Healthcare Providers' Willingness to Provide Trans-specific Healthcare in Jamaica

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Contents

Executive Summary

Introduction: Trans people encounter unique challenges and inequalities in their inability to seek and access appropriate healthcare and health screenings. One in every four trans persons reportedly experience barriers to accessing healthcare, both in private and public facilities, with transwomen more likely to report barriers than other groups (TransWave, 2020). While some 'underground' healthcare professionals in Jamaica are willing to manage trans and gender non-conforming patients with gender affirming therapy and medical management, they too are fearful of experiencing stigma and discrimination by association (TransWave, 2020). Therefore, this study aims to get a better understanding of healthcare providers' willingness to provide trans-specific care in Jamaica.

Method: In this qualitative study, elite interviews provided data from 20 healthcare professionals. Participants included medical doctors, nurse practitioners, registered nurses and practical nurses. Snowball sampling was used to recruit healthcare professionals from public, private, and public/private healthcare facilities. They were interviewed via Zoom online platform. Ethical considerations were taken into account based on the topic.

Results: Findings indicated that participants generally felt comfortable in providing trans-specific care and as such, their willingness to provide care for trans people was also positive. While they held certain religious beliefs, their medical education and training, which may be linked to their identity as healthcare professionals, seem to act as a buffer in their willingness to provide care for trans patients. Participants generally felt unprepared to provide trans-specific healthcare and advocated for curriculum adjustment to meet the needs of this population.

Conclusion: It is recommended that a trans health toolkit be developed for public and private health care providers to improve their knowledge and skills working with trans patients. Future work may consider using a mixed methods approach to better understand healthcare professionals' willingness to provide trans-specific healthcare in the Caribbean given that the population of trans people is increasing, globally.

CHAPTER 1

Introduction

The Ministry of Health and Wellness' 876 Study (2018) estimates the transgender (trans) community in Jamaica within 5,000-6,000 people. The report approximates the population of trans women close to 4,000. While trans people are at high risk for non-communicable diseases (NCDs), there are no local data to indicate prevalence among this population (TransWave, 2020), which is of great concern given that NCDs are a major public health burden in Jamaica (MOHW, 2021). Trans people are also at great risk for HIV, as local studies find a more than 50% prevalence rate among trans women, which is the highest prevalence of any population group (Figueroa et al. 2020; MOHW, 2018).

Trans people encounter unique challenges and inequalities in their inability to seek and access appropriate healthcare and health screenings (Health Policy Project, 2023). A needs assessment of the 'lived experiences' of trans Jamaicans by TransWave, Jamaica (2020), shows that while transgender people have high level health-seeking behaviours, they mostly access healthcare from private facilities. This may be due to increased access to specialized services and advanced treatment techniques that private facilities offer (Beuermann & Pecha, 2020; Lacombe-Duncan et al. 2022), as opposed to public healthcare.

Further, a report by TransWave (2020) adds that one in every four trans people reportedly experience barriers to accessing healthcare, both in private and public facilities, with transwomen more likely to report these barriers than other groups. Local studies find that stigmatization and discrimination are the more common barriers that are reported, especially in public facilities, which subsequently leads to low uptake of health services, due to the unaffordability of private healthcare

as an option (TransWave, Jamaica, 2020; Lacombe-Duncan et al., 2020; Logie et al., 2017). Trans people have no legal recognition of their gender identity, which hinders their ability to access public services and social assistance programmes, leaving them vulnerable to exclusion and discrimination (USAID & UNDP, 2023). In terms of HIV testing, a local study describes trans people's experiences and fear of discrimination and judgment in HIV testing provision by healthcare providers and other medical staff, which acts as a barrier to accessing HIV testing (Logie et al., 2017). It adds confidentiality concerns with the physical set-up in some HIV testing clinics, which segregates testing from other health services and a fear that clinical staff might publicly disclose their status (Logie et al., 2017). Participants in the study also believe that private healthcare facilities are less stigmatizing than public healthcare settings (Logie et al., 2017).

While some 'underground' healthcare professionals in Jamaica are willing to manage trans and gender non-conforming patients with gender affirming therapy and medical management, they too are fearful of experiencing stigma and discrimination by association (TransWave, 2020). TransWave (2020) states that healthcare efforts focus on HIV prevention, treatment, care and support reaching the trans community, however, "there are no services with trans-specific health programmes or medical interventions in the public, private or CSO [civil society organizations] health sectors" (p. 15). Consequently, trans people are at higher risk, compared to the general population, of suffering from more chronic health conditions and experience higher rates of health problems related to substance misuse, and mental health problems like depression, anxiety and suicidal ideations (CAP, 2023; MayoClinic, 2023), which will ultimately determine their life prospects. It is, therefore, fundamentally important to understand healthcare providers' willingness to provide trans-specific care in Jamaica.

Study Aims

This study aims to understand healthcare providers' willingness to provide trans-specific healthcare in Jamaica. Study findings may help to identify and address gaps in providing trans-specific healthcare among health professionals. Also, this study may identify healthcare providers who are willing to provide trans-specific healthcare which, in turn, may potentially create safe spaces for trans people to seek and access appropriate healthcare and health screenings so they may live a better quality of life and to achieve appropriate levels of social development.

Report Roadmap

The next chapter of this report will provide an overview of the study's methodology. This will be followed by chapters presenting and discussing findings on providing trans-specific healthcare in Jamaica.

The report also contains two appendices, which offer more detailed information related to the study:

Appendix A: Interview guide

Appendix B: Table of findings

CHAPTER 2

Method

This study utilized a qualitative research approach to data collection and analysis. Elite in-depth interviews provided data for the study. This approach provided an in-depth understanding of healthcare providers' experiences, perspectives, and willingness to provide healthcare for transgender persons. This was a cross-sectional study, in that, data were collected at one point in time.

Population

The population for this study was healthcare professionals, 18 years or older, with at least 5 years of work experience in public or private healthcare facilities. Healthcare workers were selected from 4 health professional levels, as shown in Figure 1. Medical doctors are the highest ranked and can include general or specialized medical practitioners. At the next level are the nurse practitioners or advanced practice registered nurses, followed by registered nurses at the second level. At the lowest level are practical nurses and/or assistive personnel (certified nursing assistants, patient-care technicians).

Sample size

The study aimed to collect data from 5 healthcare workers in each category of medical profession identified in the study population. Therefore, a total of 20 participants were approximated to provide sufficient data saturation for this study. If findings were found to be

heterogeneous during data collection, then the sample size would have had to be increased until saturation was achieved.

