoom calls. Each interview lasted 60-90 minutes. Interviews were audio- and video-recorded using the functionality of Zoom software. The researcher transcribed each interview within 1 week. A copy of the transcript was emailed to each participant to review. Each participant was also asked to provide a copy of the recruitment post to any friends or other contacts they felt might be interested in participating in the study. Recruitment continued until the point of saturation was reached.

Once collected, data were stored securely. All digital data are kept on an encrypted and password-protected external drive when not in use. This drive are stored in a locked drawer when not in use, along with any physical data. Data will be maintained for 5 years after publication, then destroyed through deletion and the burning of the drive along with any physical documents.

## **Data Analysis Plan**

The data from the interviews were analyzed to answer the single, overarching research question. To this end, the qualitative thematic analysis was applied to the data. The data analysis was carried out with the assistance of NVivo qualitative data analysis software. Qualitative thematic analysis is a six-phase process as follows.

Phase one is to build a strong familiarity with the dataset (Clarke et al., 2015). This phase involves repeatedly reviewing the transcripts until a sense of familiarity arises. This familiarity with the data serves to ground the analysis in the dataset more fully. The second phase is to conduct open coding on the data (Clarke et al., 2015). Open coding is the process of labeling all potentially relevant ideas in the dataset with the same label or code each time they appear. The open coding process drew upon an initial codebook developed from the literature. However, coding was not limited to the codes in the codebook; emergent codes could also be used. Then, the third phase is to use the codes to develop key themes (Clarke et al., 2015). Themes represent larger ideas in the data that may be relevant in answering the research questions. Themes can be identified by observing the occurrence of codes and how those codes occur in relation to one another in multiple places throughout the dataset.

In the fourth phase of thematic analysis, the themes must be validated (Clarke et al., 2015). Validation requires that each theme be carefully cross-checked against the underlying data to ensure it is actually reflective of ideas in the data. Once each theme is individually validated, the fifth phase is to cross-validate the themes (Clarke et al., 2015). Cross-validation involves comparing the themes to each other. In this phase, each theme

must be given a name once it has been confirmed to both represent a complete idea and to be meaningfully distinct from the other themes. The final phase of thematic analysis is to compile and discuss the resulting themes (Clarke et al., 2015). The results and discussion, conclusion, and recommendation sections of the study include the realization of Phase 6.

### **Issues of Trustworthiness**

Trustworthiness is the qualitative version of validity and reliability (Moen & Middelthon, 2015). Therefore, trustworthiness was critical to the study. All four major dimensions of the trustworthiness construct were addressed as follows.

#### **Credibility**

Credibility is the equivalent of internal validity. Hence, credibility involves a sound research process (Merriam & Tisdell, 2015). Credibility was achieved in two main ways for this study. First, the important components of the study were carefully aligned. The research purpose was a direct extension of the research problem, and, in turn, the research question operationalized the research purpose. The interview guide was developed in such a way as to ensure that the research question could be answered using the data it elicited. In this way, the study was internally coherent. Additionally, transcript review was used to ensure that the interview transcripts captured what participants actually meant to convey.

#### **Transferability**

Transferability is the equivalent of external validity. Hence, transferability refers to how well the results apply in other contexts (Moen & Middelthon, 2015). However, a qualitative study is not generalizable in the same way as a quantitative study. Instead, the

task of qualitative research is to document the research process sufficiently so that future readers can assess whether they should apply the results (Merriam & Tisdell, 2015). To this end, data collection was carefully discussed herein. In addition, the results contain a full description of the final sample.

### **Dependability**

Dependability is the equivalent of reliability. Since qualitative studies are expected to yield the same precise results on being repeated, dependability applies better to the analysis (Merriam & Tisdell, 2015). In particular, the key to dependability is a robust and well-designed analysis that any other research could repeat to obtain the same results. Hence, the analysis in this study carefully followed the steps laid out in the prior section, and evidence for the analysis are provided in the form of the codebook and quotes.

### **Confirmability**

Confirmability is the equivalent of objectivity. Therefore, confirmability refers to demonstrating that the study was conducted impartially (Moen & Middelthon, 2015). The first strategy for achieving confirmability included discussing the researcher's potential biases and preconceptions regarding the limitations. Additionally, member checking, the repeated validation steps in the data analysis, and the liberal use of quotations from the participants serve to bolster confirmability.

### **Ethical Procedures**

Ethical research practices were adhered to at every stage of the research. Prior to collecting any data, IRB approval was sought and obtained. Where appropriate, site

authorization was obtained from social media platforms. If it seemed prudent, approval to recruit in groups was sought from group leaders/administrators. All participants were provided with informed consent documentation. These documents were reviewed, e-signed, and returned for a participant to participate. All participants were assigned code names to protect their confidentiality. Only the researcher and approved university personnel had or will have access to the original data containing the participants' identities.

All data are stored securely. Data are kept on an encrypted and password-protected external drive when not in use. This drive is stored in a locked drawer when not in use, along with any printouts or other physical data that arise. Data will be maintained for 5 years after publication, then destroyed through deletion and the burning of the drive along with any physical documents.

Participants could contact me by email to withdraw their data from the study at any point prior to the publication of the study. Any identifying information was cleaned from the data prior to analysis through redaction. No coercion was involved in the recruitment of participants. As the study addressed a sensitive topic, participants were provided with the contact information for a low- or no-cost mental health hotline. Participants could also ask to pause or terminate their interviews at any point or decline to address a particular topic. In this way, the risk to the participants, who are a twice-vulnerable population, was minimized as much as possible.



## Summary

In summary, the research problem guiding the study was that African American transgender adults face significant barriers to obtaining desired and necessary healthcare services to manage optimal health, and no research had examined the barriers to obtaining healthcare services to manage optimal health among African American transgender adults (Howard et al., 2019). The purpose of this generic qualitative study was to explore the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health. This purpose was addressed through a single, overarching research question: “What are the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health?” This chapter addressed the research methods.

The central phenomenon of interest for the study was the barriers to healthcare faced by African American transgender adults. To address this phenomenon, a qualitative approach and a generic qualitative research design were adopted for the study. In this study, I was positioned as an impartial observer. The population of interest for the study was all African American transgender adults in the United States. Within this overall population, the target population was African American transgender adults in the Mid-Atlantic region of the United States. Sampling within this population was conducted through a combination of purposive sampling and snowball sampling. A sample of 8–10 participants, adjusted for saturation, was sought. The primary instrument of data collection for the study was qualitative, semi-structured interviews conducted by me. Purposive sampling was conducted through social media platforms. Qualitative thematic

analysis was applied to the data with the assistance of NVivo qualitative data analysis software to answer the research question. The next chapter contains the results of the data analysis.

## Chapter 4: Results

The purpose of this generic qualitative study was to explore the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health. The phenomenon investigated in this study was the barriers to healthcare faced by African American transgender adults, as this population continue to experience obstacles in obtaining desired and necessary healthcare services to manage optimal health (Howard et al., 2019; Seelman et al., 2021). The generic qualitative research design allowed for a descriptive and exploratory inquiry on the subjective experiences of adult African American transgender adults on accessing healthcare services. Based on the research purpose, problem, and design, the research question developed to guide this study was, “What are the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health?”

This chapter contains the results that answered the research question. To contextualize the results, the setting and demographics are reported in this chapter. The data collection, data analysis, and trustworthiness techniques applied to the methodology are also described in this chapter. The themes that emerged from the analysis are then presented along with narratives and excerpts from the data.

### **Setting**

This study was conducted with a target population of African American transgender adults in the Mid-Atlantic region of the United States. As of 2022, an estimate of 1.3 million adults identify as transgender in the United States (Herman et al., 2022). The Mid-Atlantic region has an approximate transgender adult population of

253,000 (Herman et al., 2022). Approximately 0.6% of transgender adults in the United States are African American (Herman et al., 2022). This percentage is similar to the racial distribution of the general population in the United States (Herman et al., 2022).

