

A survey of experiences with **surgery readiness assessment** and **gender-affirming surgery** among trans people living in Ontario

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The Gender-Affirming Surgery Experience Survey received ethics approval from the Research Ethics Board at the University of British Columbia (certificate #H16-00800).

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Executive Summary

This report is based on data from the Canada-wide Gender-Affirming Surgery Experience Survey. The survey was originally designed through a partnership between the Stigma and Resilience Among Vulnerable Youth Centre (SARAVYC) at the University of British Columbia and Trans Care BC, and resulted in a first report focused on British Columbia, which was published in October 2017. After hearing about this work, three Toronto-based healthcare and research centres contacted SARAVYC about compiling a report based on the Ontario-specific data collected in the survey. They include the Centre for Addiction and Mental Health (CAMH), Sherbourne Health Centre (SHC), and Women's College Hospital (WCH) and will be referred to in this report as the Toronto Partners. Through funding from the Toronto Central Local Health Integration Network, the Toronto Partners are working to enhance the coordination and availability of health services and supports for trans and gender non-conforming people throughout Ontario (ON). For example, in March 2016 regulations changed in Ontario that allowed more health professionals to conduct assessments for gender-affirming surgery.

Launched in July 2016, the survey had 751 respondents and was open to anyone residing in Canada who had undergone assessment and/or surgery in the last five years, capturing people's experiences since 2011. After partnering with the Toronto Partners, SARAVYC focused recruitment efforts for a second wave of the survey in Ontario, and translated the survey into French as well. The survey asked trans people at various stages of accessing gender-affirming surgery about their experi-

ences with the process, including their experiences with surgery readiness assessments, surgery, and post-surgery recovery.

The following key findings and recommendations emerged from the data reported by participants. It should be noted that most of them likely experienced their assessment and surgery before the March 2016 policy changes.

KEY FINDINGS

- We asked about gender identity a couple of different ways. While 12% of respondents identified as non-binary (as compared to transmasculine or transfeminine), in a separate question they were asked to write in their gender identity and the large number of different responses suggests that more complex understandings of gender are needed throughout the surgery process, especially non-binary genders identities.
- Wait times across the journey to surgery varied greatly. This included the wait between referral and assessment (waits from a few days to 10 years) and between assessment and surgery (waits between less than a month up to a few years).
- For a majority of types of surgeries, respondents in ON reported waiting for their readiness assessments an average of more than six months longer than respondents from other provinces.

- In ON, just over half of people (55%) found it easy to get an assessment appointment and most (72%) had it covered by the Ontario Health Insurance Program (OHIP).
- Over half of people who had surgery covered by OHIP (60%) expressed the cost of travel for themselves and caretakers, aftercare facilities, and aftercare supplies proved burdensome. Some respondents reported spending up to \$10,000 on costs beyond surgery itself.
- Most people in ON who paid for surgery entirely out of pocket were able to choose the surgeon they wanted (94%) compared to about half of those who were funded entirely by a government health plan (47%). However, of respondents from other provinces who were funded by government plans, only about a quarter (27%) were able to choose their own surgeon.
- Over half (57%) of respondents in ON had to travel over 2 hours to have surgery. While this is not surprising, as many surgeries are not performed in ON, many of the written comments recommended limiting travel and the associated costs as key measures to improve the experience.
- People scored on average 7 out of 10 on a support scale for post-surgery support, meaning that they had quite a bit of social supports available to them.
- Additionally, complication rates after discharge from surgery doubled for respondents with long travel times. Self-reported complication rates were 20% when the person had to travel less than 2 hours to their surgery appointments and 46% when the person had to travel more than 2 hours to their surgery appointments.

KEY RECOMMENDATIONS

- Increase trans competence trainings for assessors to ensure a greater number of trans-competent local primary care providers.
- Develop policy to provide consistency in the assessment process to reduce discrepancies in terms of what information people are able to obtain from the assessment process, and who can perform assessments.
- Emphasize a patient-centered, informed consent model that would ensure people have all the information they need to make the best decision for themselves.
- If assessments remain mandatory, their costs should be fully covered by government health plans to avoid disparities between those who are able to pay out of pocket for services, and those who cannot.

- Ensure people can assess transparent, streamlined paths to surgery, with reduced wait times.
- Explore means to remove barriers to surgery due to BMI so that those who are able to safely access surgery can do so.
- Work to increase access to trained surgeons within a 2-hour radius of an individual's home community.
- Develop policies to provide coverage for travel and aftercare costs, especially for people that have surgeries performed outside of Ontario.
- Change existing policies to cover surgeries such as breast augmentation, tracheal shave, electrolysis, facial feminization, etc., as access to these procedures is critical for trans people to feel like they can more happily, confidently, and safely navigate everyday life.

Introduction

As awareness of gender diversity grows in Ontario and across Canada, so do options for gender-affirming care for trans people. We use the word trans in this survey as an umbrella term for people whose gender does not match the sex and gender that they were assigned at birth. This includes trans men, trans women, and non-binary people, although many people use a wide variety of terms to talk about themselves and their gender.

Gender-affirming care is a broad category that includes routine health care provided in a gender-affirming way, gender-affirming counselling, hormone therapy, and surgical interventions. Trans people may choose to access one, many, or none of these forms of gender-affirming care. This report is focused on access to gender-affirming surgery, which is considered medically necessary for many people, and is an effective treatment for ‘gender dysphoria’ as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). As a result, this report focuses on trans people who seek out these surgeries, but it is important to note that not all trans people want or seek out medical interventions such as hormone therapy or surgery.

This survey is the first to provide a detailed overview of the experiences of trans people in Ontario who are accessing, or have accessed, gender-affirming surgery, and the first of its kind to offer holistic feedback about the experiences of people in Ontario who have had gender-affirming surgery.

PURPOSE OF THE SURVEY

The collaboration between SARAVYC and the Toronto Partners was created to improve the delivery of health services to trans and non-binary people in Ontario. Because the Toronto Partners coordinate services for trans and non-binary people across Ontario, the intention was to get a better sense of people’s experiences with assessment and surgery in order to inform the program in its work throughout the province.

While the survey was open to anyone residing in Canada, this report focuses on the experiences of respondents who reside in Ontario. In the assessment section, however, the report includes the experiences of people from other provinces who are required to come to Ontario for their surgical assessment appointments. Reporting on this group specifically highlights how trans and non-binary people who live in Ontario experience the surgery process, including Ontario-based health centres, OHIP, etc.

There is very little information in the academic and clinical literature on people’s experiences with the process of accessing gender-affirming surgery. We developed a survey that could provide information on how gender-affirming care is delivered in Canada, and how people navigate and experience the current health care system. It was a priority to make sure that the voices of trans people were heard in this process.

Having clear and detailed information on the access to, and the delivery of, gender-affirming surgery is essential to inform future policy decisions and best practices for health care practitioners. This report will help improve existing systems of care for trans people in Ontario.

METHODS

The original on-line survey was developed in partnership with the Trans Care BC team in Vancouver and a peer reference group, which included members of trans communities from across BC. The first draft was shared with these groups and we received feedback on how questions could be improved or what other questions should be asked. This feedback was integrated into the survey and the peer reference group was invited to test out the survey and give further feedback ahead of its public launch. The survey was also translated into French.

Data for this report was collected from July 1, 2016 through June 30, 2017. Participants who had undergone a surgical readiness assessment and/or gender-affirming surgery in the past five years were able to participate. People could respond to the survey online, either on a computer, tablet, or smartphone, as well as on the phone if they contacted us directly. SARAVYC promoted the survey through our professional and interpersonal networks, through the peer reference group, through advertisements via social media and websites, and on cards distributed during public events that were aimed at trans communities. The Toronto Partners and Ontario-based trans community groups also promoted the survey to local communities. The study received ethics approval from UBC's ethics board.

The survey was anonymous, but asked for participants' province and postal code, and checked the country location of their IP addresses so we could exclude surveys from people who were not eligible to participate in the study.

Throughout the survey, comment boxes were available for respondents to provide more detailed feedback on their experiences. The quotes included in this report are from those comments, and they include brief information on the person who wrote that comment: that person's age and their gender (in their own words).

Who participated in the survey?

In order to be eligible for the survey, people had to be 18 or older, live in Canada, and fit into one of three groups:

- Had a gender-affirming surgery in the past five years and/or
- Had a surgery readiness assessment in the past five years and/or
- Were currently waiting for a surgery readiness assessment.

