

ABORTION BEYOND THE BINARY:

Transgender people have historically been left out of abortion and reproductive health research.
Now, two researchers are bringing their experiences to light.

by

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Submitted to the Program in Comparative Media Studies/Writing in partial fulfillment for the
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ABSTRACT

When it comes to accessing abortions and other reproductive healthcare, transgender people throughout the United States face a minefield of issues—from getting insurance coverage to dealing with medical providers who don't know how to treat them, to weathering discrimination—but very little research exists on how bad these problems are, the impacts they have, or potential solutions. Currently, only a few national-level studies have investigated how trans people experience the US healthcare system, and no major studies measure the number of trans people who undergo abortions, the type of abortions they receive, or the challenges they face when accessing these services. The few studies that do exist suggest that, due to myriad legal, financial, and social barriers, trans people often struggle to obtain the healthcare services they need.

In 2017, this knowledge gap spurred Heidi Moseson and Sachiko Ragosta, two public health researchers at Ibis Reproductive Health in Oakland, California, to begin developing the first national-level survey into the reproductive healthcare experiences of trans Americans. The survey, which ended data collection in 2019 and is still in the analysis phase, included input from more than 3,000 transgender and nonbinary respondents. The project is unprecedented in terms of size, scope, and specificity, and is currently the only major study in this field that was designed with consultation from those within the trans community and is led by a scientist who is gender diverse themselves—Ragosta identifies as nonbinary and uses they/them pronouns.

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Abortion Beyond the Binary

Transgender people have historically been left out of abortion and reproductive health research. Now, two researchers are bringing their experiences to light.

In 2011, just a few days after their twentieth birthday, Jack Qu'emi Gutiérrez desperately needed an abortion. They'd been having sex with their on-again, off-again boyfriend—a bad-news high school sweetheart who'd followed Gutiérrez from Miami to the University of Central Florida in Orlando—when, one night, the condom broke. Gutiérrez initially wasn't fazed. They took Plan B, and for the next few weeks, everything seemed fine. But after a third pregnancy test came back positive, it was clear they were in trouble.

Gutiérrez didn't want children, but pregnancy felt earth-shattering for another reason. Just a few months prior, they had come out as nonbinary—an identity that doesn't align with traditional categories of male and female. Gutiérrez was assigned biologically female at birth and raised as a girl, but for as long as they could remember, womanhood had been a source of discomfort and distress. As a child, they never identified with the girls they saw depicted in magazines and on TV, but they assumed that their discomfort would fade as they got older—that womanhood, like a pair of too-big shoes, was just something they needed to grow into.

But that sense of confidence and belonging never came. It wasn't that Gutiérrez disliked femininity—they wore earrings and glittery nail polish and loved experimenting with makeup—but being perceived as female and referred to with feminine pronouns felt awful. And while other women treated menstruation as an annoyance, Gutiérrez dreaded getting their period, sometimes becoming so depressed that they contemplated suicide.

This mismatch between gender identity and assigned sex, called gender dysphoria in medical parlance, is a common experience for transgender people like Gutiérrez, and its mental health impacts are severe, including depression, low self-esteem, and, in some cases, self-harm. Major medical associations like the American Psychiatric Association and the World Professional Association for Transgender Health (WPATH) widely agree that exploring gender identity through means like adopting a new name, pronouns, or clothing, can effectively treat gender dysphoria and alleviate symptoms.

That's what Gutiérrez did. When they came out as nonbinary, they started going by the name Jack, which better reflected their gender identity, and they began using singular they/them pronouns. But events like unwanted pregnancy can trigger extreme dysphoria and make trans people feel like they have lost control over their bodies and their identities. Many trans individuals report that they'd rather end their own lives than endure unwanted pregnancies.

Gutiérrez, then a skinny college kid with a face full of metal piercings, felt similarly. But the process of getting an abortion was also a psychologically destabilizing reminder that the US medical system often leaves trans patients out, especially when it comes to reproductive healthcare.