### **Demographics**

The sample of this study was eight African American transgender adults living in the Mid-Atlantic region of the United States. Specifically, the participants of this study were: (a) African American, (b) identify as transgender, (c) living in the Mid-Atlantic region of the United States for at least one year, (d) at least 18 years of age, and (e) have accessed healthcare or attempted to access healthcare in the Mid-Atlantic region to ensure relevant experiences. These eligibility criteria were indicated in the participant recruitment letter. The participants underwent a screening interview for their eligibility prior to data collection. The information were verified during the interview proper.

Seven participants reported seeking the services of a primary care doctor, while five participants stated additionally seeing sexual-health doctors. One participant sought the services of a dermatologist. Six participants sought healthcare services for hormone therapy, routine check-ups, general health concerns, and other illnesses. The descriptive information of the participants' healthcare-seeking behaviors is presented in Table 1.

**Table 1***Descriptive Information*

Participant	Type of Doctor Seen	Purpose for Seeing Doctor
Alex	Primary care doctor	Hormone injections and general health concerns
Jordan	Primary care doctor	Hormone injections and family history of heart disease
Blake	Dermatologist	Hormone injections and allergies
Casey	Primary care doctor, sexual health doctor, gender-affirming care doctor	Hormone therapy, gender dysphoria and routine physical health check-up
Riley	Primary care doctor, sexual health doctor	Hormone injections, gender dysphoria and routine physical health check-up
Jamie	Primary care doctor, sexual health doctor	Hormone therapy and routine physical health check-up
Ariel	Primary care doctor, gynecologist	Routine physical health check-up
Robin	Primary care doctor, gynecologist	Routine physical health check-up

**Data Collection**

The data collection method in this study was individual interviews. The interviews were semi-structured in nature. Data collection occurred from July to November of 2023. Prior to the interviews, necessary approvals and consent were obtained from the Walden University Institutional Review Board (IRB) and the participants. The IRB application included the proposal for this study and the draft of the participant recruitment letter. The recruitment letter contained a brief introduction of the researcher, the nature and purpose of the study, and the eligibility criteria for participation. The researcher's e-mail address was also indicated in the recruitment letter which the prospective participants used to contact the researcher regarding inquiries and

interest in the study. No permissions were needed for the recruitment of potential participants from social media platforms Facebook and LinkedIn.

Potential participants who expressed their interest in joining the study were scheduled for a brief screening interview via Zoom online conferencing platform. The screening questions were about the participants' ethnicity, age, area of residence, and if they accessed or attempted to access healthcare in the Mid-Atlantic region to check if they met the eligibility criteria. The participants who met the eligibility criteria were asked for their preferred interview schedule via Zoom online conferencing software. During the initial screening interview, the contents of the informed consent form were also discussed to the eligible participants. The informed consent form contained information about the protection of the participants' rights and the terms and conditions of participation. The stipulations included the voluntary nature of participation, transparency in potential risks in participation, and agreement for the audio and video recording of the interview for data collection and analysis purposes. Zoom has a recording functionality which was utilized in the transcription process. A digital copy of the informed consent form was sent to each participant via e-mail with the instructions of returning a signed copy prior to the interview schedule. All eight participants complied and expressed their understanding and agreement to the stipulations of participation.

During the interview, the contents of the informed consent form were reviewed and the eligibility of the participants were validated. The participants were informed that the maximum duration of the interview session was 90 minutes. An interview protocol was used as a guide to maintain the alignment of the data collection to the research

question of this study, while the semi-structured nature allowed for the collection of more in-depth information through asking probing and follow-up questions. All five interview questions were asked to all the participants. Apart from the interviews with Alex and Ariel during which minor connectivity issues occurred, all the interviews did not have any problems. The connectivity issues with Alex and Ariel did not seem to have a significant impact on data collection as the interview duration for both interviews were similar to that of the other six interviews averaging at approximately 60 minutes.

At the end of each interview, the participants were informed of the member checking process. The member checking process entailed the participants' review of the interview transcript and the summary of the information they shared based on the researcher's understanding. The purpose of the member checking process was to establish the accuracy of the data and the researcher's interpretation of the data (Merriam & Tisdell, 2015). Thus, immediately after each interview, the recordings were transcribed, a summary was produced, and the transcripts and summary were sent to the participants via e-mail to allow them to review whether the researcher accurately encapsulated their insights.. The participants were asked to return their validated transcripts within 14 days, after which, the transcript was considered approved and ready for data analysis. All of the raw and processed information collected from the participants were kept in the researcher's personal password-protected computer and encrypted cloud storage. These data will be permanently deleted 5 years after the conclusion of this study.

## **Data Analysis**

The data analysis procedures for this study were based on the six-step thematic analysis framework developed by Clarke et al. (2015). The six steps were: building familiarity with the dataset, open coding, developing categories, validating themes, cross-validating themes, and compiling and discussing the themes (Clarke et al., 2015). The qualitative data analysis software NVivo version 14 was utilized as a tool for managing and organizing the data during the analysis.

Building familiarity with the dataset involved multiple immersions in the data. The researcher became exposed to the data starting from the individual interviews with the participants followed by listening to the interview recordings and transcribing the interviews. After the participants' transcript validation and member checking process, the researcher imported the eight final transcripts to NVivo and read them three times as a whole to acquire a holistic understanding of the data. Next, the open coding process was conducted. The transcripts were read line-by-line in search of ideas that were relevant to this study. The ideas within the lines of texts were summarized into concise descriptions to form codes. Lines of texts with similar ideas were assigned to the same code. Table 2 shows examples of lines from the transcripts and the codes assigned to them.



**Table 2***Sample Codes*

Sample codes	Quotes
Experienced double discrimination	“So it's a double discrimination. face discrimination related to my race and gender simultaneously.” “Casey”
Difficulties with name change	“Plus it goes back to the insurance company tells them that I haven't had my name changed, then I have to pay, I literally have to pay the state to have them change my name.” “Alex”
Difficulties accessing some treatment plans	“it's sometimes difficult, like finding treatment plans, um, medication. Healthcare in general sometimes can be, um, tricky because you have to find providers and, you know, like when you're filling out your forms, you know, everything is not covered, like everything is not specifically labeled, like that type of thing.” “Blake”
Speaking up	“I definitely try to fix it. I try to face it head on. Try to speak to the issue, the root.” “Casey”
Seeking referrals for a suitable doctor	“I've called my health insurance before and they've directed me to the appropriate healthcare professional that could assist and referrals from other providers as well.” “Casey”
Receiving support from community	“And my intersectional identity connects me to communities of both African American and LGBT individuals. And so these networks offer a source of understanding the advocacy, and I want to say resilience.” “Casey”

The third step was to develop categories which refer to larger and more abstract ideas than codes (Clarke et al., 2015). Categories were developed from codes with similar patterns within the ideas and were relevant to the research question of this study. The transcripts were treated as a whole dataset from which the codes and categories emerged instead of breaking down the analysis per interview question. The codes and categories are presented in Table 3.

**Table 3***Codes to Categories*

Codes	Categories
HCWs' assumptions against them Misgendered and feeling looked down on Systemic issue	Experienced double discrimination
Being true to who they are Representing transgender women in the local community Speaking up	Advocating for themselves
Avoiding conflicts Willing to drive elsewhere Telemedicine	Avoiding encounters with discriminatory doctors
Receiving support from community	Receiving support from community
Need for cultural competency training among HCWs Need for respect Need more effort to help transgender woman, specifically praying for change	Recommendations for change
Seeing a transgender doctor Seeing an African American doctor Seeking referrals for a suitable doctor	Seeking open-minded and accepting doctors
Not given the help needed	Denied help by HCWs
Hinders transition	Not taken seriously by HCWs
Don't know how to help	Perceived lack of knowledge of HCWs about transgender individuals
Unwilling to help	Perceived unwillingness of HCWs to help transgender individuals
Difficulties accessing some treatment plans No clear protocols for transgender patients	Difficulties with insurance
Difficulties with name change No options for non-binary gender in forms	Difficulties with paperwork for health insurance

The fourth step was to validate the categories. Theme validation involved reviewing the coded texts in each theme to verify that the themes were sufficiently

supported by the data and that they emerged from the data instead of the researcher's interpretation or bias. During this step, the categories with incomplete narratives were compared and contrasted against each other to identify whether a broader theme would emerge. From 12 categories, four final themes were developed as seen in Table 4. The final themes were further reviewed through cross-validation in the fifth step of the analysis. During this step, the themes were given their final names that describe the idea they conveyed in a way that answered the research question. Cross-validation also entailed contrasting the themes against each other to ensure that no themes overlapped.