In total, 751 people participated in the survey, 284 of which live in Ontario. Estimates suggest that between 0.2%-0.5% of the population seek out medical transition², although no numbers are available in Canada.

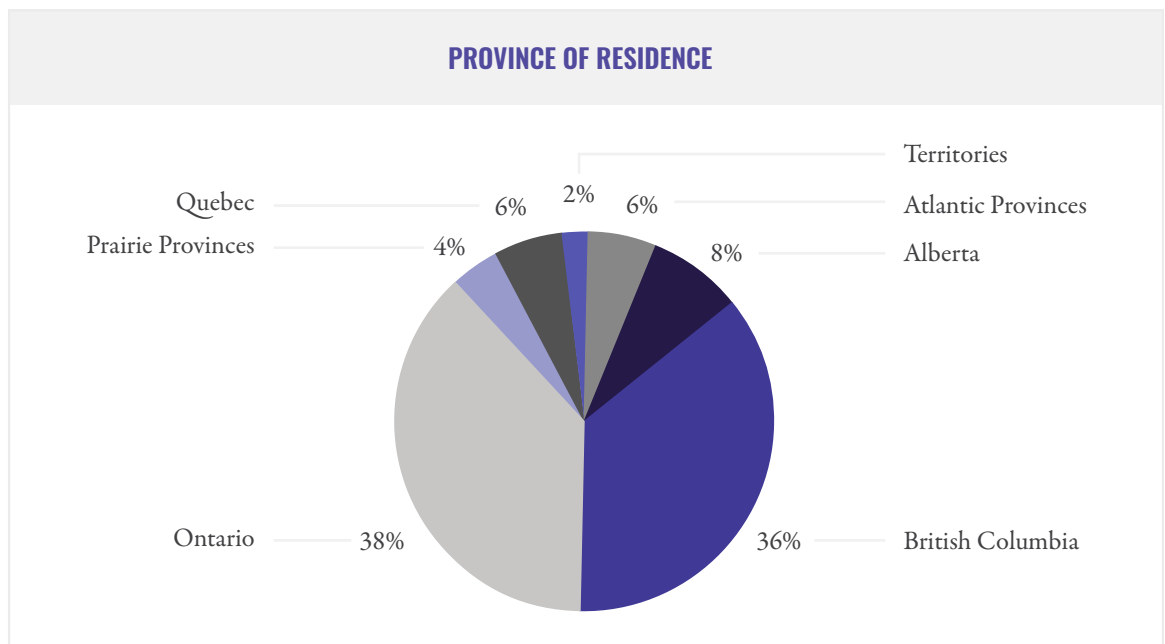
LOCATION

Our recruitment strategy was focused primarily on people who lived in British Columbia and Ontario; as a result, over one third of respondents (284) were residents of Ontario. When we mention “respondents in ON,” it refers to this group. However, not every respondent in ON answered every question.

Based on the postal code that people reported, only a small number (7%) lived in rural and small towns as defined by Statistics Canada³.

² Gender Identity Research and Education Society (GIRES) (2011). The Number of Gender Variant People in the UK-Update 2011. <https://www.gires.org.uk/assets/Research-Assets/Prevalence2011.pdf>

³ du Plessis, V., Beshiri, R., Bollman, R. D., & Clemenson, H. (2002). Definitions of “rural”. Agriculture and Rural Working Paper Series: Working Paper No. 61 (Catalogue No. 21-601-MIE). Ottawa: Statistics Canada.



SURGERY STATUS

Among people who had surgery, respondents from ON identified what procedure(s) they had undergone. In total, respondents in ON reported having had 81 lower body surgeries or procedures and 96 upper body surgeries or procedures. These numbers reflect the total number of surgeries or procedures had by all respondents in ON, not the number of respondents who reported having had a surgery or procedure.

LOWER SURGERIES/PROCEDURES (N=81)

Vaginoplasty	37%
Orchiectomy	7%
Labiaplasty	6%
Phalloplasty	9%
Metoidioplasty	5%
Clitoral release	4%
Hysterectomy	32%

UPPER SURGERIES/PROCEDURES (N=96)

Breast augmentation	9%
Chest surgery	79%
Facial feminization*	6%
Voice feminization*	0%
Tracheal shave*	5%
Pectoral Implants*	0%
Liposuction*	1%
Electrolysis*	0%

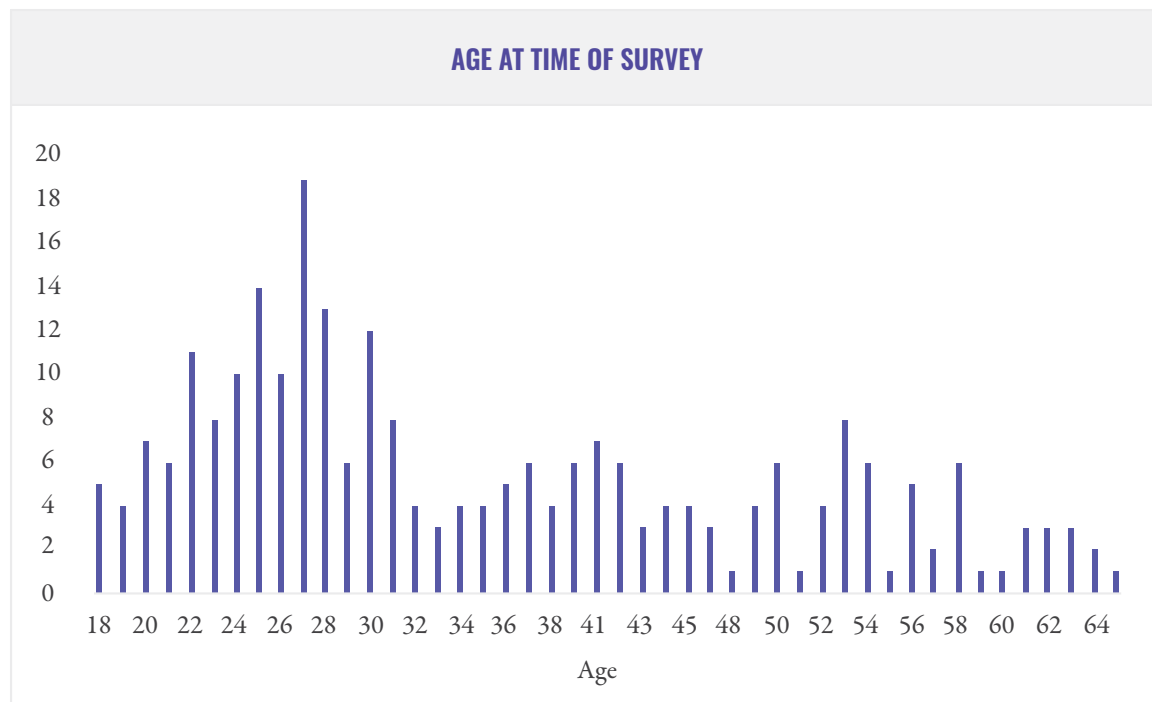
Note: People could select more than one answer.

*Not publicly funded in OHIP.

DEMOGRAPHICS

AGE

Age of respondents in ON ranged from 18 to 69. The average age of survey respondents was 36 years old and the median age was 31 years old.



GENDER

To ask people about their gender, we used a two-fold approach. First, we asked people what their gender identity was, leaving space for people to be able to enter their specific identity(ies).

Some participants who used the comment box wrote in binary gender identities, such as “male,” “transwoman,” or “FTM.” However, many people used this open-ended box to indicate not only non-binary identities but also a wide variety of identities and labels, such as “male, gender fluid,” “Two-Spirit,” “genderqueer trans masculine,” “agender,” “demi-boy,” “nonbinary,” etc.