After pushing past anti-abortion protestors outside of Planned Parenthood, Gutiérrez found that the intake forms didn't have a spot to list preferred names and pronouns. They cringed when clinic staff referred to them using feminine terms like "girl" and "Miss," but the worst moment came when Gutiérrez learned that, due to a state law passed earlier that year, a transvaginal ultrasound was required before proceeding with the abortion.

Gutiérrez had taken conscious steps to avoid anything that they thought might trigger dysphoria. They had opted for a medication abortion—a procedure that involves taking medication to end the pregnancy, as opposed to a more invasive surgical abortion, in which suction is used to empty the uterus. The ultrasound, a procedure that is not medically necessary and is only required in 10 states, felt violating and made Gutiérrez hyper-aware of their uterus and ovaries. While Gutiérrez was still in stirrups, the doctor, bound by legal obligation, offered them a printout of the ultrasound.

The medication abortion itself was also far more arduous than they had expected. For months, they endured nausea, cramping, and bleeding so severe they were forced to quit their job. In addition to physical pain, every excruciating cramp and wave of nausea served as a reminder of body parts Gutiérrez wished they didn't have. Costs were also a problem. Gutiérrez had health insurance, but it was their parents' military plan, which didn't cover abortions. Paying out of pocket meant that Gutiérrez ended up not being able to afford food that month. For weeks, they barely ate anything.

Twelve years after their abortion procedure, Gutiérrez is a writer, activist, and erotic boutique manager in Hollywood. They keep their curly black hair in a short undercut, dress in tank tops and beanies, and wear a single silver ball piercing in their upper lip—a holdover from younger, more adventurous days. They are proud of their identity as a queer, nonbinary individual.

Gutiérrez characterizes their abortion as "the best thing I could have done for myself," but the experience of getting one as a trans person, along with other bad experiences seeking medical care in the years since, has made them wary of medicine. They don't go to the doctor unless it's an emergency and haven't seen a dentist for almost 10 years. They know that not seeking healthcare could put them in serious danger—their most recent Pap smear detected potentially cancerous cells on their cervix, but Gutiérrez refuses to return to the gynecologist for further testing. For them, the known misery of being trans at the doctor's office outweighs the potential risk of a deadly disease. "For all I know, I have cervical cancer," they say. "Cancer runs in my family on both sides.

Gutiérrez's experience is far from unique. When it comes to accessing abortions and other reproductive healthcare, trans people throughout the United States face a minefield of issues—from getting insurance coverage to dealing with medical providers who don't know how to treat them, to weathering discrimination—but very little research exists on how bad these problems are, the impacts they have, or potential solutions.

Currently, only a few national-level studies have investigated how trans people experience the US healthcare system, and no major studies measure the number of trans people who undergo abortions, the type of abortions they receive, or the challenges they face when accessing these

services. The few studies that do exist suggest that, due to myriad legal, financial, and social barriers, trans people often struggle to obtain the healthcare services they need, and many likely go without, resulting in an increased rate of illness and injury.

In 2017, this knowledge gap spurred Heidi Moseson and Sachiko Ragosta, two public health researchers at Ibis Reproductive Health in Oakland, California, to begin developing the first national-level survey into the reproductive healthcare experiences of trans Americans. The survey, which ended data collection in 2019 and is still in the analysis phase, included input from more than 3,000 transgender and nonbinary respondents.

The project is unprecedented in terms of size, scope, and specificity, and is currently the only major study in the field of reproductive health research that was designed with consultation from those within the trans community and is led by a scientist who is gender diverse themselves—Ragosta identifies as nonbinary and uses they/them pronouns.