**Table 4**

*Categories to Themes*

Preliminary Themes	Themes
Experienced double discrimination	Experiences of gender- and race-based inequalities in healthcare settings
Advocating for themselves Avoiding encounters with doctors' discrimination Receiving support from community Recommendations for change Seeking open-minded and accepting doctors	African-American transgender adults' practices of overcoming the barriers to accessing healthcare services
Denied help by HCWs Not taken seriously by HCWs Perceived lack of knowledge of HCWs about transgender Individuals Perceived unwillingness of HCWs to help transgender individuals	Healthcare needs of African-American transgender adults are unheard and not addressed by healthcare workers
Difficulties with insurance Difficulties with paperwork for health insurance	Difficulties with paperwork and health insurance claims

The final step was to report the results. The report of the themes was organized logically through the number of occurrences in the data. The report includes narratives and excerpts from the data to support the findings.

### **Evidence of Trustworthiness**

Trustworthiness is a vital to the demonstration of a rigorous qualitative study (Moen & Middelthon, 2015). Chapter 3 included a presentation of the issues of trustworthiness based on the criteria of credibility, transferability, dependability, and confirmability. The following sub-sections contain the techniques applied to the methodology to address the issues and establish the trustworthiness of this study.

#### **Credibility**

Credibility refers to the extent to which the data can be assured as accurate representation of the participants' actual experiences (Merriam & Tisdell, 2015). Credibility was established through the alignment of the components of the study and through member checking. The components of the study that were aligned were the research problem, purpose, question, and methods. The phenomenon of the African American transgender adults' experience of barriers to obtaining healthcare services is not widely researched. Thus, a descriptive and exploratory approach such as a generic qualitative design was appropriate for this study. This design entailed the use of open-ended questions to elicit in-depth and detailed responses from a sample of eligible participants which was achieved in this study through the use of semi-structured interviews and purposive sampling. The participants contributed to the member checking process through transcript reviews and validation of the researcher's summary of the interview data.

**Transferability**

Transferability refers to the extent to which the results can be applicable to similar contexts (Moen & Middelthon, 2015). Readers can validate the applicability of the results of this study through the detailed descriptions of the data collection and data analysis processes. The setting and demographics of this study were also reported. Furthermore, the assumption that the sample of this study were members of a twice-marginalized group, which is being African American and transgender, was also disclosed.

**Dependability**

Dependability refers to the extent to which the results remain consistent despite replication of the methodology (Merriam & Tisdell, 2015). Obtaining similar results through repetition of the study depends on the richness and thickness of the descriptions of the study materials and procedures. The development and validation of the interview protocol were included in Chapter 3. The interview protocol is presented in Appendix B. The utilization of the interview protocol as a data collection tool was reported in this chapter. In the analysis of the data, the steps of thematic analysis and the use of NVivo data analysis software were described. The development of the data into codes and then codes into themes are shown in the codebook (see Appendix C).

**Confirmability**

Confirmability refers to the extent to which the results are objective and replicable (Moen & Middelthon, 2015). The researcher's potential biases as a mental health counselor with specialization in working with the LGBTQ+ community were divulged and described in the previous chapter. The methodological limitations and the procedures

to address them were also detailed in the previous chapter. To remain objective in the analysis of subjective interview data, a systematic coding schema was followed based on the data analysis procedures recommended by Clarke et al. (2015).

### **Results**

This section contains the results of the analysis of the experiences of African American transgender adults in obtaining or attempting to obtain healthcare services in the Mid-Atlantic region of the United States. This section contains the results of the analysis of the experiences of African American transgender adults in obtaining or attempting to obtain healthcare services in the Mid-Atlantic region of the United States. The results answered the research question, “What are the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health?” Four themes emerged from the analysis. The themes were: (a) experiences of gender- and race-based inequalities in healthcare settings, (b) African American transgender adults' practices of overcoming the barriers to accessing healthcare services, (c) healthcare needs of African American transgender adults are unheard and not addressed by healthcare workers, and (d) difficulties with paperwork and health insurance claims. The presentation of the themes is organized from the most highly recurring to the least recurring idea within the dataset. The number of times the themes recurred along with the number of contributing participants is presented in Table 5.

**Table 5***Theme Occurrences*

Theme	No. of Contributing Participants	No. of Occurrences in the Data
Experiences of gender- and race-based inequalities in healthcare settings	8	52
African American transgender adults' practices of overcoming the barriers to accessing healthcare services	8	46
Healthcare needs of African American transgender adults are unheard and not addressed by healthcare workers	8	40
Difficulties with paperwork and health insurance claims	5	18

**Experiences of Gender- and Race-Based Inequalities in Healthcare Settings**

All eight participants reported experiences of gender- and/or race-based inequalities in their access or attempt to access healthcare services. The inequalities were experienced from HCWs such as doctors, nurses, and health insurance staff. Seven participants shared their perceptions that they experienced, the word of Casey, “double discrimination” for being both African American and transgender. Casey elaborated:

I would say it's a double discrimination ... it's created a unique form of bias that affects my quality of care received ... So there's already challenges in being African American alone, and then there's separate challenges for being transgender alone. But the differences in being one or the other, I would say they can be overlooked or marginalized within both the African American and transgender community, which creates feelings of isolation.

Jamie explained that being a racial minority and a gender minority was the reason for their experience of double discrimination in the healthcare setting. Jamie stated, “Being African American and transgender is just a walking target. I don't know. It's only a dream to get good healthcare, to be honest.” Jamie later on found a new doctor who treated them “like family.” Jamie shared that they trusted their new doctor and had a positive experience talking to them. Ariel and Robin perceived that discrimination against African Americans and transgender individuals was not limited to the healthcare setting, but in society in general. The two participants stated that they were not respected as individuals in most settings. Ariel shared that because of the discrimination they experienced, a positive outcome was that they became more determined to “fight harder” for their rights to equal access to healthcare services. In the healthcare setting, Robin shared an experience of a friend who was disrespected by a doctor. Robin narrated:

I only had seen one. He wasn't my specific doctor. It was one prejudice doctor who really doesn't, I guess, they don't accept us or don't agree. My friend went there. They was really nasty. He was really trifling to her. Tried to continue to tell her he would not give her healthcare. I just felt like that was disgusting. I felt a type of way, even though it didn't happen to me, because it's within the whole community.

In Robin's experience, the positive aspect was that a nurse intervened and advocated for them. The nurse also assisted them in finding a new doctor.

Jordan also compared their experiences with their friends, particularly their White transgender peers who the participant described to have experienced fewer obstacles in



obtaining healthcare services than they did. Jordan perceived that African American transgender individuals experienced more inequalities in the healthcare setting than White transgender individuals because of economic status. Jordan thought that White transgender individuals tended to have better financial resources than African American transgender individuals to be able to afford quality healthcare. Jordan elaborated:

I feel it's much, much less for people who are just transgender because I have a lot of white transgender friends and stuff who access healthcare. And most of the time I don't really hear them having to fight with their doctors about their levels and things and what medications they're taking... Again, because I think healthcare is expensive and those sorts of things, and not to be that guy, but a lot of the white transgender people I know have had their parents finance their transition.

However, in terms of personal experience, Jordan have not had notably positive nor negative race- or gender-based discrimination. Jordan stated, "Yeah, there's not been anything particularly noteworthy, really, really good experiences. But there haven't been any really, really bad experiences either."