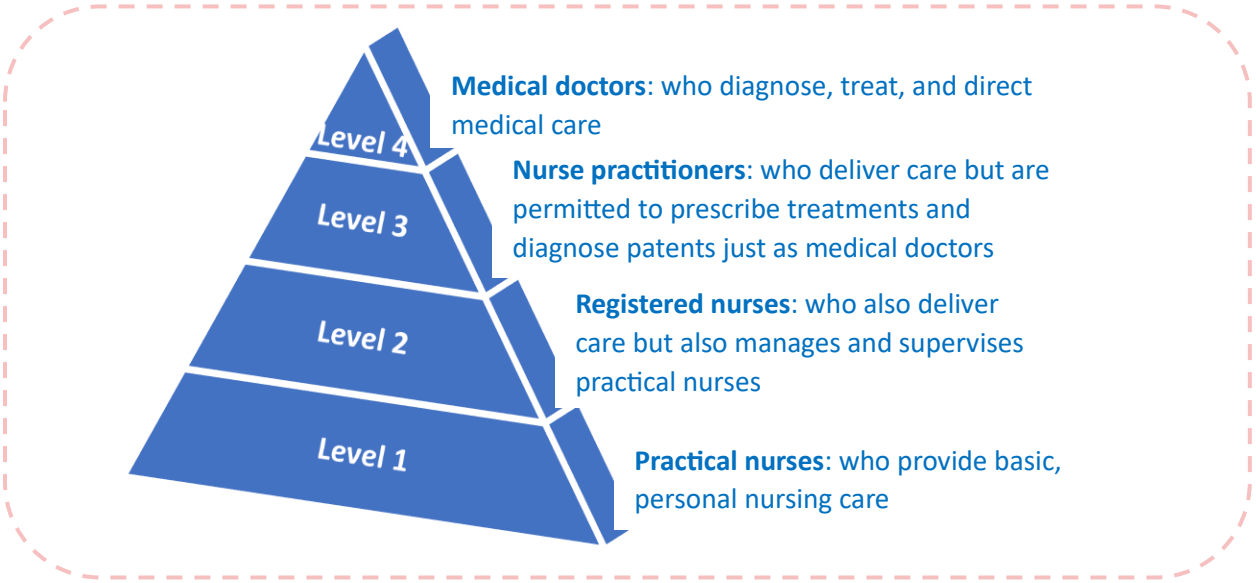

Figure 1: Healthcare professionals' hierarchy and functions

Sampling

Participants were recruited using snowball sampling, in that, the principal investigators knew at least one healthcare worker from each professional category and asked them to make recommendations or to assist with recruitment of their colleagues for the study. When contact was made with the prospective participants, the researchers informed them of the nature of the study and confirmed their criteria for participation. Only after accepting the invitation and meeting the study's criteria that a date and time were scheduled for interviewing.

Procedures

Interviews were conducted via the Zoom online platform and recorded for transcribing purposes only. The duration of each interview was approximately 30 minutes. An interview guide was designed specifically for this study based on the primary aim of this research (see appendix A). It consisted of approximately eight key open-ended questions to allow participants to share their perspectives on providing trans-specific healthcare. We used an open coding process which involved coding and developing themes that emanated naturally from the data.

Ethical considerations

Participants' rights were protected throughout the research process according to the *Declaration of Helsinki*. Prior to the start of data collection, participants were duly informed of the nature of the study (see appendix A). Researchers received verbal consent from participants to be interviewed, to record the discussion, and to use the information they provided for producing a report and any future publications. They were assured confidentiality, in that, any identifying information was to be removed from subsequent reports and publications. Instead, unique codes were utilized to protect participants' identities. They were informed that they may stop the interview at any time without prejudice and they were also assured that any information already provided would be removed from the records. Interviews were recorded via a personal Zoom platform and downloaded on the principal investigator's computer hard drive on a password-protected computer, that only the lead investigator had access to. There was no foreseeable risk associated with participating in this study and no direct compensation was offered for their interview.

CHAPTER 3

Findings

There were 21 healthcare professionals who were identified and recommended for participation in this study, however only 20 were successfully recruited. A registered nurse who worked at a public health centre declined participation in the recruitment process after she was informed about the topic. The participating sample therefore consisted of 5 medical doctors, 5 nurse practitioners, 5 registered nurses and 5 practical nurses. Their experiences as healthcare providers ranged between 5 and 40 years. Of these participants, 7 reported working in private medical facilities, 6 in public healthcare and 7 in public and/or private health institutions. Only 2 participants identified as males.

Findings are put forward based on key themes that emanated naturally from the qualitative data collected (see box 1).

Box 1. Key themes

- Understanding of transgender people
- Experiences of providing trans-specific healthcare
- Perceived comfort to provide trans-specific healthcare
- Perceived identity and caregiving
- Perceived willingness to provide trans-specific healthcare
- Psychological care – beyond scope of practice
- 'Just don't' infringe on my rights'
- Reservations about pronouns and names
- Perceived workplace willingness to provide trans-specific healthcare
- Religious beliefs and perceived willingness to provide trans-specific healthcare
- Perceived preparedness to provide trans-specific healthcare

Understanding of transgender people

We first asked participants what their understanding of trans people was. There was a general description that a trans person is someone whose gender identity differed from the socially accepted gender that is associated with sex assigned to them at birth. They also put forward that trans persons may modify their biology to represent the gender that they identify with, which can include surgical and hormonal replacement. A practical nurse explained it best,

> “ They have made a conscious decision that the gender that they currently have from birth till adulthood isn’t what they feel is their correct gender and through augmentation or modification, surgical procedure, chemically induced hormones, they have transitioned from their birth gender to their preferred, or what they believe is their current gender, and choose to live a normal life after that procedure has been completed (PN, 1). ”

One registered nurse held the view that trans people, “got the wires crossed” but went on to share the general notion of a transgender person. She added, “They're practically males who feel that they are females and they have started the process of changing genitalia or their features to become feminine, and vice versa” (RN, 2). Nurse practitioners also shared similar descriptions however, one participant had several questions about transgender persons as she reflected on the question. She questioned,

> “ Even if you're a man transitioning to a woman, who are your sex partners? Do you have sex with men? Sex with women? Can you still have men or women who transition to men or the opposite sex and still having sex with traditional partners? (NP, 1). ”

Medical doctors too discussed similar perspectives of transgender persons however, they all added to their descriptions, a concern about mental health comorbidities among this population. One of the participants observed, “There can be quite a bit of mental health related comorbidities and so in that case, for mental health conditions, we do refer over to our counseling unit” (MD, 2). Another medical doctor indicated, “They have their health issues, mental, physical that needs to

be addressed and certainly high rates, especially of mental issues, which needs a lot of attention" (MD, 3). To explain mental health among transgender persons, a participant revealed,

> "It has to do with mental health issues in terms of persons not accepting them for the change, in terms of, OK, I was born female, I am now male, and there have been really emotional issues in terms of their gender (MD, 4)."

Experiences of providing trans-specific healthcare

Some participants reported caring for transgender persons however, they only provided general or personal healthcare and not trans-specific healthcare. A medical doctor indicated, "There are few that have come through and it's not related specifically to them being transgender, it's more general care" (MD, 2). For some doctors, they weren't sure whether they provided medical care for transgender persons because they were either not informed of their trans identity or that their ailments were not trans-specific. Another doctor reflected,

> "I probably would have had a passing experience with patients who were holding that transgender identity then, but not willing to express it to me. Or, I may not have been sensitive enough or sharp enough at that time as a physician to pick it up and to respond (MD, 5)."

Some registered nurses acknowledged that they had experiences providing personal healthcare for transgender persons. A nurse described her experience,

> "So, there's a confusion, one male who identified himself as female. He fell ill and had to be admitted and he insisted on being admitted to the female unit, which they eventually did admit into this female unit. So that was my one experience caring for him on the female unit and to me, I wasn't seeing a female, to be honest, because of his outward appearance and everything. Unless you knew, you would not know that you were caring for transgender person (RN, 1)."