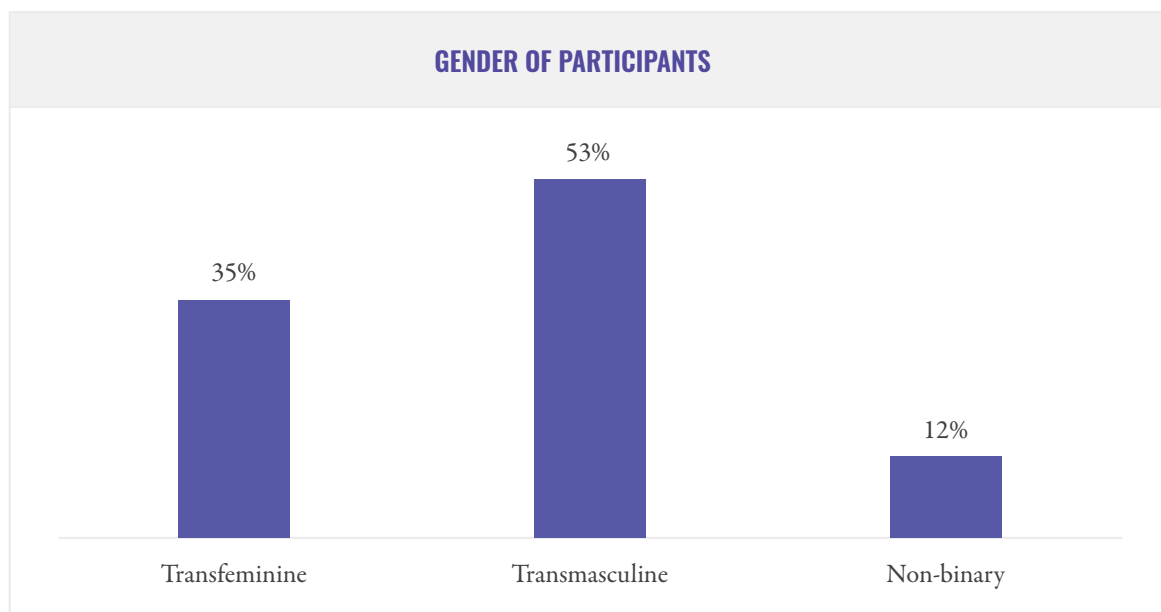
This diversity of answers suggests the importance of making room for people to write in how they describe their gender, and that labels resonate in a variety of ways with different people. This is especially true for people with non-binary genders, since the English language is still limited in this respect. Some people used this space to explain their gender identity in one or two complete sentences, highlighting how one's gender might not be able to be described by a single-word identity category.

Second, we asked people which terms best described them between the following three options:

- transfeminine/woman/MtF
- transmasculine/man/FtM
- non-binary/genderqueer

It was important to be able to categorize people within these broader labels so that we could contrast and compare findings among different populations. As the graph below indicates, 35% of respondents in ON selected transfeminine, 53% selected transmasculine, and 12% selected non-binary.

We also asked people to identify what sex they were assigned at birth. Of the respondents from ON, 42% were assigned male at birth and 58% were assigned female at birth. In a separate question, we also asked about whether or not people were born with an intersex body, and 2% said they were, with an additional 15% who were not sure if that was the case.



ETHNO-CULTURAL BACKGROUND

We asked people to identify their ethno-cultural background. A large majority of respondents (90%) were white. The three largest minorities were Aboriginal/Indigenous, Black/African, and East Asian, each group comprising about 2% of respondents. Additionally, 12% of people identified as belonging to multiple ethnic groups. In comparison, according to the 2011 National Household Survey from Statistics Canada, roughly 4% of Canada identified as Aboriginal/Indigenous and nearly 20% as a visible ethnic or racial minority.⁴ These low numbers mean we cannot meaningfully report on differences in experiences and outcomes based on ethno-cultural background.

⁴ <http://www.statcan.gc.ca/eng/start>

The low participation of people of colour and Indigenous/Two-Spirit people should be cause for concern, as it reflects other studies showing the barriers facing transgender people of colour and Two-Spirit people in accessing many health and social services. Unfortunately, if they encountered barriers in accessing gender-affirming surgery, they might not have been able to participate in this study, given its focus on formal medical services. It also may reflect higher barriers to participation in research. This suggests that future research needs to better engage under-represented communities, and there should be more studies that centralize the experiences of trans people of colour and Two-Spirit people, so that their experiences can help shape policy and procedures that will ultimately support them.

ETHNO-CULTURAL BACKGROUND OF PARTICIPANTS

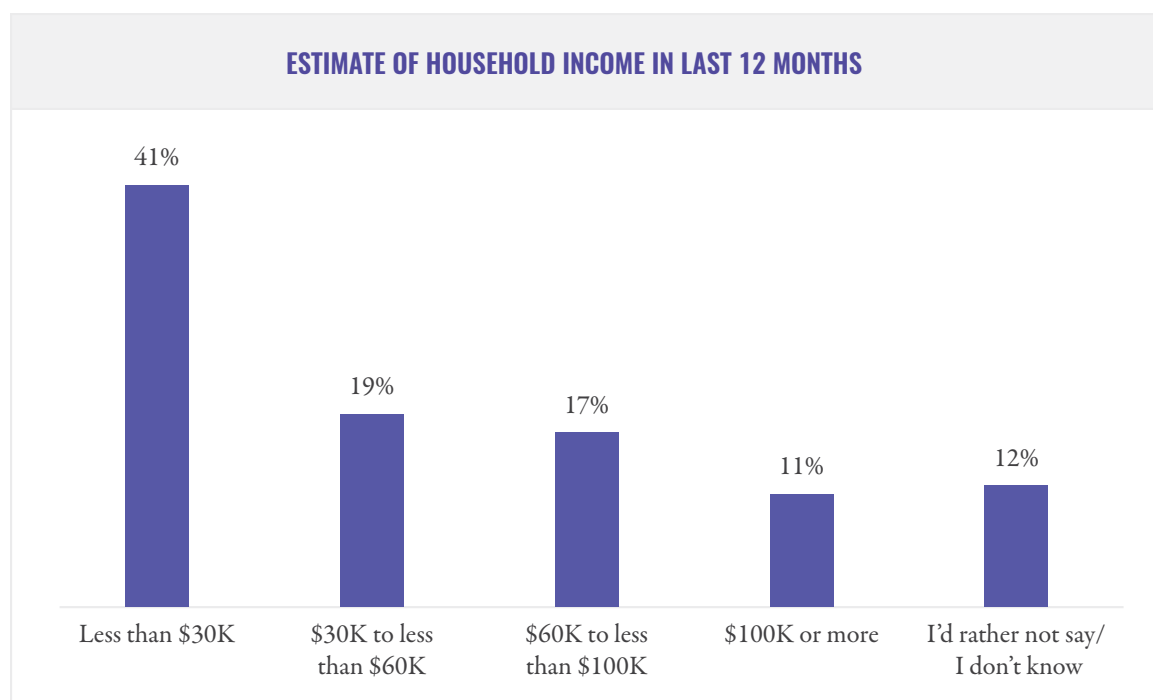
Aboriginal/Indigenous	2%
Black	3%
Filipino	<1%
East Asian (Japanese, Koreana, Chinese)	3%
South or Southeast Asian	1%
West Asian or Arab	<1%
White/European descent	89%
Other	<1%

CITIZENSHIP AND INCOME

The vast majority (98%) of respondents from ON who answered the survey were Canadian citizens, while 2% were Permanent Residents.

The table below shows estimates of household incomes among respondents. Just under half (49%) of people reported an annual household income of \$40,000 or less. In comparison, the median Canadian family income in 2015 was \$70,770. Additionally, just over 10% did not know or did not want to share their income. The majority of people (82%) indicated that their annual household income supports either themselves or themselves and one other person; the remaining 18% report having between 2-5 other people supported by their income.

Under half (45%) of respondents in ON reported they had access to some form of benefits. Overall, almost 60% of respondents in ON with benefits indicated that they had access to multiple forms of benefits (paid vacation, paid sick leave, or short-term disability). These are especially important when considering the travel time and recovery time that goes along with having surgery, which often require people to take weeks off of work. Additionally, 14% of respondents in ON were on some form of social assistance.



Surgery readiness assessment

ASSESSMENTS: KEY HIGHLIGHTS FROM RESPONDENTS IN ONTARIO

- A majority (68%) of people had one or two surgical readiness assessments
- Almost half (45%) of respondents found it challenging to access an assessment
- Respondents reported waiting an average of six months longer for assessments as compared to respondents from the rest of Canada
- Broken down individually, respondents in ON reported waiting at least six months for an assessment for a majority of the surgeries/procedure included in this survey
- Respondents had to travel an average of 90 minutes to their assessment appointments
- A majority (75%) of respondents had the assessment covered by insurance (OHIP or private plan)
- Just over half (56%) of respondents had their assessment with a healthcare provider they already knew
- Most (82%) respondents found that their assessors created a safe space to talk about their surgery
- Over half (62%) of people found the assessments helpful in their preparations for surgery
- More than half (56%) of respondents had to wait one month or less after their assessment to learn of their approval for surgery

In this section, we focus on people who reported having had at least one surgery readiness assessment anywhere in Ontario to describe the experiences of respondents who received a surgical readiness assessment in ON. We refer to this group as “respondents in ON.” In this section of the report, this includes a number of respondents (about 10) who live in other provinces that required residents to have the assessment done at CAMH in Toronto.