Nonetheless, six of the participants perceived that being transgender led to more discrimination than being African American in the healthcare setting. The participants shared their experiences of being misgendered and dismissed. Robin shared, "On my I.D. it definitely says that I identify as a female. The doctor did start saying he, as in male...They didn't see my gender how I wanted to be seen...I felt mislabeled." Jamie shared:

But even before I transitioned, when I started my period, my cramps were really bad, so they were going to prescribe me birth control, but my insurance company had already thought I was a boy, so I couldn't get that. So they had no problem calling me he or him then. But when I would come in and actually change my pronouns after they changed my pronouns to she/her after the incident, it was like they didn't want to call me the correct pronouns, so they just left it alone. But I could feel the shift in the environment.

Four participants perceived that the inequalities they experienced as African American transgender adults in the healthcare setting were a systemic issue. Systemic meant that the issue was prevalent and recurring in society, as in the explanation of Jamie, “Really just history, honestly. It's the domino effect. Everything repeats itself.” Casey, Riley, and Ariel shared that the issue of inequalities they experienced in accessing healthcare services was a result of a systemic problem regarding the lack of policies specific to minority populations. Riley shared, “So misgendering and deadnaming, they don't necessarily always have clear protocols in process or in place to respect my gender identity.”

### **African American Transgender Adults' Practices of Overcoming the Barriers to Accessing Healthcare Services**

All eight participants shared that with the challenges they experienced in accessing healthcare, they have established some practices that allowed them to overcome the barriers. One practice shared by seven participants was to seek HCWs who were known to be open-minded and accepting of any individuals. The participants found

suitable HCWs primarily through referrals. Casey, Riley, and Jamie sought referrals from their insurance company. Riley shared:

And then my health insurance, I've called my health insurance before and they've directed me to the appropriate healthcare professional that could assist and referrals from other providers as well. I've come in contact with prescribers or providers that didn't necessarily meet my need as a transgender and so they gave me a referral for other providers that would be able to meet my needs.

Participants Casey and Riley additionally sought referrals from the LGBT community as they believed that the community shared similar challenges that they experienced in accessing healthcare services. Casey shared, "So I access those services through community support in the LGBT community. We all talk and everybody always get together and give recommendations of where they went and different clinics that they've may tried." Jordan did their researched and asked the online community for referrals. Apart from referrals, Participants Casey and Riley shared that they found emotional support from their communities. Casey shared, "The thing is ... engaging with supportive networks and advocacy groups to find information and emotional support and resources to assist other LGBTQ members who may be experiencing or having the same experience as I."

Five participants shared that they stood up for themselves during experiences of discrimination by HCWs. They spoke up against the inequalities they experienced. Robin stated, "I definitely try to fix it. I try to face it head on. Try to speak to the issue, the

root.” Alex and Blake perceived that speaking up and standing up for themselves meant they were true to who they are. Alex elucidated:

When they see me, they're like, [birth name], and I stand up and they see the way I dress and they're looking at me, they're look at the clipboard. They was like, you're [birth name]? And I'm like, yes, is there a problem? No, no, no, just come on in. And then I explained to them and they're like, okay, now I get it. Because I basically explained to them first who I am and what I am. And then I lay down the ground rules really quickly. My mom is basically just like, be honest first and then let them ask questions later.

Casey recommended one way to advocate for African American transgender individuals to receive quality healthcare services was to provide cultural competency training for the HCWs. The participant explained that cultural competency training includes teaching HCWs to be “sensitive to the unique needs” of specific populations. Robin perceived that HCWs did not necessarily need more training, but needed to develop more respect towards minority individuals.

Four participants shared that they consciously avoided HCWs who were already known to be discriminatory. Alex, Jordan, and Blake used telemedicine to reach doctors who they find suitable. Blake additionally shared that having friends who worked in the healthcare industry was helpful in their experience of addressing their health issues. Alex and Jordan also found the use of telemedicine to be cost-efficient. Jordan stated, “It's just a bit more easier to access things through telehealth programs online to get it. And it's often much cheaper in that way.” Jordan also stated that a positive aspect of healthcare

was the ease of access because of the telehealth programs. For services that required physical appearance, Alex and Jordan shared that they were willing to drive farther to avoid the discriminatory HCWs in their area. Jordan shared, “I'm not even going to chance it. I'm going to go into the city, I'm going to go there for [treatment].”

### **Healthcare Needs of African American Transgender Adults are Unheard and are not Addressed by Healthcare Workers**

All eight participants reported experiencing being unheard and having their healthcare needs unaddressed. Seven participants believed that some HCWs lacked knowledge about minority individuals, particularly about transgender people. Alex and Riley stated that most HCWs did not have “lived experiences” of being an African American transgender person. Blake and Robin thought that HCWs typically did not know how to identify them and help them. Jordan specified an experience of HCWs not knowing about their bodily function. Jordan shared:

I find myself having to explain how certain things about my body works and stuff, because when I go to a primary care physician and they start asking me questions about how often I've had my periods and stuff, I don't get regular periods because of testosterone and stuff. And so they get immediately concerned, start asking me about could I be pregnant.

Four participants shared their experiences of explicitly being refused or denied healthcare services which they attributed to their gender and/or their race. Ariel stated, “I believe, because I'm a transgender. The doctor really didn't want to see me, so I had to go see another doctor. Just going to the doctors, they just be skipping over me basically like

I'm not even there.” Blake expressed that some HCWs could not be bothered to treat them like an individual person and address their healthcare needs. Blake shared, “You get misgendered, um, sometimes there's issues with like getting medication, um, treatment plans, things like that, because they're looking at you like you're just an it.” Pertaining to race, Jordan shared their perception certain medication were not suitable for African Americans but could be effective for Whites. Jordan experienced speaking up about this concern, but was dismissed by a dentist. Jordan described:

I went to the dentist not too long ago. Just as a general thing, I feel quite often that things like pain isn't quite treated the same way as it would be when if I was not black or trans because when they're working on your teeth and they're putting the orgel and stuff on them, and I'm like, ‘Hey, orgel doesn't necessarily work for me. I need the injections and stuff.’ . . . I remember reading somewhere...there was something dealing with the sorts of medications that they give to Black women during pregnancies versus White women during their pregnancies where it's seen as black people feel pain differently than white people or something like that.

The participants shared that their transition was one of the reasons they seek healthcare services. However, four participants stated that HCWs did not take their needs seriously. In Alex’s experience, doctors they saw questioned their decision to transition. Alex shared, “Some doctors that basically want you to do something different or really wants you to see a psych eval just to make sure that you know where you're stepping into it.” Jordan shared, “So at the beginning it was real uncomfortable things. And it just feels, I feel you're not being taken seriously I guess.”

Three of the eight participants disclosed that they encountered HCWs who were not willing to help them. Alex, Blake, and Ariel attributed HCWs' unwillingness to help them to poor attitude. Alex stated, "Their attitude shows that they're not willing to help, not even to accommodate a person." Ariel stated, "They show us very little respect. They're not compassionate and they don't care."

Nonetheless, another finding was that four participants reported having positive experiences in obtaining healthcare services. Jamie and Robin shared that they found allies in some HCWs. Robin shared that a doctor misgendered them, but a nurse called out the doctor to show them respect. Jamie specifically stated that they experienced respect and quality healthcare from younger doctors. Jamie shared, "The doctors that I go to now, they're kind of millennial, Gen Z kind of, and they're cool." Casey and Riley shared that they experienced having supportive doctors who made them feel validated and empowered. Casey stated that a positive aspect of their experience in accessing healthcare was to have healthcare providers who acknowledged their identity and their needs.

### **Difficulties With Paperwork and Health Insurance Claims**

Five of the eight participants shared their experiences of difficulties with health insurance including the paperwork and the claims. The participants' difficulties with health insurance claims were specific to the rejection of coverage for certain treatment plans especially in sexual and reproductive health care causing them to pay out of pocket. The rejection of health insurance claims was a result of supposedly gender-specific procedures such as pap smear in the experience of Jordan. Jordan shared, "But I do know

that there are some difficulties surrounding getting things like pap smears, gynecologist appointments and stuff when you are legally recognized as male and things of that nature." Alex, Casey, and Riley shared that procedures and treatment plans related to transition were often not covered by insurance. Alex and Jordan stated that they experienced vague protocols regarding insurance. Alex shared, "I'm having disqualifications with the insurance and everything because first minute they agree, next minute they don't."