Nurse practitioners also provided general or trauma healthcare as one participant explained,

> "Yes, I've had experiences with them. Most of the times what I've seen is trauma because you know that it is not socially acceptable for a lot of persons. So, some of the time I see that they have come in [the hospital] because of trauma, maybe altercation, beaten (NP, 4)."

Practical nurses are usually responsible for providing personal healthcare to patients which can include trans-specific care, however, those in this study indicated their experiences as providing general healthcare. A participant noted,

> “When they come to the office and if they have to get any like dressing, injection, any procedure to be administered or something like that, that’s the only thing but nothing, nothing personal. I do their blood pressure, all their vitals (PN, 5).”

Perceived comfort to provide trans-specific healthcare

A profound theme that derived from the data regarding participants’ comfort to provide care for transgender persons is a sense of professionalism in which they deliver to or would care for their patients, especially among practical nurses in this study. A practical nurse, who had no experience working with transgender persons, held this view.

> “A transgender person at the end of the day is still a person and care has no gender, religion, race, any of that. So, care is care. Would I have to be cautious around a transgender person? Yes, because this is somebody who have done augmentation to their body, both chemically and physically, so the care that I have normally been taught to give, I would have to modify it so that I, in my professional setting, do not violate their rights, nor do I make any mistake that might harm or further harm the patient. But overall, I have no problem giving care to a transgender person. At the end of the day, they're still a person and there is no real limitation on the person (PN, 1).”

This sentiment was emphasized among the registered nurses also; a participant put forward,

> “I wouldn't have any level of discomfort. I mean, they are someone too, and they need care. So, I would deliver the same care as I would to a ‘normal’ person. For me, I think that they would have already been a bit uncomfortable knowing that in terms of their sexuality or their transgender, they already are a social outcast, so to speak. So, I would try to minimize that level of discomfort, you know, treat them like just a regular person (RN, 5).”

Nurse practitioners too were of the same opinion; according to one participant,

> “I mean we are trained to be nonjudgmental, in the end, you have to be professional and you have to just accept that these people are doing what they want based on what they feel is right for them, because you wouldn't want them to judge you based on the choices that you made. So you try not to judge them on the choices that they have made (NP, 1).”

Finally, medical doctors reported that they would also be comfortable providing healthcare for trans people. A medical practitioner advocated,

> “No way different from any other patient. I’ve had to not only diagnose patients with HIV, but to hold their hands through the whole thing and of them getting used it. And I figure, any patient is a patient, I need to just look after them, whatever their complains are, they need care (MD, 1).”

Perceived identity and caregiving

Another key theme in the discussions was one’s professional and social identity, which seemed to have a profound influence on participants’ perception of providing healthcare. A practical nurse argued,

> “As a general nurse, my profession is to care for your patient. It is my utmost best to give the best care that I can to allow them to get healthy, to feel comfortable. Because remember, it is the care, it is not an intimate relationship. It is the care that you give and you give that care in the way that it ought to be given, you should not have a problem (PN, 2).”

A registered nurse who reported caring for transgender persons shared her experience, she indicated,

> “In me administering care, I don’t have a problem because that’s my role as a healthcare provider. It’s to not put my personal beliefs and my views ahead of the patient, unless if I may end up in some legal issue. But morally, my role is to care for the patients. So, I put my views aside and I treat them just as I would treat anybody else (RN, 1).”

Nurse practitioners were of the same opinion as one participant noted,

> “I have no problem with performing whatever task once it's within legal and physical scope of practice as a nurse. So, if I'm supposed to give an injection, I’ll give an injection. If I’m supposed to give care to you, I’ll give it. So, whatever that is necessary (NP, 4).”

Among medical doctors, a participant explained this view best,

> “I will treat everybody the same and I’m presuming that all doctors, once we make a decision to become a doctor, especially in our field, meaning, family medicine in general, I feel that you have to know, you have to accept whoever and you have to know how to provide care (MD, 1).”

Perceived willingness to provide trans-specific healthcare

Of primary importance to this study is healthcare providers' willingness to provide trans-specific healthcare. While medical doctors were comfortable and willing to provide general healthcare, they expressed some hesitancy in that, they felt that they were unprepared to offer trans-specific healthcare and would prefer to deliver care within their scope of practice. One medical doctor described hesitance best,

> "Let's say somebody had top surgery and they removed breast tissue, I would probably not be comfortable reviewing them very close post-surgically. That would be the job of their surgeon. And I've never come into contact with anybody with bottom (genital) surgery either, that would be a little challenging. I would say, once everything's healed, not a huge deal, but I have heard it is ongoing care especially when, for instance, a male genitalia is removed. Don't quote me because obviously I've never learned about it but I've heard that there is ongoing care, dilatation and things like that have to be monitored for and adjusted for and I'm not even quite sure who would be the person to refer them to. I'm comfortable dealing with your chest pain and your gastritis and your headaches and any of that stuff but certainly anything surgical, I'm probably not super equipped to manage, especially incisions. Because those surgeries are major, especially around the genitalia, things like fistulas can be very common around that area. I just wouldn't know what I'm really working with to tell you the truth, but I would never deny care for certain. I would examine and if it's out of my scope, then refer onwards to whoever is the appropriate person (MD, 3)."

Nurse practitioners generally expressed their willingness to provide healthcare for transgender persons. One participant shared her opinion,

> "If I'm like a post-op nurse, I'm definitely going to be the person who's going to do the post-op care for them. If I'm in the health centre that they are discharged and then they have to be sent to me, I would definitely do what I got to do (NP, 1)."

Registered nurses also talked about their willingness to provide healthcare, but within their scope of practice. A nurse believed,

> "As long as it's within my scope of practice I would do it. So, as long as it's something I am certified to do, yeah. So, if it's a transgender male that's changed to a female and the person is supposed to get a catheter and I'm able to put a catheter, I will put the catheter. I'm not going to pass off, to delegate that task to someone else (RN, 5)."

Practical nurses shared the same opinion as registered nurses. One participant indicated,

> “If I have a patient who is a transgender, I have to remember that I am a professional. I have to do what I made a vow to do and what I was trained to do. Since the fact that this person is a transgender, I'm not going to say that I can offer certain type of medical care. I will be prepared to go the extra mile to make sure that person to me is still a patient, is comfortable and I give that person the best care that I possibly can offer (PN, 3). ”

Psychological care – beyond scope of practice

While healthcare professionals in this study generally expressed comfort and willingness to provide care for transgender persons, medical doctors felt that offering psychological care was beyond their scope of practice. At the same time, they also felt that trans people urgently need psychological support, especially during the transitioning process. A medical doctor maintained, “I think they do need counselling as part of the whole transitioning, I would refer transgender people. I think that the physical needs that they have, once I can provide it, I will (MD, 1). Another participant supported this view,

> “ I'm pretty comfortable I think depending on the issues or depending on what the health needs are. I would say, from a psychological standpoint, I would probably not be equipped because I am not a psychologist. In terms of like psychological support, I don't think I would be equipped to do that. You know, they have their health issues, mental, physical that needs to be addressed and certainly high rates, especially of mental issues as well, which needs lot of attention (MD, 3). ”

Similarly, another participant emphasized this point,

> “There would be more trans-specific things that I probably would have referred on to, especially just not for a lack of unwillingness, but because I think they’d be better served. So, for the trans community, there can be quite a bit of mental health related comorbidities, a lot of the time the mental health conditions we do refer over to our counseling unit (MD, 2). ”

‘Just don’t infringe on my rights’

A concern that participants shared was that they were willing to provide healthcare to transgender persons as long as they did not impose their sexual orientation or beliefs on them. This was a common theme among health professions, except medical doctors. A practical nurse declared,

> “As long as you have not hindered my right as a heterosexual male and you try not to force my belief in any way shape or form or try to take advantage of me in any physical manner, emotional manner, or sexual manner, then I believe from my experiences that we can coexist in a in a peaceful environment (PN, 1).”