Moseson and Ragosta aim to complete their data analysis this year and use their findings to design better education materials for trans patients and more inclusive clinical care guidelines for healthcare providers. Their research has faced many obstacles, including funding problems, skepticism from other researchers, and transphobic harassment. Their work also comes amid a monumental wave of abortion reform following the recent overturn of *Roe v. Wade*; a bevy of new local and state laws that restrict or eliminate transgender rights, including access to healthcare; and a backlash from both conservatives seeking to deny healthcare to trans Americans and from feminists and pro-choice activists who argue that abortion is a *women's* rights issue and who reject gender-neutral language, like “pregnant people” and “birthing parent.” (After the American Civil Liberties Union tweeted that the LGBTQ community is disproportionately harmed by abortion, British journalist Helen Lewis said that gender-neutral language was equivalent to “declaring a war on saying women,” while actress Bette Midler told her female followers on Twitter that gender-neutral phrases like “people with vaginas” were attempts to “erase you.”)

Moseson says that these restrictive laws and increased hostility will have particularly severe repercussions for trans and nonbinary people, who already face healthcare barriers that are “orders of magnitude above what cis[gender] folks face,” but the dearth of reproductive health research on these populations limits scientists’ ability to find solutions. Moseson and Ragosta’s study is an important step to uncovering and breaking down these barriers, but making abortion care equitable for trans Americans will require change on an institutional and societal scale.

The case of the missing data

It’s only within the last decade that researchers started seriously looking into the reproductive lives and experiences of trans Americans. In 2016, the Williams Institute on Sexual Orientation and Gender Identity Law at the University of California, Los Angeles, published a report—the first of its kind—estimating the number of people in the US who identify as transgender. The number is currently around 1.5 million—about the same size as the population of Hawaii—or roughly .005% of the general population.

Up until recently, these 1.5 million people have been all but invisible to the reproductive health research community. In fact, when the Williams Institute report came out, there were only two major studies that documented transgender health at all.

In 2015, Mitchell Lunn and Juno Obedin-Maliver, two medical doctors at Stanford University, launched the pilot phase of the PRIDE Study, the first long-term national health study of LGBTQ+ people. That same year marked the publication of the first US Transgender Survey (USTS), the largest study ever devoted to the experiences of trans people. Leading the USTS was civil rights advocate Sandy E. James, who had previously worked on the 2008 National Transgender Discrimination Survey, and his co-investigators—public policy expert Jody Herman, one of the authors of the Williams Institute report, and trans consultant Josie Caballero. While neither study explicitly focused on reproductive health, they did provide insight into some of the more overarching challenges trans people face when accessing care.

According to the USTS, transgender people in the US are twice as likely as their cisgender counterparts to live in poverty and are unemployed at three times the rate of the general population. Workplace discrimination is a major reason why. Almost one-third of respondents reported being fired, denied a promotion, harassed, attacked, or experiencing some other form of mistreatment in the workplace as a result of their gender identity. Sixteen percent reported losing their job.

Stann Midwood is among that group. Midwood, who identifies as nonbinary and uses the neopronouns hey/hem/hez, was working at a library in rural New Mexico in 2015. Midwood was open about being trans, but after asking to be referred to using hez preferred pronouns, a coworker passed hem a note declaring there are only two genders. When Midwood reported the incident to a supervisor, the coworker was required to attend sensitivity training, while Midwood was fired.

Unemployment, and the loss of income and insurance that came with it, was a serious blow for Midwood, who is disabled and requires specialized healthcare. Circumstances became more dire when Midwood later got pregnant and needed an abortion. Feeling like hey had lost control over hez own body, Midwood spiraled into a deep depression, had difficulty sleeping or eating, and sometimes considered suicide. After scraping together the funds to travel to the closest abortion provider, which was located several hundred miles away, Midwood found the process of getting the abortion invasive and violating, but also lifesaving. Midwood is not sure if hey would have survived without the ability to obtain an abortion.