Additionally, Alex and Blake experienced challenges in the paperwork related to health insurance. Blake shared that some forms did not include options to identify as transgender. Blake stated, "As far as having help and being able to access services . . . the forms just are straight up black and white, male or female . . . and there's no true [gender] identity." For Alex, the challenge regarding paperwork was due to their name change. The insurance company did not recognize their changed name due to the lack of supporting documents such as a social security card which were still being processed. Alex shared:

I have to wait until they change birth certificate, social security card, medicines, you name it. They got to change all that stuff around and then sometimes it takes a while for them to change to have that stuff stamped and just basically published out there that your name is now [Alex] . . . insurance is looking at that you're violating them and they're still paying for you to get your medicine. So if you ain't changed your name, they will automatically stop your medicine and you will have to pay out of pocket, which that costs tons of money. And I'm like, y'all might as



well just keep it underneath my actual name because I don't have that kind of money to have my name changed. Not right now. I'm still stuck.

Overall, African American transgender adults experienced obstacles regarding insurance because of their gender. Insurance companies lacked protocols on the coverage of certain sexual and reproductive healthcare service targeted for transgender individuals. Additionally, the paperwork regarding insurance claims may not be inclusive of transgender individuals and the process of obtaining supporting documents for identification of one's new legal name took time. These obstacles resulted in the participants' experiences of paying for healthcare instead of being able to rely on insurance.

### **Summary**

This chapter contained the presentation of the results of this study. This study addressed the purpose experiences of exploring the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health using a generic qualitative design. Eight African American transgender adults from the Mid-Atlantic region of the United States were purposively selected as the sample of this study. The participants were interviewed individually and the interview data was analyzed thematically. The analysis generated four themes that answered the research question, "What are the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health?" The themes were: (a) gender- and race-based inequalities in healthcare settings, (b) African American transgender adults' practices of overcoming the barriers to accessing healthcare services, (c)

healthcare needs of African American transgender adults are unheard and not addressed by healthcare workers, and (d) difficulties with paperwork and health insurance claims.

Overall, the participants of this study experienced more gender-based discrimination than race-based discrimination; however, double discrimination was experienced prevalently. Gender-based discrimination by HWCs was manifested through denial of treatment, disrespect, and bias. The participants' gender-based needs were not taken seriously and not addressed by HCWs. Race-based discrimination included unfair treatment. Some participants perceived that racism and sexism are systemic issues that are exacerbated in the healthcare setting due to the lack of policies and protocols specifically for addressing the health needs of minority individuals. In relation, the participants experienced challenges with health insurance claims particularly in filling up forms without options for non-binary gender and in dealing with name change. Often, the participants experienced a prolonged process of paperwork and denial of insurance claims. Additionally, the participants perceived that HCWs were not well-informed about transgender individuals and their needs and were not willing to exert extra effort to help their minority group. Positive experiences with accepting doctors were reported by only two participants. To overcome the difficulties in accessing healthcare services, the participants shared that they actively sought suitable doctors through referrals from trusted people, avoided conflicts and encounters with possibly discriminatory HCWs, and advocated for themselves.

These results show the participants' experiences of the barriers to obtaining desired and necessary healthcare services. These barriers and the practices to overcome

them were identified from the participants' experiences as both African American and transgender. This intersectionality will be interpreted and discussed in the next chapter through the lens of Crenshaw's (1990) intersectionality theory. The conclusions of the study are also presented in the next chapter.

## **Chapter 5: Discussion, Conclusions, and Recommendations**

Transgender adults face significant barriers to obtaining desired and necessary health care services to manage optimal health (Howard et al., 2019; Seelman et al., 2021). Because of the importance of health care, when these barriers prevent access for an already vulnerable community, such as African American transgender people, there is a profoundly detrimental effect on the members of that community that can create serious hardships and even trauma (Hobster & McLuskey, 2020; Milner et al., 2019). However, little is still known about the intersectional barriers facing those who are both African American and transgender within a health care context (Cicero et al., 2019; Kcomt et al., 2020; Howard et al., 2019).

The purpose of this generic qualitative study was to explore the experiences of African American transgender adults obtaining necessary health care services to manage optimal health. The sample of this study was eight African American transgender adults living in the Mid-Atlantic region of the United States. Specifically, the participants of this study were: African American, identified as transgender, lived in the Mid-Atlantic region of the United States for at least one year, were at least 18 years of age, had accessed health care or attempted to access health care in the Mid-Atlantic region to ensure relevant experiences, and had experienced barriers when accessing or attempting to access health care in the Mid-Atlantic region. The data was collected using semi-structured one-on-one interviews. Seven participants reported seeking the services of a primary care doctor, while five participants stated additionally seeing sexual health doctors. One participant sought the services of a dermatologist. Six participants sought

health care services for hormone therapy, routine check-ups, general health concerns, and other illnesses.

The interview data was then analyzed thematically, and this analysis generated four themes that answered the research question: “What are the experiences of African American transgender adults obtaining necessary health care services to manage optimal health?” These themes were (a) gender and race-based inequalities in health care settings, (b) African American transgender adults' practices of overcoming the barriers to accessing health care services, (c) health care needs of African American transgender adults are unheard and not addressed by health care workers, and (d) difficulties with paperwork and health insurance claims.

Overall, the participants of this study experienced more gender-based discrimination than race-based discrimination. However, the intersectionality of double discrimination was experienced prevalently. Gender-based discrimination by health care workers was manifested through denial of treatment, disrespect, and bias. The participants' gender-based needs were not taken seriously and not addressed by health care workers. Race-based discrimination included unfair treatment.

Some participants perceived that racism and sexism were systemic issues that were exacerbated in the health care setting due to the lack of policies and protocols that were designed to specifically address the health needs of minority individuals. The participants also experienced challenges with health insurance claims, particularly when filling in these forms without options for non-binary gender and when dealing with a

name change. Often, the participants experienced a prolonged process of paperwork and denial of insurance claims.

Additionally, the participants perceived that health care workers were not well-informed about transgender individuals and their needs and were not willing to exert extra effort to help their minority group. Positive experiences with accepting doctors were reported by only two participants. To overcome these difficulties in accessing health care services, the participants shared that they actively sought suitable doctors through referrals from trusted people, avoided conflicts and encounters with possibly discriminatory health care workers, and advocated for themselves.

### **Interpretation of the Findings**

In this section, an interpretation of the findings of this study will be given that will discuss in further depth how these key findings answered the research question. In the process, these key findings as previously noted will be discussed within the context that they confirm, disconfirm, or extend the related extant literature. These key findings will then be analyzed within the context of the conceptual framework.

### **Experiences of Gender and Race-Based Inequalities in Healthcare Settings**

The first significant theme that answered the research question of the current study was experiences of gender and race-based inequalities in healthcare settings. All eight participants reported experiences of gender and or race-based inequalities in their access or attempt to access health care services. These inequalities were experienced from health care workers such as doctors, nurses, and health insurance staff. Seven participants shared their perceptions of experiencing double discrimination for being both

African American and transgender. However, for one participant, there was a positive aspect to experiencing these inequalities when a nurse intervened, advocated for, and assisted this participant with finding a new doctor. Several studies in the literature reviewed also revealed discriminatory practices in their findings within health care settings that were based on gender and or race-based inequalities. Alizaga et al. (2022) used a quantitative research methodology and conducted a latent class analysis to better understand the types of discrimination faced by transgender people of color. These researchers found that many transgender people of color either experienced or anticipated discrimination, and those who experienced discrimination received decreased quality of health care service or no health care service at all. Salerno et al. (2020) also specifically studied Black transgender people and concurred with Alizaga et al. (2022) that there were discriminatory practices that influenced this population's access to quality health care. Howard et al. (2019) explored the health care experiences of transgender people of color using a qualitative method with data from interviews and focus groups among 22 participants. These researchers further concurred that all participants described negative experiences with health care providers because of discriminatory biases against their race or gender identity.