A nurse practitioner maintained,

> “Once you do not want me to behave and dress like you, or you're making a pass at me, then I'm fine with you. So, once you do not impose your sexual orientation, do not impose your beliefs on anybody else, I will tolerate them because I'm doing care, barring that you do not infringe on my rights (NP, 4).”

Another nurse practitioner insisted,

> “As long as they don't try to force their beliefs and their desires on people, we should just allow them. I mean, I wouldn't want somebody to come up and be forcing me and say, ‘oh! you have to go and become a man (NP,1).”

Registered nurses talked about this imposition also; according to one participant,

> “I will render care if it's not going to affect me personally. Alright, maybe I have a view about transgender, I would not want that to affect my care for the person, then I wouldn't want him or her to impose anything on me that will affect my own belief too. I will not impose anything on him or her, I wouldn't want the person to impose anything on me that will affect my own beliefs too. I will try to keep the relationship as therapeutic and formal as much as possible (RN, 4).”

Reservations about pronouns and names

Some participants also had reservations about communicating with trans patients by the gender they identify with. They said that in their professional capacity, they will call patients by

the name that's on the docket even though persons may ask to be called another name, especially if it does not match their phenotype. Some participants reported that they would refer the patient if they insisted on using a name different from the docket while some argued that they will respect the patient's request and provide healthcare even though it's against their beliefs. Practical nurses, however, were very comfortable with using the pronouns and names that patients provided. A participant explained,

> " You try not to do the discrimination and maintain respect, at all times you refer to them in a very professional way. You know, you can ask them what is it that they would like you to refer to them by and you refer to them by that name. Because as you know, the transgender, sometimes they change around the name and stuff. So, based on what they say to you, you can actually have a communication with them based on what they say to you in regards to making reference to them by that name (PN, 3). "

In comparison, a registered nurse expressed her disapproval and shared her experience providing healthcare for transgender people. She reflected,

> " I go back to my emergency room experience where I've had two occasions. I would like to think that they were transgender because they were male. One would not identify as a male. When you asked, 'Sir, what was your name'? She wouldn't answer. So, they said, 'Maybe if you said Miss'. I'm like, 'I'm sure if I pull the pants, I'm going to see a penis so, it's a male!' And that was when I got the name (RN, 2). "

Similarly, a nurse practitioner who worked in public health centre for approximately 7 years, expressed her difficulty with patients' gender identification and pronouns. She revealed,

> " So, I remember once I met a gentleman who had a sexual transmitted infection and I had to give him some treatment and then he told me that the next day he will bring his partner, and then he came and he was saying to me, 'nurse nurse, here she is'. And I'm like, who? And he said 'there she is' and I said, 'well, that's not a girl, that's a male'. But then he told me a girl name and I said, 'but no, no, no'. And then he told me a male name and then I said, 'there you go, it's a male' and then he said 'no, but his female name is' and he gave me a female name. So, I was like, come on now, this person is a male, let me just give the care… but I don't necessarily agree with what you're saying in terms of asking me to accept that you are a male when you're a female or vice versa (NP, 5). "

A medical doctor too had reservations. A participant with 10 years work experience in a public health center and hospital shared her encounter with a transgender person,

> “ I had an experience with a person born female, change to male and my approach to these patients are generally, I will call you by your name because from a personal standpoint, I’m not in agreement with you, but I can’t refuse to treat you. So, what I do to them, I inform them that I will call you by the name that is on the docket in front of me to prevent any confusion. Your name is John Doe and I will call you John Doe versus the pronouns, him or her. Legally, I would have to go by name that is on the file in front of me and I will have to explain that and if that is now an issue, then I will have to perhaps ask someone to see them. I'm not going to be calling them, subscribing to whatever it is that they’re they want me to call them. I’m not willing to call them by this new name” (MD, 4). ”

In the private medical facility however, medical doctors were more accommodating. A participant of 9 years as a medical doctor revealed,

> “ The docket name, they don't identify with it, right, and the gender and the docket, they don't present as. So, you realize and you just assimilate in terms of, once they made me aware as to what name they prefer to refer to as, what pronoun they prefer, that was fine. Okay, for example, let's say you say that your name is James, right? But your ID still has your ‘dead name’ or something to that effect, they're not going to accommodate you at registration at all. So, your dockets are gonna (going to) come around with your ‘dead name’ still and I know that can be quite triggering for some individuals. Because I’m trying essentially, not intentionally misgendering you, once I do realize, I just make a note on the docket so at least I can refer to you by your appropriate name (MD, 2). ”

Perceived workplace willingness to provide trans-specific healthcare

To get a broader understanding of healthcare professionals’ willingness to provide trans-specific healthcare, we asked participants about their perception of co-workers’ willingness to provide care for transgender persons. For the most part, practical nurses agreed that their colleagues will provide healthcare to transgender persons. A participant reported,

> “ At the time at my public health center, yes, yes, yes, the nurses there were, in terms of offering caregiving. And so, I remember at the time, there was a nurse who just came on and she said, ‘nurse, we can’t turn them back, that’s what we are there for’. So, none of my colleague show any attitude towards any of them, I don't know about now (PN, 4). ”

However, another practical nurse who worked in a private health facility added that some of her co-workers will discriminate against transgender persons. She claimed,

> “Not all of them. I have seen high level of discrimination and I’ve seen it and I’ve heard it and the harassment is there also. Harassment, meaning that they will cancel their appointment. They would even bad mouth and say ‘why you walk in here for?’ They don't feel like they’re to care for a transgender. They’re not giving them their rights here, and certain services and care aren’t given to them. Right there and then is the higher level of discrimination (PN, 3). ”

Among the registered nurses, participants believed that some of their colleagues would be willing to provide healthcare for transgender persons. A nurse who worked in a private health facility declared,

> “Alright, for other nurses like myself, if I should grade it like a percent, I think I will put it at 10%, but I believe other nurses outside of my workplace would just say this is my job. This is what I do. A client is a client and I have to do my work. So, I would agree with that (RN, 3). ”

Another nurse from a public health center had a similar perspective; she revealed,

> “They will do it, but not everyone will do it with a smile on their face. You know, with no sense of compassion. There will be no empathy or anything like that because as far as they concern, they don't approve and you know they will let you know that they don't approve. You know, they won't hide it (RN, 1). ”