Midwood isn't alone. Trans people are far less likely to have health insurance compared to the general US population, according to the USTS. Many, like Gutiérrez, end up relying on federal health insurance, which, due to regulations laid out in the Hyde Amendment, does not cover abortion procedures. And while some can depend on financial support from their parents, this option isn't available to many trans people, who often risk being disowned or kicked off of their parent's insurance when they come out.

Cazembe Jackson, a trans activist in Atlanta, has personally dealt with this lack of support. He received an abortion in 2001, when he was a junior in college, after being abducted and raped by

four men. The trauma of the attack sent him into a deep depression, which intensified when he found out he was pregnant. Jackson didn't have enough money for an abortion, and he knew he couldn't rely on his family for help. Jackson identified as a lesbian in college, a fact that didn't sit well with his religious mother. When he turned to her for help after the assault, she said that the rape and pregnancy were God's punishment for living a homosexual lifestyle.

She drove Jackson from Huntsville, Texas back home to Austin, where there was a Planned Parenthood close by, but refused to help pay for the procedure. Abortion funds weren't common at the time, so Jackson took out a high-interest payday loan. He spent the next six months paying it off, and even though the abortion procedure only cost \$300, the loan cost him more than triple that amount. "Class plays a really huge part in abortion access," he says.

Even when trans people can afford quality health insurance, they often face challenges getting their insurance to cover certain procedures. One-quarter of USTS respondents reported experiencing problems with their insurance as a result of being trans. Of those, 13% said they were denied care for services considered "gender-specific," such as Pap smears, prostate exams, and mammograms. Although this type of denial is technically illegal, reversing it can be arduous, and any delays concerning insurance can have major health consequences.

According to Moseson and Ragosta, these insurance denials stem from a lack of gender-inclusive language in the American electronic medical billing system. This system, used by hospitals and insurance companies throughout the US, relies on deeply binary language, which can make it impossible to accurately bill a trans person for procedures or treatments that are traditionally regarded as being exclusive to men or women.

Past research has also indicated that a lack of provider knowledge, as well as blatant discrimination, makes it difficult for trans patients to access quality care. One-third of USTS respondents reported having at least one negative experience with a healthcare provider that related to being transgender, including harassment and provider ignorance. These experiences drastically range, from the anxiety and mental exhaustion that comes from having to explain and justify one's gender identity to flat-out refusal of treatment.

A few years after their abortion, Gutiérrez attempted to get a hysterectomy but was denied because they were under age 30. The doctor, who assumed that Gutiérrez was a heterosexual woman, urged them to consider whether their husband would want children in the future. Even now, years later, access to this care is still a problem. "It's been ten years," says Gutiérrez, who no longer dates men and remains firm in their decision not to have kids. "Still, no one will sterilize me."

Many patients, fearing this type of reaction, don't disclose their transgender status when they go to the doctor, and while this is often the safest or easiest option for patients, it's a major reason why there isn't enough research on this population. Prior to Moseson and Ragosta's project, researchers didn't know how many trans people get abortions because, according to Moseson, that type of data just wasn't collected—all patients seeking abortion care were automatically presumed to be women. Obtaining that type of data requires trans people to out themselves in a clinical setting, which many are understandably hesitant to do.

These encounters represent part of a wider issue as well—many doctors, particularly those who don't have specific training in sexual and reproductive health, avoid talking about topics related to sex, contraception, and pregnancy. Grayson Schultz, an Ohio-based trans activist, has spent the last year researching the health experiences of queer patients, and he's found many just aren't having conversations with their doctors about sexual and reproductive health. "It seems like providers just really don't explain issues around sexual orientation or sexuality, sexual health, to their patients," explains Shultz. The stigma surrounding these topics is part of the problem, he adds—when doctors are already unsure of how to provide proper care for trans individuals, they aren't likely to want to broach the subject, and patients invariably suffer.