Similarly, Kattari et al. (2020) supported the possibility of such discriminatory biases when studying the intersecting experiences of health care denials among this population. These researchers conducted a quantitative study with data that was gathered from a nationally representative 2015 trans study with 27,715 participants. Around 8% had been denied trans-specific healthcare, while over 3% had been denied general health

care (Kattari et al., 2020). Health care denial was also most strongly predicted by older age, biracial or multiracial status, and lower-income status.

Clear consensus was found in the current literature reviewed that there were biased and discriminatory practices within health care settings against those who were transgender and or African American (Alizaga et al., 2022; Howard et al., 2019; Kattari et al., 2020; Salerno et al., 2020). Kattari et al. (2020) also had findings that recognized age and income status as significant factors that may further contribute to these inequalities and discriminatory practices within health care settings. Therefore, the first key finding of the current study of experiences of gender and race-based inequalities in healthcare settings confirmed the consensus in the existing literature.

The conceptual framework of this study was intersectionality theory (Crenshaw, 1990) that provided a foundation to particularly focus on problems arising from the intersection of people who are both African American and transgender. Crenshaw introduced the concept of intersectionality that was initially derived from critical race theory (Carastathis, 2016; Meer, 2014). This theory's concept emphasizes the interaction of gender and race and the lack of understanding of how this intersectionality can further marginalize people, that was first exemplified in the experiences of African American women (Meer, 2014). Crenshaw also revealed that intersectionality was a concept used to theorize how the law responded to issues about race and gender discrimination (Meer, 2014).

This theory was applied to the current study to better understand the intersectionality of being both African American and transgender. The first key finding



from this study indicated that seven out of the eight participants perceived that they had experienced double discrimination within health care settings because of both gender and race-based inequalities. Therefore, this first key finding supported the tenets of this conceptual framework.

### **African American Transgender Adults' Practices of Overcoming the Barriers to Accessing Healthcare Services**

The second significant theme that answered the research question was African American transgender adults' practices of overcoming barriers to accessing healthcare services. All eight participants shared that with the challenges they experienced in accessing health care, they established some practices that allowed them to overcome these barriers. One practice shared by seven participants was to seek health care workers who were known to be open-minded and accepting of any individual. The participants also found suitable health care workers primarily through referrals. Five participants also shared their positive experiences of learning to stand up for themselves when overcoming discrimination with health care workers. Two participants reported the positive experiences of finding needed emotional support in their communities.

Multiple studies in the literature reviewed also recognized the barriers that African American transgender adults faced when attempting to access health care services. First, it was noted in the literature that African Americans alone, without the added minority status of gender identification, faced significant barriers to health care (Cheatham et al., 2008; Hammond et al., 2010; Wheeler et al., 2007). These barriers were further described in the literature to also be related to cultural and religious beliefs among

their population, bias and discriminatory practices, socioeconomic status, disparities in health care costs based on race, and a lack of knowledge (Ali et al., 2018; Chandler et al., 2021; Charron-Chénier & Mueller, 2018; Muvuka et al., 2020; Planey et al., 2019; Sacks, 2018). When these racial inequities were combined with other minority characteristics, such as variances in gender identity, the problem of barriers to accessing health care increased (Carter et al., 2020; da Silva, 2020; Salerno et al., 2020; Teti et al., 2021).

Other studies in the literature reviewed focused research on solutions to these barriers. These solutions included increased education for health care providers (Ali et al., 2018; Butkus et al., 2020; Moseson et al., 2020; Oliphant et al., 2018). Gender affirmation was also recognized as a solution to these barriers (Butkus et al., 2020; Moseson et al., 2020; Oliphant et al., 2018; Snow et al., 2022).

Sevelius et al. (2021) further elaborated that out of all of the suggestions for ways to mitigate barriers for transgender people of color, the most prevalent involved practitioners using proper gender affirmation and patients being able to obtain treatments that suited the gender with which they identified. This quantitative study included a sample of 858 transgender women of color. Their results yielded that affirming a person's gender and empowering health care choices significantly influenced the overall impact of sexual orientation-related intolerance on viral inhibition (Sevelius et al., 2021).

However, there were contrasting perspectives that were also found in the literature reviewed regarding these solutions of increased education for health care providers and gender affirmation. Stoumsa et al. (2019) conducted a quantitative study on the topic of formal education for health care providers on transgender health. These

researchers found no correlation between increased hours of education and enhancement of the health care providers' knowledge of transgender health care. The discrepant findings of Stoumsa et al. (2019) from the previous consensus of the solution of increased education for health care providers to mitigate the barriers that African American transgender people face (Ali et al., 2018; Butkus et al., 2020; Moseson et al., 2020; Oliphant et al., 2018) therefore indicates the need for further research on this topic to better understand what significant factors are involved that may make transgender health education more or less effective.

Goldenberg et al. (2020, 2021) examined health care access for transgender youth of color. These researchers found that the youth participants reported more stigmatization associated with health care, even when they had received gender affirming care. These findings of Goldenberg et al. (2020, 2021) contrasted as well with the previous consensus of gender affirmation as a solution to help mitigate barriers for African American transgender people when accessing health care (Butkus et al., 2020; Moseson et al., 2020; Oliphant et al., 2018; Snow et al., 2022). Therefore, more research is also needed to better understand specific variables like stigmatization or other significant factors that may still be barriers to accessing health care for the African American transgender population, even when they are receiving gender affirming care.

Consensus was found in the literature reviewed that the African American transgender population faced barriers to accessing health care (Carter et al., 2020; da Silva, 2020; Salerno et al., 2020; Teti et al., 2021). Therefore, the second key finding of the current study of African American transgender adults' practices of overcoming

barriers to accessing healthcare services partially confirmed this consensus in the existing literature by recognizing that these barriers exist. The extant literature did focus also on solutions to these barriers, with some discrepant findings, pertaining to the education of health care providers and gender affirmation. However, none of these studies focused on the solutions of the African American transgender population themselves for overcoming these barriers. Therefore, this second key finding also extended the literature by providing valuable insight into specific ways that this population overcomes these barriers through seeking health care workers who were known to be open-minded and accepting of any individual and through the referral process.

Regarding the conceptual framework, the intersectionality of being both African American and transgender was illustrated again through the second key finding of this study. The double discrimination these participants experienced of gender and race-based inequalities in health care settings manifested into the need to then also have to overcome real barriers when accessing health care. Therefore, the second key finding of the current study also supported the tenets of this conceptual framework.

### **Healthcare Needs of African American Transgender Adults are Unheard and are not Addressed by Health Care Workers**

The third significant theme that answered the research question was healthcare needs of African American transgender adults are unheard and not addressed by health care workers. All eight participants reported experiencing being unheard and having their health care needs unaddressed. Seven participants believed that some health care workers lacked knowledge about minority individuals, particularly about transgender people. Four

participants further believed that most health care workers did not have the lived experience of being an African American transgender person or typically did not know how to identify and help them. However, four participants also reported having positive experiences when obtaining health care services that included finding allies in health care workers who were willing to advocate for them, and health care workers who were more sensitive to their needs or made them feel validated and empowered, particularly among younger doctors.

A few studies in the literature reviewed also examined culturally insensitive health care practices in depth as a specific type of barrier that the African American transgender population may have to overcome. Harb et al. (2019) and Tishelman et al. (2019) requested awareness of structural inequities among health care practitioners to increase culturally-sensitive care among this population. Macdonald et al. (2019) studied access to oral health care among transgender youth and young adults. The 36 participants in this qualitative study reported wanting to be treated like an average person, yet feeling exhausted from constantly reminding practitioners of their identified gender. However, these participants also reported primarily positive results, with negative results occurring from misgendering that were corrected immediately by the oral practitioners. This improvement in knowledge was further determined to possibly indicate increased awareness among practitioners, or particularly among dentists who may have received better culturally-sensitive training on transgender health than in other healthcare industries (Macdonald et al., 2019).