Nurse practitioners believed that most of their colleagues would provide healthcare for transgender persons. As one participant reported, “I believe so, for the most part. I mean, I know that persons are of the opinion that once they do not impose their views on them and then I think my colleagues then they are comfortable with it” (NP, 4). However, practical nurses’, registered nurses’ and nurse practitioners’ were skeptical of doctors’ willingness to provide trans-specific healthcare. Nurses at all levels shared negative experiences they’ve encountered, both in public and private settings with doctor-transgender patient care. One public nurse practitioner shared her experience,

> “I remember just one time there was an incident where 2 ‘male’ had come to see the doctor and one was sick, but the other one was accompanying and doctor was not really fond of that kind of arrangement. So, he asked him to step outside so that he could see the client that was ill. It was like denying the person care, he was just not accommodating the person accompanying somebody else (NP, 5). ”

From medical doctors' perspective, they believed that their colleagues would provide trans-specific health care, for the most part. A doctor who worked in a private health facility responded, "I think so. I mean my colleagues, in terms of the medical doctors, I think, yes, definitely, they would be fine. The nurses, I'm not so sure" (MD, 3). Another participant who worked in a public health center and hospital was skeptical about some of her colleagues' willingness. She argued,

> "Not everybody, because some persons would be, in my opinion, I know there might be one or two persons who may not. Two persons maybe, based on their belief. Not just religious believe because there are persons who are not Christians that just don't believe in this changing your body and the whole homosexual, bi-sexual kind of thing (MD, 4)."

Religious beliefs and perceived willingness to provide trans-specific healthcare

The topic of religion was brought up in the discussions and so, participants were asked whether their religious beliefs affect the care they provide for transgender persons. Participants generally disagreed that religion influenced their willingness to provide healthcare for transgender persons. Even among participants who reportedly never worked with transgender persons, they suggested that they would *bracket* their religious views if a transgender person came to them for healthcare. A registered nurse explained her position on this topic, placing emphasis on professionalism and ethical oath. She reflected,

> "I personally don't approve of transgender, I call them the alphabet community, I don't approve of it. I'm a Christian and as such, we grew up reading our word and know that this is an abomination. We were raise to love ourselves for how we were made and who we are. God made women and God made men and God made us with one main aim in mind is for procreation and you stray from that. There is no way to procreate, a man cannot have a child with a man and vice versa. Woman cannot have a child for a woman. So, in that sense, my religion does have a great impact on me. But I put religion aside. I take my job as a nurse very seriously because our oath says that we're supposed to treat the person irrespective. Because it's a human being and I always take that very seriously. So, irrespective of your social status, irrespective of your religion in respect of your race, irrespective of your gender, I give you the care that you are required to receive (RN, 1)."

Nurse practitioners were of a similar opinion, citing their ethical oath as a health professional. One participant explained,

> “And then you know the nursing code of ethics and or legal and ethical of training that we have gotten, it would have emphasized that we would have cared for patients regardless of their religious, socio economic status, sexual status, creed, class coloration. So, while it might have not been specific to say transgender, we are of the view or I’m of the view that whatever minority group would have been included. And my work views of these people are different from my religious views, I don't have a problem with caring for them as an individual, as long as they give consent (NP, 4). ”

Other nurse practitioners summed their perspectives quite succinctly, they declared, “I can't deny them, although I believe in God, God is not a male or female” (NP, 2), and another recommended, “You can say prayers afterwards” (NP, 1). Medical doctors echoed similar perspectives, as one participant declared,

> “There’s some dimensions of care that may bring in things like religious beliefs, my own personal belief about what really gender should be and you’re changing something that may be God gave you. But, I would still remain comfortable because I tend to practice in a way that I like to learn the patient… So, in as much as I may have particular beliefs, my own religious beliefs that may be counter to some of the stuff that’s going on in that office with that patient, I put that aside (MD, 5). ”

As for their colleagues, some participants believed that religion impacted their willingness to provide trans-specific healthcare. A registered nurse held the view that,

> “Some people are so fanatical about their religion that sometimes it affects the way they give care to people. So, it will be a personal thing to be able to decide whether you want to give care to a transgender or not. So, peoples’ personal religious inclination will have a great impact on the way nurses will take care of transgender people so that one is personal (RN, 4). ”

Medical doctors also validated this believe as one participant indicated,

> “There is a subgroup that is grounded strongly in their religious beliefs where it would impact more because I think that on analyzing the bigger culture in Jamaica, a homophobic culture, you put transgender into that LGBTQ, there is an anti-kind-of-feeling from the religious side. I think that would be a kind of inhibitor to the care that people give (MD, 5). ”

Perceived preparedness to provide trans-specific healthcare

During the discussions, participants shared their perceived preparedness to provide trans-specific healthcare. Among those healthcare providers who raised this point, there was a general feeling of unpreparedness. They not only recommended training for themselves, but for other healthcare providers too and that training should be across the medical profession. A practical nurse suggested,

> “I think you should be trained to deal with this person. If you are homophobic, it is important that you are trained in this capacity because we're living in a world that is far expanding from what we are used to, and so, I believe there should be some form of training, even a three-month class (PN, 2).”

Another practical nurse recommended training as part of nursing schools’ curriculum, “In the nursing school, I think they need to be orientated about these things as part of the curriculum” (PN, 5). A registered nurse gave an example to support her recommendation for trans-specific healthcare training, she said,

> “I’m not at all prepared, because I would have to go back to school for that. You know, in our time that was not very predominant in my training. So, it’s something that’s maybe the medical professions and the associations would have to take up as a CME (continuing medical education) and do additional courses. Because, for instance, you can come across a patient with a condition like a male, for instance, having a prostate issue but he comes to you as a female. How do you deal with that? Not just giving him medication, but how do you have a man sitting in front of you with prostate related symptoms? So, we do need to know how to cope with situation like that (RN, 1).”

Nurse practitioners were of similar opinion; according to one participant,

> “I definitely will need training to treat a person who is going from male to female. I'm going to have to retrain myself. The health sector is gonna (going to) need a re-education on how to deal with them in terms of preventative care, like prostate. A man becoming a woman still has his prostate in his body. A woman becoming a man, unless she has a total hysterectomy, still has a cervix, she’s still going to have to do pap smears and I guess you would do a mastectomy. You’re gonna (going to) have to learn to help with mastectomy here. I think that is a topic they need to bring in the nurse practitioner programme because of the change (NP, 1).”

Medical doctors also reported an urgent need for education as one participant emphasized this point,

> “There is an urgent need for training and getting up to speed with the educational levels, the knowledge and the skills and the attitude of our health professionals and physicians because people knock on the physician doors saying they should know everything…We need many actors on the stage to be operating within the health profession, something for doctors, the nurse practitioner, the pharmacist... But, for this thing to work, we have to look at it at the societal level” (MD, 5). ”

CHAPTER 4

Discussion

This study focuses on trans-specific healthcare and from the onset it would be useful to examine this concept for clarity. Trans-specific healthcare may be considered from the perspective of healthcare that deals specifically with the psychological and surgical process of an individual transitioning from one gender. The former aspect of this process involves a social transitional stage in which an individual begins to take on the persona of the gender that they wish to identify with and may need psychological support to deal with the body dysmorphia that they experience. They may also use different pronouns and change their names during this phase of transitioning. There are also the medical, nonsurgical techniques used to feminize or masculinize the individual which can involve hormone therapy, puberty blockers, and hair removal, all of which increase the gender characteristics to which the person aspires. Then there are the surgical procedures normally used during the more advanced transitional stage which includes gender affirmation surgeries such as facial reconstructive surgery, chest or 'top' surgery, genital or 'bottom' surgery (Cleveland Clinic, 2024). Gender-affirming surgeries alter the physical body to better align with one's gender but are not without attendant health issues that can arise from the transitional processes.