One way is by getting incorrect information about their reproductive health. For example, Shultz's research shows that doctors may fail to properly communicate what effect hormone-replacement therapy (HRT)—a type of gender-affirming care that involves using hormones to better align a patient's body with their gender identity—will have on fertility. While the hormone testosterone does reduce fertility in patients who were assigned biologically female at birth, it is not a substitute for birth control. Trans men and nonbinary people are often still able to get pregnant. Many doctors are unaware of this, so they fail to discuss methods of contraception with their trans patients.

Some trans and nonbinary people, like Gutiérrez, end up avoiding seeking medical care entirely. But avoiding routine medical appointments means minor problems can become emergencies, and being trans can make it difficult to access emergency care. When Stann Midwood, who suffers from complex chronic health problems, went to the hospital complaining of abdominal pain, ER staff said that the pain resulted from menstrual cramps and was simply part of being a woman. If the nurse had taken the time to speak with her patient beforehand, she would have learned that Midwood had previously received a hysterectomy and no longer menstruated. Instead, Midwood's care was delayed until doctors later discovered a potentially fatal gastrointestinal bleed.

One major reason why healthcare providers don't usually have a clear picture of trans healthcare needs or challenges is because they don't receive training about it. A 2011 study published in the *Journal of the American Medical Association* found that one-third of medical students received no education on LGBT care, while a more recent 2020 study published in *BMC Medical Education* found that medical students often received just a few hours of class time devoted to LGBT health in a year's worth of instruction. Part of the reason these curriculums are so scant, especially when it comes to trans health, is because there is simply no data from which to draw.

Heidi Moseson says that this problem of missing data is pervasive in the wider field of reproductive healthcare and research. Abortion, and reproductive health in general, is stigmatized worldwide. As a result, people often aren't willing to participate in studies, and obtaining funding to conduct any research in the first place can be a struggle. Members of the trans community, who have long been forced to reckon with their existence being pathologized in medicine and the media, have particular reason to be wary of researchers. To do her own work in this field, Moseson would need to overcome more than just scientific challenges.

The minds behind the research

Moseson's interest in reproductive health started early. Her mother worked as an obstetrician-gynecologist (OB/GYN), and pregnancy and abortion were regular topics of conversation in their household. A Mexican immigrant and a Catholic woman, Moseson's mother internalized religious and cultural shame, but that shame didn't dampen her commitment to providing abortions, which she viewed as necessary healthcare, to people in her community. Despite backlash from her neighbors, she always provided needed services to those who were struggling and even started a reproductive healthcare clinic for immigrant women.

As a child, Moseson herself felt backlash, too. In their small, conservative town in the Pacific Northwest, abortion was heavily stigmatized and Moseson frequently felt the atmosphere in a room sour when her mother's work came up at school. But that only fueled her desire to follow in her mother's footsteps.

At first, Moseson dreamed of becoming an OB/GYN, but during her college years, she began thinking about health on a larger scale. She earned a Ph.D. in epidemiology from the University of California, San Francisco, where her dissertation focused on improving methods of documenting abortion. "It's this super common health experience, yet because of all these layers of stigma and privacy, it's a really hard thing to measure," she says. Over time, she began realizing just how much this lack of data makes it difficult to provide information and services to the people who need them most.

Moseson joined Ibis Reproductive Health—a nonprofit research and activist organization that focuses on global sexual and reproductive health issues—in 2017 and quickly noticed that the vast majority of public health research failed to include the experiences of transgender people. "This population, which is so diverse and so broad, has been just left out of our conversations," she says. "How can that be?"

Moseson decided to start filling in the research gaps herself. Later that year, she secured a grant from the Society for Family Planning to conduct a small preliminary study into the contraception and abortion experiences of trans patients. To ensure that the project could be conducted both by and for trans people, Moseson partnered with members of the PRIDE Study and the Williams Institute and designed a 40-question-long survey on reproductive health that covered everything from general healthcare to abortion access. Recruiting participants through social media and community networks, Moseson's team conducted 27 in-depth telephone interviews with trans patients, as well as clinicians, advocates, and researchers working within that community.