There have been recent changes to policies surrounding the assessment process for residents of ON. As of March 2016, qualified providers can conduct assessments and make referrals for surgery. Prior to this date, all individuals desiring surgical procedures funded by the Ontario Health Insurance Plan (OHIP) were required to have assessments done at CAMH in Toronto. However, because of the timing of when the survey was developed and administered, it is not possible to report whether or not the policy affected the experiences of any of the respondents. This policy, however, was intended to cut

down on the long wait times to schedule and have an assessment appointment, the subsequent frustration of having to wait, and the long travel times for people who live far from Toronto.

Professionals from a range of disciplines have been trained to work as qualified assessors, including psychiatrists, psychologists, nurse practitioners, registered nurses, registered social workers, and GPs. According to OHIP requirements for gender-affirming surgery^{5 6}:

For chest surgery, a patients need one supporting assessment recommending surgery from a qualified physician or nurse practitioner who has the appropriate training.

For genital surgery, a patient will need two supporting assessments recommending surgery from qualified physicians, nurse practitioners, registered nurses, psychologists or registered social workers who have the appropriate training with the following restrictions:

- At least one of these assessments must be from a physician or nurse practitioner.
- A registered social worker refers to a social worker that has a master's degree in social work and holds a current certificate of registration from the Ontario College of Social Workers and Social Service Workers.

While receiving an assessment in ON does not preclude one from having surgery in other provinces or out of the country, to have the surgery covered by OHIP, the

assessment must be completed in ON. As such, focusing on respondents in ON offers an opportunity to learn how they describe their interactions with local health service providers and assessors, the Ontario Ministry of Health, OHIP, and so on.

A surgery readiness assessment is conducted by a qualified health care professional to ensure that the person is prepared for the surgery, in order to have the best possible health outcomes. It is distinct from other gender-related counselling people that may have accessed elsewhere. While most surgeons in ON adhere to the World Professional Association for Transgender Health (WPATH) Standards of Care (7th version)⁶ for referral criteria, accepting a referral is up to the clinical judgment of the surgeon. The WPATH standards are guidelines, and therefore requirements may differ from surgeon to surgeon.

Currently, there is variation in terms of what a surgical readiness assessment entails, what questions are asked, what information is provided, etc. The 7th version of the WPATH Standards of Care (SOC) does provide some broad guidance around the role of the assessor, as well as the recommended content in a referral for surgery:

Mental health professionals can help clients who are considering surgery to be both **psychologically prepared** (for example, has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan;

⁵ Ontario Ministry of Health and Long Term Care: Sex Reassignment Surgery. <http://www.health.gov.on.ca/en/pro/programs/srs/>

⁶ <http://www.statcan.gc.ca/eng/start>

has included family and community as appropriate) and **practically prepared** (for example, has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery. (p. 26-27)

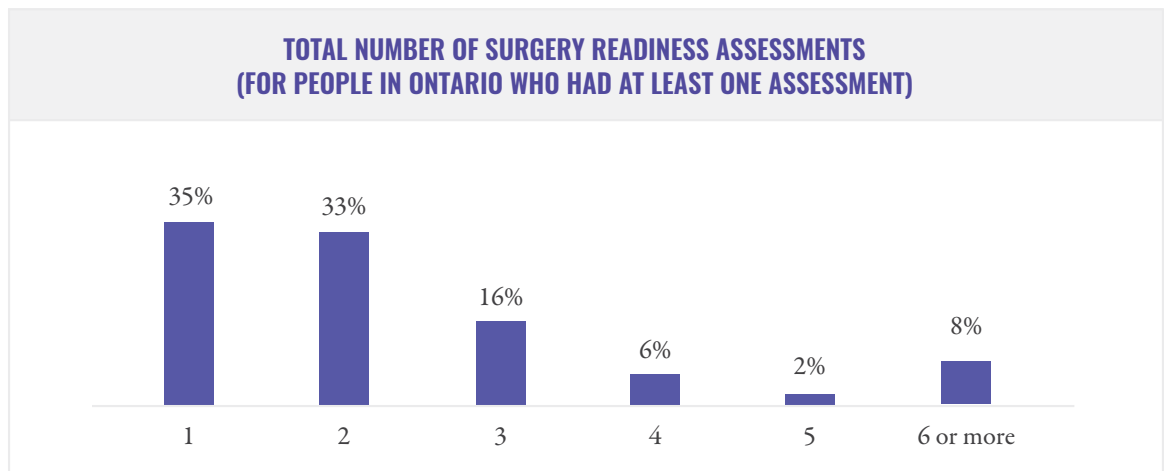
The WPATH SOC also emphasize a patient-centered informed consent model:

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client’s decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. (p. 27)

While the SOC allow for an individualized approach to best meet a patient’s health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one’s gender identity. (p.60)

Based on the feedback of respondents, practitioners in ON who perform readiness assessments generally appear to align with these standards

Some people may seek a readiness assessment for more than one procedure in one assessment process. Others may seek assessment for different procedures at different times. Respondents in ON had on average 2 surgery readiness assessments; people ranged from having 1 to 6 assessments, though most had only 1 or 2.

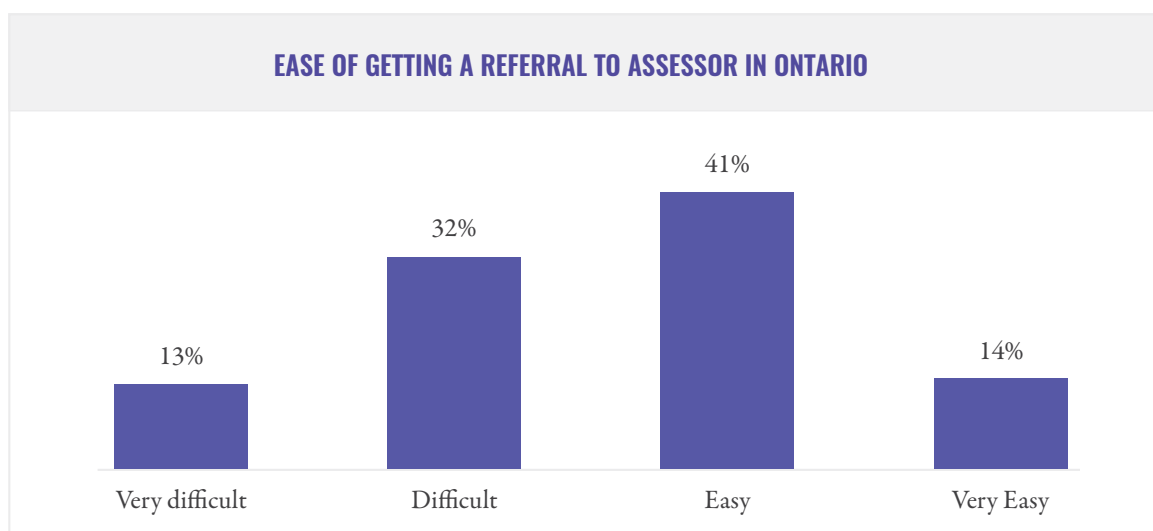


ACCESSING SURGERY READINESS ASSESSMENTS

We asked respondents how easy they found it to get a referral for their assessment. While just over half respondents in ON (55%) found it easy or very easy to do so, 13% found it very difficult to get a referral for a surgical readiness assessment appointment.

“ I think my difficulty [was] in beginning trying to get the assessment. All the waiting from [assessor’s] end was hard to overcome. You are anxious and terrified at the same time.

- 28, TRANSMAN



WAIT TIMES

The average wait time between referral and most recent surgery readiness assessment for respondents in ON was nearly 14 months (408 days). This is six months longer than average wait times for respondents from other provinces, who reported waiting about 8 months (241 days).

However, wait times varied greatly in ON, with some respondents waiting as little as 4 days and as long as 10 years. There were approximately as many respondents

who waited less than 180 days as those who waited longer. Access to gender-affirming surgeries and the policies around them have changed greatly in the past ten years in Ontario, and because the survey did not ask when respondents had each assessment, some longer wait times could have occurred before certain present-day policies and procedures were set in place. This includes the March 2016 policy that expanded the number of assessors in the province.