Some healthcare needs along the transition pathway can involve psychological support (TransWave, 2020; CAP, 2023; MayoClinic, 2023), monitoring of liver pathology as a result of the use of testosterone (Jaruvongvanich et al., 2017) or even regular dilation of the newly constructed vagina. This kind of health care that deals with the direct consequences of the transition process is one way of conceptualizing trans healthcare and would require care from specialist healthcare professionals. Usually, the patient who is in the transitional process has a medical team of specialists, physicians and nurses who have an established therapeutic relationship. The likelihood

of social issues arising with these health care professionals is assumed to be minimal to nonexistent because they are focused on this aspect of health care.

However, they may have other healthcare needs and by the very fact that they are transgender, this can create difficulties for those persons who wish to access healthcare. From this conceptual perspective, trans-specific healthcare focuses on healthcare professionals' willingness to provide general healthcare to transitioning persons, inclusive of any healthcare related to the transitional process. For instance, the phenotype of a trans person who is being presented to a healthcare worker will not be in keeping with their genotype, which may create a potential for stigmatization and discrimination in providing care for this trans person. Therefore, this paper focuses on the concept of trans-specific healthcare and suggests looking at key healthcare professionals' willingness to provide care for trans persons, in whichever stage of their transition, as the primary objective of this paper.

The wisdom of focusing on healthcare provided to trans persons become apparent from the interviews that describe participants' encounters with trans people. The informants suggest that the care they provide is not necessarily related to issues of the transitioning process but, for general healthcare. Participants explain that trans people seek treatment for STDs, rectal tears and fistulas in the rectal area. They also suggest that they have had trauma cases, resulting from transgender persons being involved in fights with each other over shared sexual partners or with encounters with anti-homosexual/homophobic persons. Therefore, based on the data collected, trans persons reportedly sought general care from the health practitioners, not for issues of their actual transitioning process but, because of general health care problems, with no regard to their state or stage of transition.

Given that the trans population is estimated to be relatively small in Jamaica, it is expected that some healthcare professionals may not have experience caring for them. Furthermore, the conditions that they present with may not allow the health care professionals to recognize that they are caring for a transgender person. They may have suspicions based on certain mannerisms but may not be able to confirm these suspicions. For example, if there was an accident where a limb needed treatment for bruises or cuts, there is no opportunity to identify the individual as transgender. As a result, some participants suggest that there is a possibility they may have provided healthcare for trans people but unaware of their gender identity perhaps because they may not have been as experienced to make an assessment and/or that patients have not explicitly make their gender identity known to them. This may be understood in the context of the social climate in Jamaica that lends itself to stigmatization and discrimination against trans people (TransWave, 2020), so trans patients may not feel comfortable to overtly inform their health provider of their gender identity.

Findings also suggest that participants have a clear, but general understanding of human nature of trans people, describing them as persons who are uncomfortable with the gender they are assigned at birth and was in a process of changing their bodies to reflect the gender they identify with. Most informants expressed an understanding of stressors that a trans person may be feeling as they negotiate through a society that does not fully embrace their lifestyle. Despite some empathy, many informants still feel that perhaps it is not the best lifestyle, but there is a certain amount of tolerance evident in their communication. The two groups of health professionals who show the most empathy are the practical nurses and medical doctors. The latter are more concerned about the mental health of the trans population seeking healthcare. They report that many of their trans patients demonstrate a need for psychological counselling which is unsurprising given that

studies found trans people to experience mental health challenges (TransWave, 2020) such as depression, anxiety and thoughts of suicide at a higher rate than the general population, and at the highest rate within the LGBTQ+ community (Morales-Brown, 2021). Health practitioners suggest that none of the participants in this study, including the medical doctors, feel equipped to offer psychological healthcare as they saw this as beyond their scope of practice and therefore would/refer patients to the various counselling units. Medical doctors suggest that the mental health challenges that trans people experience may simply result from body dysmorphia and difficulty accepting their gender identity, resulting in the need for gender-affirming transformation. This psychological distress would perhaps be exacerbated by age and employment status, as studies find that younger trans people and unemployment increase the risk of depression and anxiety among this population (TransWave, 2020; Hajek et al., 2023).

Participants across the four groups of healthcare practitioners in this study indicate discomfort in providing general healthcare for trans people. One of the factors that contribute to their positive orientation, however, has to do with a grudging respect for someone who decides to transition from one gender to another instead of carrying the persona of gay or lesbian. It seems that once the individual begins the process of transition, the stigma of antigay/homophobia is somewhat reduced, making it easier to reconcile the health professionals' personal and religious biases. Also, the fact that the trans population in Jamaica is small, people do not have wide interactions with them and so the impressions that are formed about this group may reflect the negative emotional bias reserved for gays and lesbians.

Findings demonstrate that when informants have real life contact and interactions with trans persons, they seem to develop more positive emotional responses to them. Participants express the opinion that trans persons tend to present with 'big' personalities, but once they get past this

characteristic, they are usually very nice persons. Some even report developing supportive relationships after personal interaction with a trans person. These supportive relationships are not exclusive to the workplace and border on supportive friendships. This is positive for trans people's access to healthcare because these relationships, healthcare professionals can play a role as gatekeepers for other members of the trans community. Although this finding is not presented as a key theme, a participant shares that her interaction with a trans person she provides healthcare for, is so well appreciated, that her patient highly recommended fellow trans people specifically to her, so that they too could access healthcare without prejudice. It must be noted that these kinds of supportive relationships are more prevalent among practical nurses who express the opinion that their role is to care for everyone who needs healthcare. Other healthcare professionals express similar opinions about caring for anyone needing care, but one gets the impression that they use this philosophy as a mental shield to help control any personal biases they may have, which seems effective in delivering appropriate healthcare to trans people.

Most religious groups in Jamaica include some variant of Christianity with some holding more extreme forms like the syncretic African retention sects such as Revivalism and Kumina. It stands to reason that many Christian Jamaicans develop their attitudes and behaviours from religious beliefs as outlined in the Bible or other influential books like those written by Helen G White for the Seventh Day Adventist followers. Religious teaching and socialization begin early in life in Jamaica with children being involved in church ceremonies and further indoctrinated through Sunday schools and daily schools' devotional activities, developed to strengthen belief and remove the ability to question the teachings of the Bible, as presented by the religious leaders. One of the main tenets of religion in Jamaica has to do with the sin of homosexuality, with stories of the Bible asserting that God has destroyed the cities of Sodom and Gomora because of such sin.

So monumental is this perceived sin that the act of anal sex is referred to as 'sodomy'. Therefore, one expects that healthcare professionals with a strong religious background would find it difficult to offer healthcare to the trans community based on religious teaching. This is supported in the literature as research shows that self-identifying as being Christian, especially with those who attend church regularly, is associated with increased prejudice toward trans people (Campbell et al., 2019).