They found that these patients cared deeply about fertility and family planning as well as access to contraception. Patients preferred contraceptive methods that prevented or alleviated gender dysphoria, stopped menstruation, and were free of estrogen and other hormones. Patients also reported experiencing a wide range of barriers to care, including the high cost of treatment, lack of healthcare access, and lack of provider knowledge, all of which, they said, were compounded by transphobic discrimination and stigma. "I've never had anybody even acknowledge that trans people have abortions," said one participant.

Many respondents emphasized the need for better educational materials for providers and patients, but they also widely agreed that more research was needed—most of the existing data had been done on small sample sizes and none of it specifically addressed reproductive health.

Moseson also doubted whether previous national-level studies of reproductive health had collected good data at all. While designing her study, she found that most of the widely used questionnaires and survey materials on reproductive health contained built-in assumptions about the gender and sexuality of respondents. These surveys regularly presumed, for instance, that anyone capable of pregnancy identified as a woman, and they often conflated gender identity with sexual orientation, skewing the accuracy of the results. For example, the National Survey of Family Growth, which was conducted from 2015 to 2017, divided participants into “female” and “male,” and exclusively referred to the partners of “female” participants using he/him pronouns. As a result, gay and trans respondents were either incorrectly categorized or excluded entirely from the results.

One of the biggest problems with previous studies in this field, Moseson explains, was that they weren’t designed or informed by trans people—a limitation she acknowledges in her own work. “I don’t have the lived experience that so many people who are our research participants have,” she says. Moseson soon realized that if her team wanted to conduct a much larger survey that accounted for the specific needs of transgender, nonbinary, and gender-expansive participants, they’d have to design it from the ground up, and they would need to collaborate directly with trans researchers.

That’s how Sachiko Ragosta, a California-based sex educator and writer, got involved. Ragosta had studied intersectional reproductive health as an undergraduate and much of their work focused on the ways in which identity can impact access to reproductive care. But their focus shifted around 2017, just as Moseson was beginning her pilot study.

After graduating from the University of California Berkeley, Ragosta applied for a Fulbright scholarship to study adolescent pregnancy in Uruguay. In the nearly two years it took for the project to be approved, “I came out as nonbinary and started thinking more about how little I knew about how nonbinary and trans folks are affected by different issues in sexual and reproductive health,” Ragosta says. This shift in perspective led them to make some last-minute changes to their project proposal and inspired them to learn more about trans identity and reproductive healthcare access.

After completing the Fulbright project, Ragosta returned to California and began running support groups for queer youth in the Bay Area, facilitating workshops on harm reduction, positive sexuality, and anti-oppression. As a health educator, they focused on providing support to youth in marginalized communities. Although the work was important and fulfilling, “I knew I wanted to go back to research,” they explain, “but I hadn’t found good examples of work that felt really inclusive to me.”

But when Ragosta came across a description of Moseson’s study on the Ibis website, they were instantly intrigued. They’d never encountered a research project that centered the experiences of trans people. “I was like, wow, this is everything I’ve been wanting to do,” they recall.

Ragosta, who later joined the team as a research assistant, started as a consultant helping to design the study. Moseson needed all the help she could get—her plan to create a national-level survey was ambitious, and she would have to overcome a number of hurdles if she wanted to see it through to the end.

The story in the data

The first major obstacle was funding. Obtaining financial support to conduct research in this field can be especially difficult, in part because certain grants and donors that reserve money for research into so-called “women’s health” exclude trans populations. Jody Herman, a scholar of public policy who studies gender identity in survey research at the Williams Institute in Los Angeles, California, has encountered these problems when seeking funding for her work. She says that the lack of prior research in this area creates skepticism among funders that the field is worth studying at all—Moseson has also had a grant proposal rejected on the basis that there wasn’t enough prior research to justify the project. Herman adds that trans health researchers also contend with peer reviewers who aren’t knowledgeable about trans identity or health issues and fail to recognize their importance. For example, Herman has witnessed reviewers conflate sexual orientation with gender identity, in one case mistakenly believing that the larger body of previous research into the health of gay men also applied to trans people and that new projects weren’t necessary.