When considering surgeries individually, with the exception of two procedures (tracheal shave and facial feminization), respondents in ON waited much longer on average between referral and the most recent surgery readiness assessment appointment than respondents from other provinces. The two procedures that had shorter wait times for respondents in ON as compared to the rest of Canada are procedures that are not covered by OHIP, for which respondents would have had to pay out of pocket.

For a majority of the procedures, however, respondents in ON reported waiting on average over six months longer than respondents from other provinces.

“ I was one of the lucky ones but I had a very smooth process. 18 month wait for an appointment [with the assessor] was not ideal but it did ensure I was ready. Then things moved quickly and I received approval in 6 months after 2 visits to [the assessor]. And then another 5 months to surgery... ”

- 58, FEMALE

AVERAGE TIME BETWEEN REFERRAL AND ASSESSMENT APPOINTMENT BY TYPE OF SURGERY

SURGERY	RESPONDENTS IN ONTARIO	RESPONDENTS IN OTHER PROVINCES
Vaginoplasty	19 months*	8 months
Labioplasty	7 months	7 months
Chest surgery	15 months*	11 months
Orchiectomy	15 months*	7 months
Hysterectomy	17 months*	11 months
Tracheal shave #	5 months	12 months
Phalloplasty	19 months*	5 months
Breast augmentation	13 months	13 months
Metoidioplasty	14 months*	7 months
Facial feminization #	5 months	16 months
Clitoral release	17 months*	6 months

* Average wait time was over 6 months longer than average for respondents from other provinces

Surgeries not covered by OHIP

TRAVEL TIMES

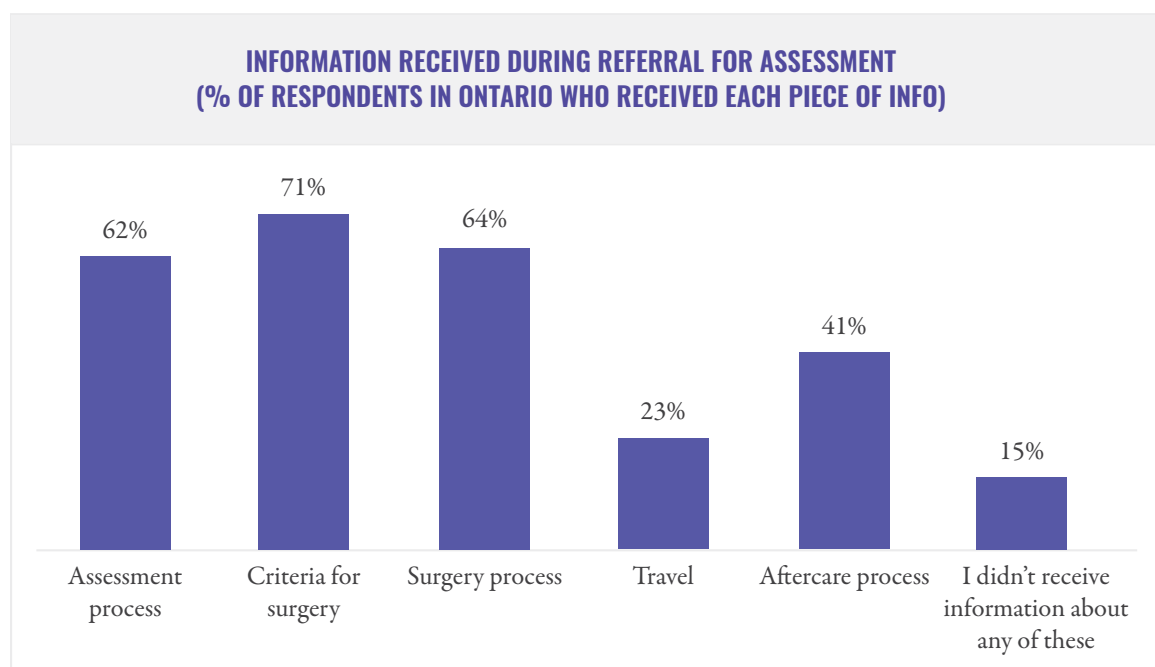
Respondents in ON reported having to travel an average of 93 minutes to get to their most recent surgery readiness assessment. Almost two thirds of respondents (64%) in ON traveled about an hour or less to the assessment.

Here again, the range of answers suggests that there are some large disparities: some respondents in ON reported having to travel as little as 5 minutes, while others reported having to travel as long as 10 hours. This includes respondents who live in the Toronto area near the offices of the assessors and those who live in other locations. Additionally, they include responses from respondents in other provinces who were required to have their assessments in ON.

KNOWLEDGE ABOUT SURGERY READINESS ASSESSMENT

We asked people what kind of information they had received when they were referred to a surgery readiness assessor. We specifically asked them if they had received information about (1) the assessment process, (2) the criteria for surgery, (3) the surgery process, (4) travel, and (5) the aftercare process. The graph below shows what type of information respondents in ON received

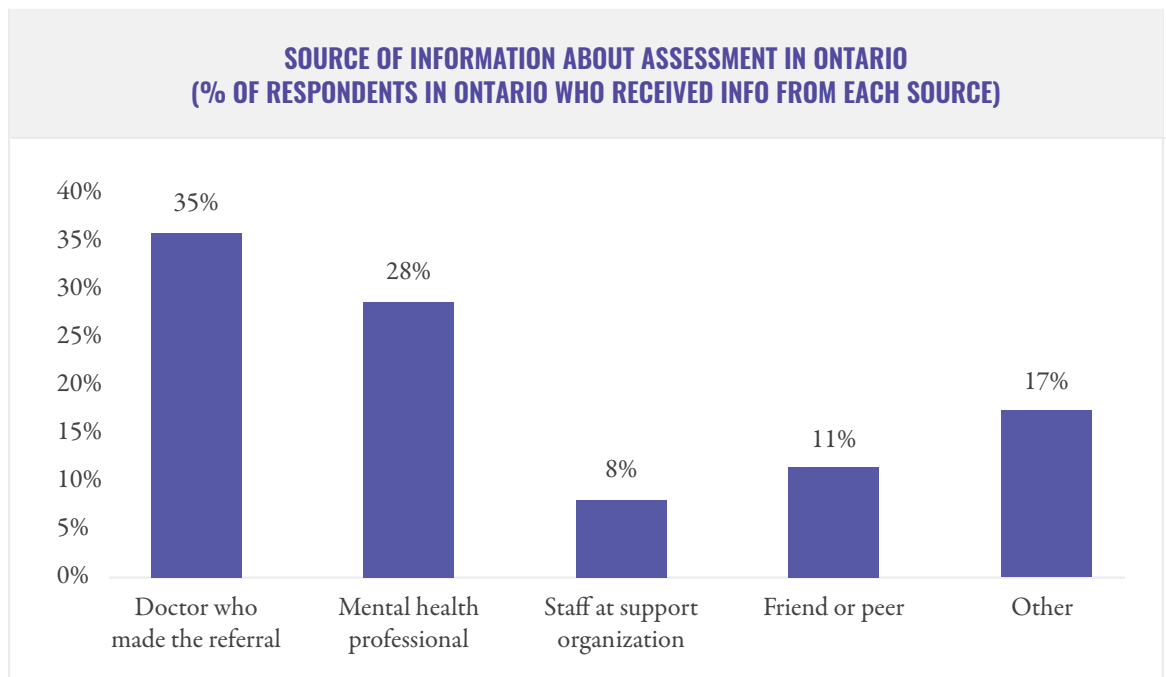
Among respondents in ON who had received information, 87% of people indicated that they had received information on multiple topics. When they had received information on only one topic, it was most frequently information about the assessment process (48%) or criteria for surgery (39%).



Note: Respondents could select more than one answer.

Respondents were asked where they received information about the assessments. The graph below shows an overview of the answers people gave. People who selected the 'Other' option most often mentioned obtaining information from their surgeon or assessor (55%), or from doing their own research (17%).

Over a third of respondents in ON (38%) indicated that they had received information about assessments from one source, and another 27% reported they had received this information from two sources. When people only had one source of information, just over half reported that source to be the doctor who referred them (51%).



Note: People could select more than one answer.