In this study, all participants affirm some level of religious upbringing with a belief that same-sex sexual activities, particularly among men, are immoral. However, it seems that socialization, which is incorporated in their health education and training, acts as a buffer to counter the effects of their religious biases they present. Medical education and training of health professionals ranged from approximately 6 months for practical nurses to 7 years for medical doctors. At all medical levels, there is a socialization process about the role of a health professional, and for these healthcare providers, there is pride in their identity as a healthcare worker. Their occupation gives them social power and recognition and they develop an identity around their job that differentiates them from others in society. It may be this identity that is cultivated over time that contributes to their positive approach to trans people which helps them to perform their functions appropriately, despite any potential religious biases that may exist.

The *symbolic interaction theory* by Mead (1972) helps to explain this position that healthcare workers take. According to Mead, people use symbols to create meanings about the world they live in, and through language and thought, they can accomplish this goal. They can reflect on self as perceived by others and may modify their thoughts and behaviours where necessary. In context of this study, participants are socialized within their respective hidden curriculum to bracket their personal feelings about patients' gender, religion and sexuality when delivering care. In cases

where healthcare professionals have moral objections to providing care, which may be based on their religious beliefs, their identity as a healthcare provider takes precedence over their personal and moral values. This therefore speaks to the significance of education and training as a useful tool to reduce stigmatization and discrimination against trans people.

Triandis' (1977) theory of *interpersonal behaviour* is also applicable to this research as it posits that healthcare professionals' intentions to provide trans-specific healthcare are influenced by their innate characteristics and emotions, which shape their personal attitudes, beliefs and social influences related to the behaviour. Providing trans-specific healthcare is primarily a function of providers' intention to provide care for transgender people (comprised of perceived consequences and social factors) and facilitating conditions which are the present situational constraints and conditions (Godin, et al., 2008).

While participants express comfort and willingness to provide healthcare for trans people, they emphasize the need to keep all interactions fully professional. This way they could provide the best possible healthcare without feeling that they were condoning the lifestyle of the trans gender person. They also indicate that they would be very uncomfortable if trans patients were to display behaviors that could be mistaken for flirting or trying to convince them of the positive nature of their personal lifestyle. They state that these behaviours are an infringement on their human rights, and they do not want the patient to attempt to influence them along a line they did not believe to be the best for themselves or their families. Keeping a professional approach would help to provide the necessary social distance to maintain a comfort zone for the health professionals as they provide care. However, the strict adherence to professionalism in the patient /healthcare worker relationship may be misconstrued by the patient as biased care.

Another area of concern, particularly for nurses, nurse practitioners and medical doctors has to do with the use of gender-affirming pronouns and selected names that did not match the outward appearance of a trans person presenting for healthcare. Participants assert their unwillingness to indulge trans persons presenting for healthcare by calling them any other name than what is written on their official healthcare file (docket). Even if the outward appearance of an individual does not correspond to what is on the docket, participants report that they would refer to the individual by the name and sex indicated on the docket, despite if the patient requests otherwise. This position creates some dissonance and discomfort for trans people who may be along the transition process and beginning to assume a new persona in keeping with their new or soon to be assigned gender. However, for healthcare professionals, dockets are legal documents, and they explain that it would breach their professional ethics to disregard the information on the docket simply because the person presenting requires them to do so. If a person's assigned sex is male, the health professional feels obliged to refer to the patient as male and/or man. Anything else could be called into question in a court of law and have potential for malpractice. Therefore, medical practitioners uphold the position to refer to patients by their legal status as male or female and their legally given name. As such, they argue that they would continue addressing patients based on the data provided on the docket to legally safeguard themselves.

Their position is also important for objective data which is used to make critical decisions about patient care. If a patient has male external genitalia, then the practitioner who is preparing the care plans would need to take this into consideration. Such a patient will not be slated for gynecological examination, but perhaps prostate examination. The chances for medical errors can be compounded if treatment is inaccurately planned according to the objective data, and so to eliminate the chance of medical errors, health professionals would insist on staying on the safer

side by using the formal docket as their guide. While all this is true, there is a place for latitude. For example, a healthcare professional explains that she would make a note on the docket that the patient is transgender and would prefer to be called another name and pronoun. The fact that this data is placed on the docket is also valuable to give personalized care for the individual patient and can help reduce unnecessary tensions. Currently, these decisions rest with the level of comfort of the person giving care. Essentially, there aren't many overtly trans people seeking health care, so the system has not yet developed new protocols to address this situation. It still depends on the individual health care providers to find the decision best suited to their situation, without breaching established protocols. As more trans people seek healthcare, the medical educational system will adjust to a gender-diverse population, and new protocols will be identified for meeting the safety needs and addressing the psychological well-being of the patient.

It is important that informants share with us their willingness to provide trans-specific care to patients seeking health care. The general sentiment across the various groups is that they have no problem providing care for trans people. Findings from this study suggest that the longer the health professional was employed in this field, the more likely they would have encounters with trans persons. The length of time also seems to be related to their comfort in working with trans people. It may be that healthcare workers develop their individual perspectives about trans persons based on their contact with this population. However, they all confirm their willingness to healthcare for trans people. There is unanimous agreement that trans people are human beings and healthcare providers are ethically responsible for providing healthcare for everyone who needs it. This sentiment is too pervasive to be just individual positions and may have derived from the socialization during their respective education and training. The responses strongly demonstrate that despite personal biases, all respondents are willing to provide care for trans persons seeking

healthcare. While the sample is small, it covered a range of healthcare professional groups and therefore can be used to suggest a positive trend.

On the other hand, there are clues that imply that not all healthcare workers are willing to offer trans-specific healthcare. Within each health profession, participants believe that their colleagues may not be as willing to support trans-specific healthcare. Participants add that members outside of their health professional category may have a problem with this kind of care. This may be due to interprofessional rivalry where one group sees the other as biased and another may misunderstand standard protocols that are used by other groups. Although not presented in the findings as a major theme, an example is taken from the interviews. In the case of a same-sex couple attending a medical facility for healthcare, a doctor refuses to have both persons in the examination room at the same time. The practical nurse sees this as bias, but the standard protocol for all patients seeking medical consultation is that a doctor does not interview both members of a family at the same time. It's easy to understand that in some cases, the patient may not want to disclose some pertinent information while their significant partner is present. One can conclude that while participants in this study are generally willing to offer trans-specific healthcare, it may be that not all healthcare professionals are willing to provide trans-specific care. This position is reinforced by the refusal to participate in the study once the potential candidate is made aware of what is being studied. To compound the issue, a candidate who works in a public health center vehemently rejected participation, which is unsurprising given that previous research finds public healthcare settings to be more stigmatizing of trans people than private healthcare institutions (Logie et al. 2017). This, however, suggests that there is need for a larger study to capture a wider cross-section of healthcare professionals to be able to generalize the conclusions in this study.

Earlier in this discussion, we allude to the point that education and training of healthcare professionals may contribute to the strongly held view that participants have an ethical and moral duty to provide care to all individuals and families seeking care. Furthermore, we explain that the more seasoned professionals who have more interaction with trans people are more tolerant and hold positive views, despite their religious indoctrination. It is then postulated that education and training may have prepared these healthcare professionals for their role in caring for any patient presenting for healthcare.