Moseson eventually obtained funding from the Society for Family Planning—the same organization that funded the pilot project. Then came the time-consuming challenge of constructing a national-level study from scratch. Throughout the design process, which lasted about a year, from May 2018 until April 2019, Moseson worked closely with many other researchers, as well as with members of the trans community. She says that colleagues in the field viewed her team and their project with skepticism, stating that the Ibis team was making things too complicated, but ensuring that the survey would capture precise data while also being respectful to study participants was a top priority, even if it meant working longer hours, she says.

Recruitment for the study mainly took place on the internet, where human beings are often at their vilest. According to Grayson Schultz, who has utilized online recruitment for his research into trans health, scientists who recruit through the internet face obstacles at every turn: ads for sexual health studies can get tripped up by website censorship policies, which often zero in on mentions of sex or abortion, while the advertisements that do make it through the censors are often targets for online harassment campaigns. Moseson’s study was no different. Online ads for the project were flooded with vitriol from transphobic and anti-abortion commenters, which Moseson says may have scared off some potential applicants.

But Moseson and Ragosta’s experience could have been much worse—publicizing yourself as a trans or trans-friendly healthcare provider or researcher can be downright dangerous. Brittany Charlton, an epidemiologist at Boston Children’s Hospital who studies reproductive health disparities in sexual and gender minorities, for example, is careful about sharing information about her work because colleagues of hers have received death threats from anti-trans activists.

In states with laws banning or restricting gender-affirming care, these doctors can also face legal repercussions.

When Moseson's study was finally ready, it was a thing of beauty. It included 328 questions and was completed by more than 3,000 participants. The team who created it included a communications specialist, an epidemiologist, an OB/GYN, a family medicine physician, an internist, qualitative researchers, a social worker, psychologists, and a reproductive health advocate—all with diverse gender identities and sexual orientations.

Moseson's team began analyzing their data in the months immediately following the completion of their survey, just as Ragosta was transitioning from their role as a consultant to a research assistant. According to Ragosta, who currently serves as the project's Senior Research Coordinator, patterns immediately emerged, as did answers to questions researchers had never been able to answer before.

First, Moseson and Ragosta confirmed what no other study had—trans people in the US get abortions, and the experience is far from uncommon. Of the survey respondents who had been pregnant in their lifetime, more than half reported that those pregnancies were unintended, and one-third reported at least one pregnancy ending in abortion. Medical abortions, due to the privacy they afforded and the lower likelihood of triggering gender dysphoria, were generally more popular than surgical ones.

Respondents also reported financial barriers when seeking reproductive healthcare—a finding largely confirmed by previous studies—and of facing stigma and discrimination when attempting to obtain reproductive healthcare. Previous testimony from members of the trans community meant that Moseson and Ragosta were well aware of these barriers, but what they didn't know was just often these obstacles pushed trans people to attempt dangerous at-home abortions.

Among the survey respondents who had previously been pregnant, nearly one in five reported attempting an abortion without clinical support, which is significantly higher than the percentage of cisgender women who do the same. Respondents reported using a wide variety of methods to try to terminate their pregnancies, including many dangerous ones. One respondent described inserting a needle into their uterus to induce a miscarriage, while another repeatedly hit their abdomen with a hammer. Another was able to get insurance to cover an abortion procedure, but had considered drinking poison when they thought they wouldn't be able to obtain one. "Dying was a better alternative to forced pregnancy," they wrote. Respondents described a wide range of reasons for attempting to end their pregnancy without clinical help, including barriers to care, like lack of health insurance, gestational age limits, and provider bias regarding trans patients—a problem that could potentially be reduced with more trans-specific training for healthcare personnel.