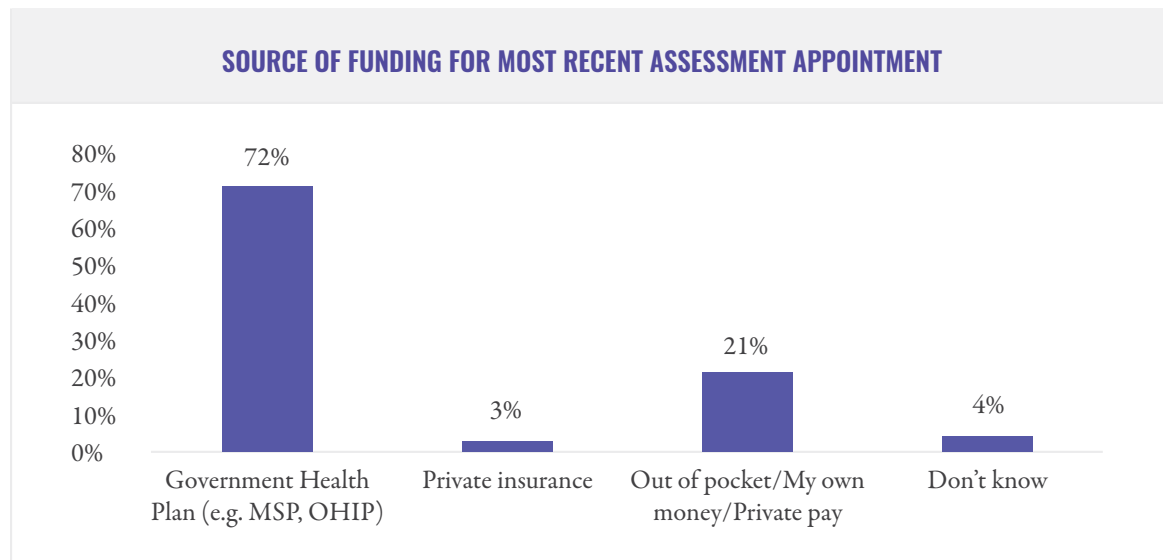
FUNDING FOR ASSESSMENTS

Nearly three quarters of respondents in ON (72%) reported their assessment appointments were covered by a governmental health plan, while a fifth (21%) paid out of pocket.

Again, there were some significant disparities among respondents: some people reported spending no money out of pocket for the assessment and some reported

spending several thousands of dollars. The average out of pocket spending for respondents in ON for assessment appointments was just over \$400.

The vast majority of respondents in ON (93%) received funding for their assessment from one source.



Note: People could select more than one answer.

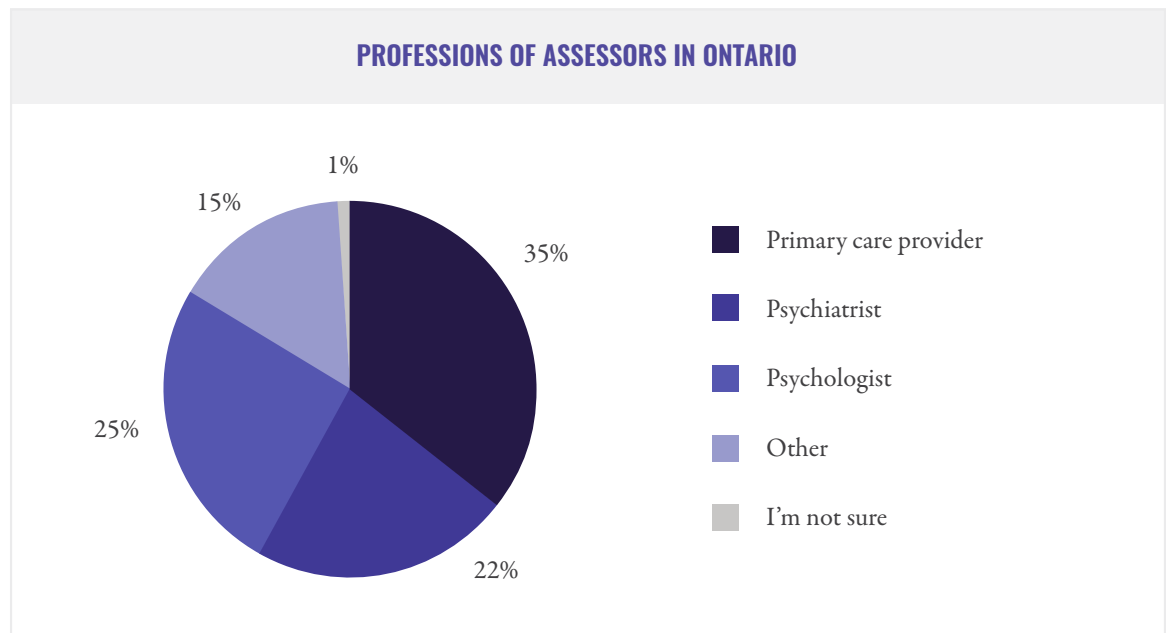
EXPERIENCE OF ASSESSMENT APPOINTMENT

WHO CONDUCTS ASSESSMENTS?

In ON, about half of the respondents (56%) had at least one of their surgery readiness assessment appointments with a healthcare provider they already knew.

Primary care providers (general practitioners, family doctors, and nurse practitioners) represented the largest proportion of assessors (35%). The 'other' category included counsellors or mental health workers, other

medical specialists (such as endocrinologists), or designated assessors whose credentials were not specified. Outside of ON, sexologists were also mentioned as part of this "Other" category and represented 1% of the assessors.



HOW PEOPLE FEEL ABOUT ASSESSMENTS

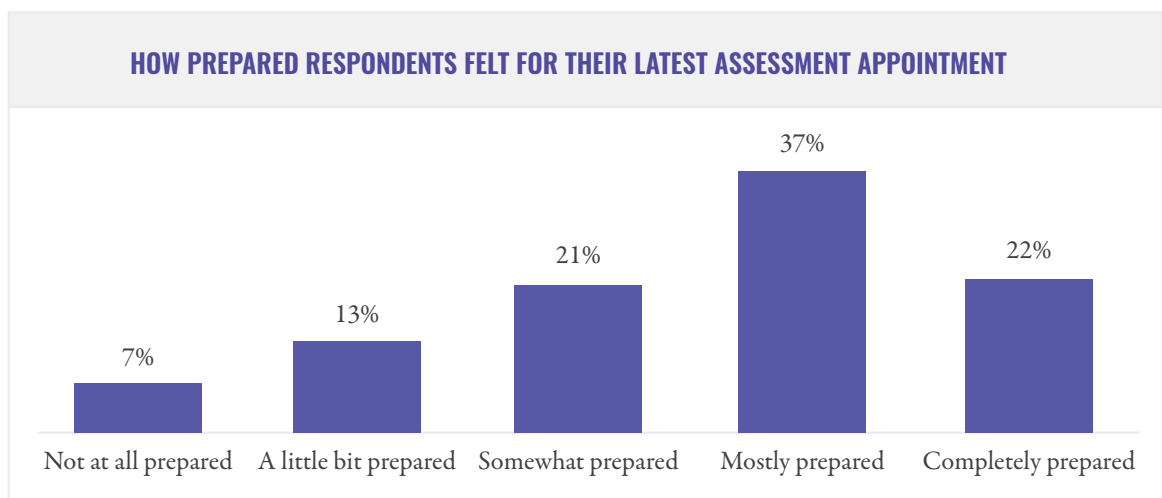
We asked people to rate their experience of their appointment for their surgery readiness assessment in terms of safety, preparedness, stress, and helpfulness.

Overall, assessors were successful at creating a space that was safe enough to talk about the person's plans for surgery: less than 19% of people disagreed or strongly disagreed with that statement.

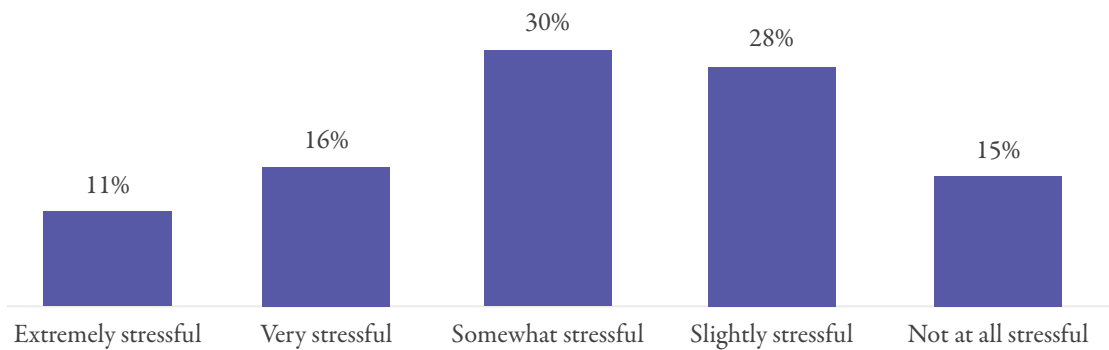


All assessments were the same questions asked over again by different people. Seems pretty redundant to me.