Participants in this study are asked about their preparation for providing trans-specific healthcare. They acknowledge that they are prepared to provide healthcare if the case is one that falls within their scope of practice. They feel that they are educationally prepared to provide general healthcare, but not for healthcare that involves the transitioning process. Participants generally believe that they do not have sufficient and adequate knowledge to understand the changes that are taking place during the transitional process, and this limits their ability to provide holistic care. While they emphasize a need for psychological care for trans people, they establish that is beyond their scope of practice.

Nonetheless, participants recommend that educational institutions should provide curricular enhancement so that they can further their knowledge of trans patients, to be better prepared to provide care for this population. These data suggest an opportunity to begin advocacy workshops with healthcare professionals, at all levels, which can help provide a better understanding of trans people to reduce stigmatization and discrimination associated with them. This may be a positive direction to support trans-specific care in Jamaica.

CHAPTER 5

Conclusion

This qualitative study provides a robust view of healthcare professionals' willingness to provide trans-specific care. Findings suggest that participants are generally comfortable working with trans people and describe their willingness to provide trans-specific healthcare as positive. They, however, expressed reservations about addressing trans patients outside of the name that is on their medical record, as well as unpreparedness to provide adequate care for trans patients. In light of these findings, it is recommended that the Office of the Prime Minister makes the process of deed poll and sex change more accommodating to trans people, providing there is adequate referral from a physician. It is also recommended that the Ministry of Health and Wellness facilitates training workshops and seminars to improve the skills and knowledge of healthcare providers to work with trans patients. This can be aided by a trans health toolkit for public and private healthcare providers. Participants also believe that some of their colleagues may not be as comfortable working with trans patients, hence, it is recommended that a study with a larger sample be conducted to better understand the views of healthcare professionals on the topic. Given that the population of trans people is increasing globally, it is further recommended that future studies on this topic involve participants across the region. A limitation of this current study is its inability to generalize findings, therefore, future work may consider using a mixed methods approach to better understand healthcare professionals' willingness to provide trans-specific healthcare in the Caribbean. Notwithstanding further work on this topic, it is also recommended that there be some advocacy for curriculum enhancement activities in the area of trans people so that healthcare professionals are better prepared to provide care for their trans patients.

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Appendix A

Interview Guide

1. **Demographic data:**
   a. What is your profession? For how long?
   b. Do you work in a public or private setting?

2. **Knowledge:**
   a. What do you know about transgender people?

3. **Experience:**
   a. What experience do you have working with transgender people?

4. **Perceived comfort:**
   a. How comfortable would you be if a transgender person comes to you for care?

5. **Perceived Willingness:**
   a. If a transgender person comes to you for care, how willing would you be to provide care for that person?
   b. What type of personal care would you be unwilling to offer to transgender people?
   c. Do you think that the people you work with would be willing to provide care for transgender people?

6. **Additional:**
   a. Anything additional you would like to share about providing care for transgender people?

-End-

-Thank you for sharing your thoughts and experiences on this topic-

Informed Consent

Title of study: Healthcare providers' willingness to provide trans-specific healthcare in Jamaica

Researchers: Leemoy Weaver & Steve Weaver, contracted by TransWave Jamaica

Procedures: We would like to ask you questions on your willingness to provide trans-specific healthcare. The interview may be approximately 30 to 45 minutes. There are no right or wrong answers to these questions so please answer truthfully.

Use of information: Information from this study may be disseminated via presentation, report and publication.

Confidentiality: No personal data will be shared in our report, presentation or publication, nor will the recording be shared with anyone or posted on any social media websites. The interview will be recorded for transcribing and analysis purposes only. Everything you share will be kept confidential. We will keep all the information we've collected on a password protected computer that only the principal investigator has access to and once the data have been fully analyzed and our reports are prepared, all information collected will be destroyed.

Participation: If you wish to stop the interview at any time, you may feel free to do so without any prejudice.

Potential Risks and Discomforts: There are no known risks involved in participating in this study.

Compensation: There is no compensation for participation.

Consent: We therefore seek your consent to participate in this interview, record the session and use your information for disseminating our findings.

Verbal consent received: Yes [ ] No [ ] (*If no, please terminate process*)

Date _____ Interviewer(s) _____

Appendix B

Table of findings

Profession & Code	Years - health worker	Employed in Private or Public Facility	Knowledge of Trans people	Experience working with Trans	Type of care provided	Comfort in giving care	Willingness to provide healthcare	Issue of infringement on rights	Willing to use pronouns	Workplace willingness to care	Religion affects care	Request for additional training
PN 1	23	Private	Yes	No	-	Yes	Yes	Yes	No Issue	Yes	No	Not mentioned
PN 2	20	Private	Yes	No	-	Yes	Yes	-	No Issue	Yes	No	Yes
PN 3	30	Private	Yes	No	-	Yes	Yes	-	No Issue	Some	No	Not mentioned
PN 4	19	Private	Yes	Yes	General care	Yes	Yes	-	No Issue	Yes	No	Yes
PN 5	32	Private	Yes	Yes	General care	Yes	Yes, WSP&E	-	No Issue	Yes	No	Yes
RN 1	20	Public	Yes	Yes	Personal care	Yes	Yes, WSP&E	Yes	-	Some	No	Yes
RN 2	23	Private & Public	Yes	Yes	Trauma & Personal	Yes	Yes	Yes	Issue	Some	No	Yes
RN 3	5	Private	Yes	Unsure	-	Yes	Yes	-	-	Some	No	Not mentioned
RN 4	12	Public/Private	Yes	No	-	Yes	Yes	Yes	No Issue	Some	No	Yes
RN 5	6	Public	Yes	No	-	Yes	Yes, WSP&E	-	-	Some	No	Yes
NP 1	17	Public	Yes	No	-	Yes	Yes	Yes	-	Some	No	Yes
NP 2	10	Private & Public	Yes	No	-	Yes	Yes	-	-	Some	No	Not mentioned
NP 3	15	Public	Yes	Yes	General care	Yes	Yes	-	-	Some	No	Yes
NP 4	14	Private & Public	Yes	Yes	Trauma care	Yes	Yes	Yes	-	Yes	No	Not mentioned
NP 5	19	Public	Yes	Yes	General care	Yes	Yes	-	Issue	Most	No	Yes
MD 1	40	Public/Private & Private	Yes	Unsure	-	Yes	Yes, WSP&E	-	-	DK	No	Not mentioned
MD 2	9	Public/Private	Yes	Yes	General care	Yes	Yes, WSP&E	-	No Issue	Yes	No	Not mentioned
MD 3	13	Public/Private & Private	Yes	Unsure	-	Yes	Yes, WSP&E	-	No Issue	Yes	No	Yes
MD 4	10	Public	Yes	Yes	General care	Yes	Yes, WSP&E	-	Issue	Some	No	Not mentioned
MD 5	40	Private	Yes	Unsure	-	Yes	Yes, WSP&E	-	No Issue	Some	No	Yes

Note: WSP&E – Within scope of practice and experience

Healthcare Providers' Willingness to Provide Trans-specific Healthcare in Jamaica

April 2024

https://transwaveja.org/