These findings of Macdonald et al. (2019) in particular partially mirrored the expression of all eight of the participants in the current study from this third key finding of experiencing being unheard, as the participants in the Macdonald et al. study reported feeling exhausted from constantly reminding practitioners of their identified gender. However, also like the participants in this study, the participants in the Macdonald et al. study expressed having ultimately positive results. It is unclear if these positive results came from the self-advocacy efforts of these participants or was only due to dentists possibly receiving better culturally-sensitive training on transgender health, or the interaction of both of these significant factors. Therefore, despite the need for further research, this third key finding confirms findings in the extant literature, although further research is needed on this topic to better understand the interaction between the self-advocacy efforts of African American transgender people and increased culturally-sensitive training for health care providers that may help to mitigate this specific type of barrier when they are seeking to access health care.

Regarding seven participants who believed that some health care workers lacked knowledge about minority individuals, particularly about transgender people, in this third key finding, this part of the finding confirmed again the previous consensus in the literature of the need for increased education for health care providers on minority transgender health (Ali et al., 2018; Butkus et al., 2020; Moseson et al., 2020; Oliphant et al., 2018). This third key finding also provided specific insight on cultural sensitivity and extended the literature through revealing that four participants further believed that most health care workers did not have the lived experience of being an African American

transgender person. The significance of having the lived experience of being an African American transgender person and how this experience may also interact with increasing the education and culturally-sensitive awareness of health care providers in these training efforts invites further research on this topic as well of how effective or ineffective these training efforts may ultimately be if these health care providers do not have this lived experience.

Pertaining to the conceptual framework of intersectionality of the current study, the third key finding supported the basic tenets of the framework as well by finding that the healthcare needs of African American transgender adults are unheard and not addressed by health care workers. This intersectionality of being both African American and transgender continued to progress through the findings of this study from the broader aspect of this intersectionality of experiencing double discrimination when accessing health care, to the need to then overcome real barriers when receiving desired health care, to then further describing the lack of cultural sensitivity as a specific type of barrier of being unheard that was related to a lack of knowledge and not having the lived experience of being an African American transgender person among health care providers. The last aspect of this third finding of a lack of knowledge and not having the lived experience of being an African American transgender person further emphasized the lack of understanding of how this intersectionality can further marginalize people that was explained in this theory.

### **Difficulties With Paperwork and Health Insurance Claims**

The last significant theme that answered the research question was difficulties with paperwork and health insurance claims. Five of the eight participants shared their experiences of difficulties with health insurance including the paperwork and the claims. The participants' difficulties with health insurance claims were specific to the rejection of coverage for certain treatment plans, especially in sexual and reproductive health care, causing them to pay out of pocket.

A few studies in the literature reviewed also examined challenges with health insurance claims, and particularly as they were related to sexual and reproductive care among the transgender population. For example, Lee et al. (2018) suggested the need to improve health care insurance for transgender people through intervention programs, agreeing with other researchers such as Houssayni and Nilsen (2018), Reback et al. (2018), and Vermeir et al. (2018). All of these researchers further concurred that low access to health insurance and health disparities in insurance claims negatively impacted transgender people's abilities to obtain primary care or access medications related to gender confirmation, such as hormone therapy. Houssayni and Nilsen (2018), Reback et al. (2018), and Vermeir et al. (2018) recommended additional research into this issue to heighten awareness of the need for more education and culturally-sensitive knowledge as well.

Consensus was found in the literature reviewed that transgender adults experienced challenges with health insurance claims, particularly as they were related to sexual and reproductive care (Houssayni & Nilsen, 2018; Lee et al., 2018; Reback et al.,



2018; Vermeir et al., 2018). However, none of these studies specifically focused on transgender adults who were also African American. Therefore, this fourth key finding of the current study of difficulties with paperwork and health insurance claims both confirms and extends the extant literature on this topic with a specific focus on African Americans.

Pertaining to the conceptual framework of intersectionality, this fourth key finding revealed another specific type of barrier that African American transgender people may experience of difficulties with paperwork and health insurance claims, especially in sexual and reproductive health care. It is further emphasized from this finding that African Americans may experience this struggle more than transgender people who are not African American. Therefore, this fourth key finding also supported the tenets of this conceptual framework.

### **Limitations of the Study**

There were several limitations that were noted by the researcher of this study. First, utilizing qualitative research presented limitations because it yielded no statistical data. Therefore, the results could not be generalized and relied on subjective data instead (Rahman, 2017). However, the researcher participated in an external audit that examined the study's process, interpretations, and findings to help ameliorate this weakness. This audit involved an external reviewer with accredited expertise who reviewed the study procedures to ensure they were sound and adequate for addressing the research question. Additionally, the generic qualitative research design involved only one source of data. Therefore, the proposed study was limited because it did not include multiple sources of

data for the purposes of triangulation. A final limitation of particular importance was the recruitment process that may have yielded a smaller sample size because the study focused on a twice marginalized population who were both African American and transgender that may have been distrustful of the research and its intentions (Marks et al., 2017).

### **Recommendations**

Recommendations for further research within the context of the strengths and limitations of the current study and the literature reviewed will now be discussed. This current study offered many strengths from a specific focus on African American transgender adults and their personal struggles and strategies when overcoming barriers to accessing health care. However, several limitations to this study were noted that invite further research. Therefore, it is recommended that further studies on this topic include African American transgender adults from regions of the United States other than the Mid-Atlantic region that may enhance generalizability. Further research could also utilize different types of research designs and methodologies that are quantitative and measure specific variables such as the age groups of African American transgender adults and how this may interact as a significant factor when seeking health care, their financial and socio-economic level, and how this may interact as a significant factor when seeking health care, and their education level, and how this may also interact as a significant factor when seeking health care. Longitudinal studies may also follow African American transgender adults through the stages of their health care journey, to better understand the

nature of these different stages, from initial access or denial of health care, to achieving their desired health care results, and beyond.

Several areas for further research were also recognized from the existing literature reviewed. The discrepant findings of Stoumsa et al. (2019) from the previous consensus of the solution of increased education for health care providers to mitigate the barriers that African American transgender people face when accessing health care (Ali et al., 2018; Butkus et al., 2020; Moseson et al., 2020; Oliphant et al., 2018) indicated the need for the recommendation of further research on this topic to better understand what significant factors are involved that may make transgender health education more or less effective. The discrepant findings of Goldenberg et al. (2020, 2021) regarding gender affirming care that contrasted as well with the previous consensus of gender affirmation as a solution to help mitigate barriers for African American transgender people when accessing health care (Butkus et al., 2020; Moseson et al., 2020; Oliphant et al., 2018; Snow et al., 2022) also indicated the need to recommend further research to better understand specific variables like stigmatization or other significant factors that may still be barriers to accessing desired health care for the African American transgender population, even when they are receiving gender affirming care. Moreover, the findings of Macdonald et al. (2019) pointed to the recommendation for further research to better understand how the self-advocacy efforts of African American transgender people interact with increased culturally-sensitive training for health care providers that may help to mitigate this specific type of barrier when they are seeking to access health care. Houssayni and Nilsen (2018), Reback et al. (2018), and Vermeir et al. (2018)

recommended additional research to heighten awareness of the need for more education and culturally-sensitive knowledge as well specifically in the area of health insurance claims.

### **Implications**

Implications of this study and its potential impact for positive social change on the individual, family, organizational, and societal/policy level will now be discussed. Next, methodological and theoretical implications will be discussed. Then, recommendations for practice will also be discussed.

On the individual level, better understanding the personal experiences of African American transgender adults when obtaining necessary health care services to manage their optimal health may help to empower these individuals to realize they are not alone in their struggle and to advocate more for themselves and others. On the family level, better understanding these experiences and struggles may foster greater empathy that facilitates being more supportive of these other family members. Better understanding these personal experiences and struggles of African American transgender people on the level of health care organizations may create enhanced opportunities for improved education and gender affirmation training for health care providers that will more effectively remove the current barriers that prevent this population from receiving optimal health care. Positive social change could also occur at the societal/policy level as health care organizations respond more favorably and then further facilitate such positive social change in areas like health insurance and in other policy areas that would continue to remove these barriers for the African American transgender population.