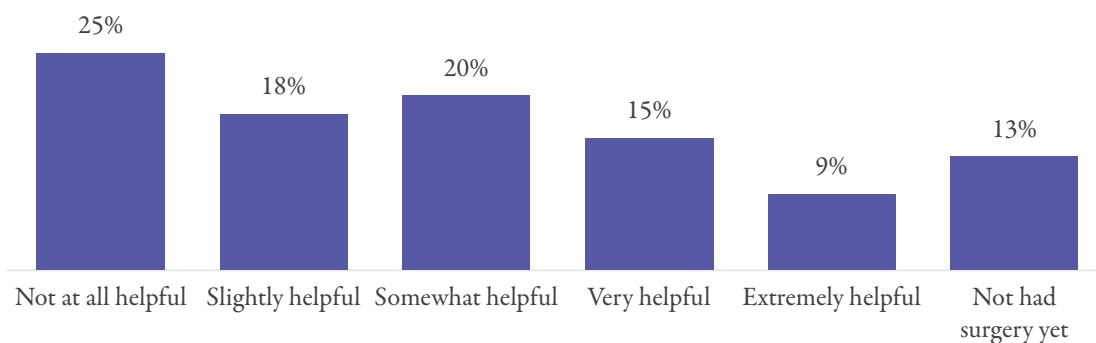
-35, FEMALE



HOW STRESSFUL RESPONDENTS FOUND THEIR LATEST ASSESSMENT APPOINTMENT



HOW HELPFUL RESPONDENTS FOUND THE SURGERY READINESS ASSESSMENT TO PREPARE FOR SURGERY



In ON, a quarter of respondents (25%) found the surgery readiness assessment not at all helpful, while only 9% of respondents found it extremely helpful. The table above shows that people had mixed experiences in terms of how helpful they found the process.

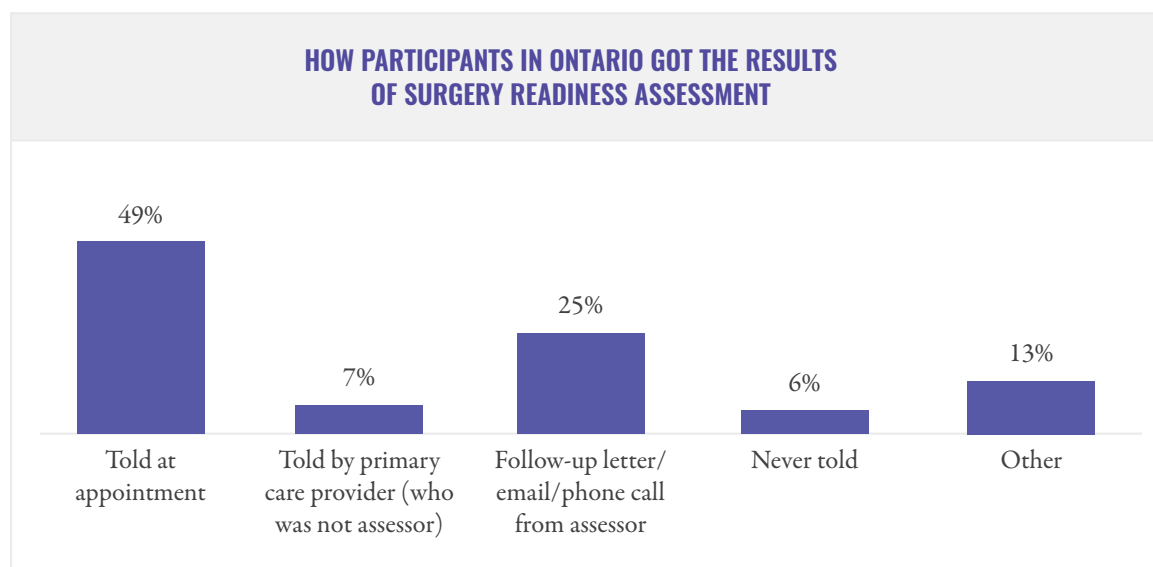
As noted earlier, there is wide variation in practice standards for assessments; this lack of consistency may in part explain the widely different experiences that people reported in the survey in terms of safety, helpfulness, stress and preparedness.

RESULT OF ASSESSMENT AND APPROVAL FOR SURGERY

We asked people to tell us how they got the results of their surgery readiness assessment. In ON, almost half people (49%) indicated that the assessor had told them during their appointment.

“ In general, I have found most practitioners concerns were to try to fit me in their charts of what trans experience should be rather than listen to my actual experience.

-42, MALE

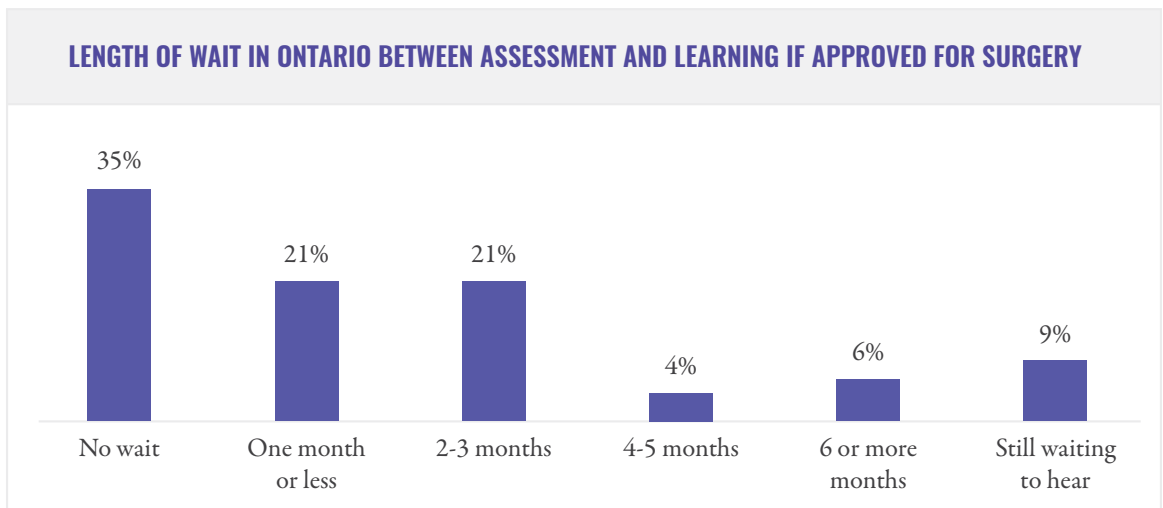


People who selected the ‘Other’ option indicated in comments that they had to follow-up themselves with their doctor or assessor to find out if they had been approved. Others also noted that they figured out that they were approved when they were contacted directly by the surgeon.

We also asked people how long they waited to learn whether or not they were approved for surgery. Just over a third of respondents in ON (35%) reported hearing they were approved right away at the appointment, with an additional 21% learning within one month's time.

A number of people indicated that their assessor told them the result of the assessment during their appointment but also indicated that they waited to find out if they were approved for surgery. This difference may be explained by the distinction that some respondents may have differentiated between the moment they were told

informally by their assessor that they would be recommended for surgery and the moment that they received official confirmation that they were approved for surgery, for example once their primary care provider received a letter from the assessor's office, or once the surgical center called them to confirm.



DETAILED FEEDBACK ON ASSESSMENT

Throughout the survey, we asked participants for feedback regarding their experience with surgery readiness assessments. We asked them what was surprising/unexpected about the assessment, what they wish they had known before their appointment, and what were positive aspects of the assessment. In line with the rest of the survey data, we found great variation among people's answers, suggesting that there is little consistency in how assessments are conducted and how they are experienced.

“ The assessment process itself was adversarial and amounted to a test of my knowledge about surgeries. It was a gate-keeping process; the assessors were not there to help me understand the surgeries the surgeries but rather to find reasons for declaring me not ready.