Ragosta notes that since survey data was collected and initially analyzed, these barriers to reproductive care—and all of the medical and safety problems they cause for trans patients—have likely gotten much worse. The overturning of *Roe v. Wade* and the subsequent wave of laws restricting or banning abortion and gender-affirming care add a new layer of access problems and potential legal punishments to the host of problems trans people already face when seeking care.

As Ragosta points out, trans and other marginalized people are at higher risk of criminalization—according to the USTS, trans Americans face higher rates of police mistreatment, incarceration, and physical and sexual assault in jails and prisons—which means these laws are likely to have a particularly harsh impact on them. “The reality is that most of the folks who are being criminalized are going to be people who have marginalized identities,” they explain.

The long road forward

Moseson and Ragosta hope that their work helps break down these barriers to quality care, but they also hope that their survey can serve as a model for getting clearer, more accurate data on trans populations. The response from survey participants was overwhelmingly positive. “I can’t tell you how much it means that you have taken such obvious and extensive efforts to be inclusive,” wrote one respondent in the survey’s feedback section. “Thank you for this thorough, thoughtful, and affirming survey,” another said.

Participants specifically praised the fact that the survey was designed in such a way that participants were able to input the words they use to describe their bodies and identities. Those customized words automatically replaced traditional medical terms throughout the survey. For example, many participants preferred to use gender-neutral terms like “chest” or “genitals” as replacements for words like “breasts” or “vagina.” Multiple study participants expressed how much they loved being able to shape the language of the survey to accommodate their own needs. Adopting this practice for future studies could help make participants feel more comfortable sharing personal information and help researchers obtain better data on this population.

Some participants suggested room for improvement—feedback that could also be of use to researchers in this field. Although many people appreciated the survey’s hyper-specificity of language, it sometimes made the experience of taking it awkward and time-consuming. Participants also pointed out that the survey mainly focused on trans people who had been assigned female at birth. Some respondents said that they would have liked to have seen more attention paid to topics like fertility preservation or assisted reproduction. Outside of Moseson and Ragosta’s work, many trans researchers, activists, and healthcare providers have pushed for future research studies to focus on the experiences of trans people of color, who often report feeling isolated and discriminated against, even within spaces that promote abortion and reproductive health access.

Looking forward, Moseson and Ragosta want to use their findings to educate trans patients about their reproductive health and help healthcare providers treat patients of all gender identities. There are already some prominent organizations dedicated to trans health, such as the World Professional Organization for Trans Health (WPATH) and GLMA: Health Professionals Advancing LGBTQ Equality, which are both made up of medical professionals who have experience treating trans patients. There are also some online databases that allow patients to search for trans-friendly providers in their area, but these databases aren’t always adequate, and many people living in underserved and rural areas often have few options when it comes to locating a trans-friendly doctor who takes their insurance and isn’t located prohibitively far

away. As protections for abortion and gender-affirming care continue to be stripped away in multiple US states, it will become even more difficult for trans patients to feel safe at the doctor's office.

Ultimately, projects like Moseson and Ragosta's epidemiological survey into the abortion experiences of trans Americans can only do so much. Making healthcare equitable for trans patients, Moseson and Ragosta argue, will require ending legislative threats to patient rights, dismantling the notion that abortion is only a "women's issue," and acknowledging that the reproductive healthcare rights of cisgender women and trans people are both under attack.

Including trans people in research, Moseson hopes, will also pave the way for greater specificity and compassion in research as a whole—as Grayson Schultz notes, there is a lot of overlap between the barriers faced by trans people and those faced by cisgender women, who are also often assumed to be a monolithic population. "We know that everybody has different hormonal makeup," says Schultz.

As activists like Gutiérrez and Jackson tell their own stories with words, Moseson and Ragosta are shedding light on reproductive issues and raising trans voices with data. So, despite persistent attempts from politicians and critics to silence them, the stories of trans Americans hopefully won't go unheard for much longer.

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