Regarding methodological implications, there is a need for future studies as previously noted that will explore the research topic of this study with an expanded sample of African American transgender adults from other regions of the United States to enhance generalizability, and with different types of research designs and methodologies to further enhance validity and reliability. Regarding the theoretical implications, this study makes a valuable contribution to Crenshaw's intersectionality theory with its specific focus on the intersectionality of being both African American and transgender and how this impacts accessing and receiving optimal health care.

Recommendations for practice within the field of health care from the findings of this study point to the need for greater understanding and empathy of the struggles and barriers that African American transgender adults face when they are accessing health care. Such greater understanding and empathy are strongly recommended to be further facilitated by providing more education and gender affirmation training for these health care providers. Also including educators and trainers who have the lived experience of being an African American transgender adult may prove to make such efforts even more effective.

### **Conclusion**

The purpose of this generic qualitative study was to explore the experiences of African American transgender adults obtaining necessary health care services to manage optimal health. Key findings from this study indicated that there were gender and race-based inequalities in health care settings that created barriers when seeking to access health care services. These barriers were also more specifically described as these

African American transgender adults being unheard and not having their health care needs addressed by health care workers and experiencing difficulties with paperwork and health insurance claims. However, some practices were reported by these participants to help them to overcome these barriers by seeking health care workers who were known to be open-minded and accepting of any individual and through the referral process. Other positive experiences these participants shared were finding allies in health care workers who were willing to advocate for them, learning to stand up for themselves in the face of discrimination from health care workers, and finding health care workers who were more sensitive to their needs or made them feel validated and empowered, along with finding emotional support in their communities. Access to necessary health care for African American transgender adults must no longer be denied to ensure their optimal health and quality of life.

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## Appendix A. Recruitment Materials



Caption: There is a new study about the barriers to healthcare faced by African American transgender adults that may help healthcare professionals provide racial and gender equality in healthcare. For this study, you are invited to describe the barriers you faced as an African American transgender adult when accessing healthcare.

About the study:

- One 60-90 minute online interview that will be audio recorded using Zoom
- Checking the transcript of your interview
- To protect your privacy, the published study would use fake names
- Individuals participating in the study will receive a \$20 Visa pre-paid card

Volunteers must meet these requirements:

- 18 years old or older
- African American
- Identify as transgender
- Have lived in the Mid-Atlantic region of the United States for at least one year
- Have accessed healthcare or attempted to access healthcare in the Mid-Atlantic region

This interview is part of the doctoral study for LaCole Cole, a Ph.D. student at Walden University. Interviews will take place before September 7, 2024. The Walden University IRB approval # 09-08-23-0347822.

## Appendix B. Interview Protocol

### Summary Information

Interview Guide:  
Healthcare Experiences of Transgender Adults Who Are African American

Date:

Time:

Location/Method of Interview:

Interviewee:

Research Questions:

Research Approach:

### Interview Protocol

#### *Introduction*

Thank you for agreeing to speak with me today. As a reminder, the purpose of this research study is to explore the experiences of African American transgender adults obtaining necessary healthcare services to manage optimal health. During our interview, we will discuss your experiences with barriers to healthcare. As appreciation for your participation in this study, a \$20 prepaid Visa card will be given to you after completing the tasks required from study participants. The gift card will be delivered to your email.

I will analyze your responses and those of other participants to reach conclusions. During that process, your confidentiality will be protected, as I will use a pseudonym for you and remove any identifying information from the interview transcript before providing information in my dissertation. I am only allowed to share your identity or contact info as needed with Walden University supervisors and dissertation committee members (who are also required to protect your privacy).

Please use your pseudonym during your interview today. After the interview, I will share your transcript with you so that you can confirm the accuracy of your responses, and I will share a final report with you summarizing the findings at the end of the study.

May I have your permission to audio/ and video record our interview today so that I can transcribe it? [Accept participant response.]

Do you have any questions or concerns before we begin? [Accept participant response.]

[If participant refuses consent]: Thank you for sharing your concerns. If you change your mind about participating, you can reach me at XXX or XXX any time before I complete the study on (insert estimated completion date). Thank you again for your time.

### *Pre-Interview*

I have a few confirmation questions before we begin.

1. First, are you African American? [Participant response should be “Yes.”]
  2. Do you identify as transgender? [Participant response should be “Yes.”]
- Have you lived in the Mid-Atlantic region of the United States for at least one year? [Participant response should be “yes”.]
4. Have you received healthcare services in the Mid-Atlantic region? [Participant response should be “Yes.”]
  5. Have you experienced barriers when accessing or attempting to access healthcare in the Mid-Atlantic region? [Participant response should be “Yes.”]
  6. Lastly, are you 18 years of age or older? [Participant response should be “Yes.”]

### *Interview*

Thank you! Now we’ll begin.

1. What kind of healthcare services do you normally access or make use of as an adult who is both African American and transgender?

Possible prompts and/or follow up questions:

- What are some of your healthcare concerns that prompt you to seek healthcare?
- Where do you normally access these services?
- How do you access these services?

2. Please describe any experiences that you had with accessing healthcare services as an African American transgender adult.

Possible prompts and/or follow up questions:

- How did this experience make you feel?
- What were the positive aspects of this experience?
- What were the negative aspects of this experience?
- How do you feel your intersectional identity as both African American and transgender relates to these experiences?

3. Please describe any difficulties you have encountered while accessing healthcare as an African American transgender adult.



Possible prompts and/or follow up questions:

- How do existing healthcare policies and procedures pose a challenge to accessing healthcare as an African American?
  - How do you feel healthcare policies and procedures pose a challenge to accessing healthcare as a transgender person?
  - How does being intersectionally African American and transgender related to these challenges?
  - How do the attitudes of healthcare workers or healthcare providers pose a challenge to accessing healthcare as an African American transgender adult?
  - What biases have you encountered as an African American transgender adult when accessing healthcare?
  - How are these biases different than for individuals who are African American *or* transgender only?
  - In accessing healthcare services, what are the other challenges you have encountered as an African American transgender adult?
4. How did you address the challenges you encountered as an African American transgender adult when accessing healthcare?
  5. In what ways can the current healthcare system be changed to improve healthcare services for African American transgender adults?

### *Closing*

I really appreciate the time you took today to speak with me. I will transcribe our recording in the next few days and share with you via email for the accuracy check that I described. At the conclusion of my study, I will also share the final report we talked about. Thank you again for your help today!

## Appendix C

## Codebook

Codes	Categories	Themes
HCWs' assumptions against them Misgendered and feeling looked down on Systemic issue	Experienced double discrimination	Experiences of gender- and race-based inequalities in healthcare settings
Being true to who they are Representing transgender women in the local community Speaking up	Advocating for themselves	African American transgender adults' practices of overcoming the barriers to accessing healthcare services
Avoiding conflicts Willing to drive elsewhere Telemedicine	Avoiding encounters with discriminatory doctors	
Receiving support from community	Receiving support from community	
Need for cultural competency training among HCWs Need for respect	Recommendations for change	
Need more effort to help transgender woman, specifically praying for change		
Seeing a transgender doctor Seeing an African American doctor Seeking referrals for a suitable doctor	Seeking open-minded and accepting doctors	
Not given the help needed Hinders transition Don't know how to help	Denied help by HCWs Not taken seriously by HCWs Perceived lack of knowledge of HCWs about transgender individuals	Healthcare needs of African-American transgender adults are unheard and not addressed by healthcare workers

Codes	Categories	Themes
Unwilling to help	Perceived unwillingness of HCWs to help transgender individuals	Healthcare needs of African-American transgender adults are unheard and not addressed by healthcare workers (continued)
Difficulties accessing some treatment plans No clear protocols for transgender patients	Difficulties with insurance	Difficulties with paperwork and health insurance claims
Difficulties with name change No options for non-binary gender in forms	Difficulties with paperwork for health insurance	