-41, PANGENDER

POSITIVE EXPERIENCES OF THE ASSESSMENT

Some people reported having a good experience. This subset of respondents often communicated that they did not experience the assessment as a stressful process. A few key elements appeared to contribute to these positive experiences:

“ [During my assessment procedure] I was referred to a psychologist who was very helpful... She was not limited by traditional narratives of trans experience (which I do not easily fit) and was able to see me as an individual and address my unique experience in a way that was supportive and validating.

-42, MALE

- **Knowledgeable assessors:** People appreciated when their assessor(s) could provide clear and honest answers to any remaining questions that they had. People especially appreciated being able to obtain clear, detailed information about the surgery (risks, different procedures, outcomes, etc.) and the recovery process.

“ I got to know what would happen during and after surgery in terms of readiness and aftercare. I felt informed on some of the after effects and what my chest might look like.

-28, TRANSMAN

- **Affirming environment:** Many people emphasized the importance of a supportive environment where the assessor was welcoming, respectful, and warm, listened carefully, and made it clear that they were an ally who was there to facilitate the process rather than someone there to evaluate whether they needed surgery.
- **Previous relationship with the assessor(s):** People often had positive experiences with the assessment process when they already knew their assessor (for example, their assessor may have been their counsellor) and had a positive, trusting relationship with that provider.
- **Supportive of non-binary identities:** For non-binary respondents, it was important to have an assessor who was explicitly inclusive of their identities.

While a number of people appreciated the opportunity that the assessment gave them to reflect and obtain information, for many people, the most positive aspect of the assessment process was simply having completed it, because it meant being one step closer to surgery.

CONCERNS ABOUT THE ASSESSMENT PROCESS

Many people also reported frustrations about the process of going through the surgery readiness assessment. Five major concerns were mentioned:

- **Being uncertain about content and objective of the appointment:** Many people commented on the lack of information that they had going into their appointment(s). Participants particularly mentioned wishing that they had known about who is qualified to be an assessor, what they were going to be asked, and how long they would have to wait afterwards before surgery.
- **Perceiving the assessment as a gate-keeping mechanism:** Many people were worried that they could be prevented from accessing surgery if they did not provide the ‘right’ answers to the assessor.

“ In the many appointments I have had with various providers I have found the assessment process largely a “gatekeeper” role that has offered very little of value to me, particularly for the time constraints and emotional and financial costs (more time off work than direct payments).

-42, MALE

As a result, they felt that they could not open up during the assessment. Part of the concerns expressed about gate-keeping came from a perception that the surgery readiness assessment exists more for the benefit of the health care system than for the benefit of the respondents.

- **Lack of an informed consent model:** A number of respondents suggested using an informed consent model that would be more supportive of peoples' identities and respectful of their knowledge about their own bodies and experiences.
- **More timely process and increase number of assessors:** Many people expressed frustration with the long wait times to get the assessment and expressed that traveling to get the assessment was a hardship. They suggested more trainings for medical professionals to be assessors across the province.
- **Not obtaining enough information:** Survey respondents also reported often leaving the assessment with insufficient information about the process. This often left them feeling disempowered to make informed decisions about their health. People mentioned not having enough information in terms of eligibility criteria for surgery (such as BMI cut-offs), different surgeons and techniques available, and surgical results (including potential complications).

“ It is not only the travel expenses you have to worry about, but lost wages from the time you have to take off work.

-27, MALE

Gender-affirming surgery

GENDER-AFFIRMING SURGERY: KEY FINDINGS

- Across all surgeries, most people (60%) had their surgery paid at least partially for through a government health plan
- Two-thirds of respondents in ON (67%) reported that they were able to choose the surgeon they wanted for their surgery, while less than half (41%) of respondents from other provinces reported being able to do the same
- Over half (57%) of respondents had to travel 2 or more hours to their surgery appointments
- Experiences with surgeons and their staff varied; however, a large majority of people (84%) agreed or strongly agreed that the surgeon created a space that was safe enough to ask questions and talk about the surgery process, and an even larger portion of people (89%) agreed with the same statement concerning the clinic staff
- A sizeable number of respondents (13%) reported not having all their questions by the surgeon or surgery centre staff before their surgery
- Complication rates more than doubled when respondents had to travel more than two hours to their surgery appointments
- People scored on average 7 out of 10 on a support scale for post-surgery support, meaning that they had quite a bit of social supports available to them after they came home from surgery

In the surgery section, we report on respondents who live in Ontario. For this surgery section when we mention “respondents in ON” it refers to this group, even though some respondents got surgeries in other provinces or out of country. It is necessary to report on experiences of surgeries performed elsewhere as lower surgeries (vaginoplasty, phalloplasty, etc.) are not performed in province. These surgeries are still covered by OHIP.

ACCESS TO SURGERY

FUNDING FOR SURGERY

We asked people how their surgery was paid for. Across all surgeries, a majority people (60%) had their surgery paid for at least partially through a government health plan.

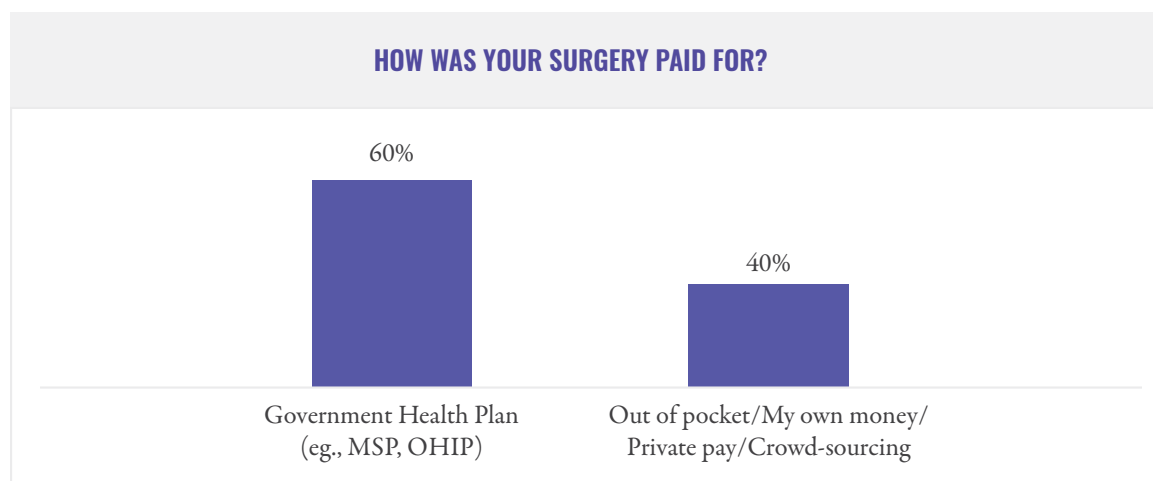
The vast majority of people (82%) only had one source of funding for their surgery.

“ Folks who go through the hospital are not always as satisfied with the quality of the surgery, as people who go through private clinics. I’m very privileged in my employment, income & family/friend/community support, but without this it is very difficult to go through this process...”

-47, FEMALE

Even when their surgery was covered, most people still had to cover a number of costs out of pocket, including travel costs, accommodation, aftercare facilities, and aftercare supplies. Although on average, people had larger out-of-pocket costs when they had paid for surgery with their own money, these costs were still high even when the surgery had been covered by a government health insurance plan.

Out-of-pocket costs for things other than surgery and aftercare facilities varied greatly across respondents and across surgeries. Respondents reported spending money on travel and accommodation for themselves and friends/family who traveled to be with them for their surgery appointments. Other out of pocket costs associated with aftercare included items such as: bandages, soaps, over the counter pain medication, moisturizers, pads, etc. Some reported spending hundreds of dollars on such expenses, while some reported spending over \$10,000.



Note: People could select more than one answer.

“ I [truly] wish that breast augmentation, facial feminization surgery and voice feminization surgery was covered.

-47, FEMALE

INELIGIBILITY FOR SURGERY

When people indicated that they were ineligible for a surgery that they wanted, we invited them to explain why they were ineligible. In addition to people who were ineligible due to medical conditions that made general anesthesia risky for them, two primary concerns were raised: surgical restrictions based on breast augmentation and BMI (Body Mass Index).

BREAST AUGMENTATION CRITERIA

The current criteria for coverage by OHIP for augmentation mammoplasty (breast augmentation) for the purpose of gender-affirming surgery is limited to individuals with no breast enlargement following 12 continuous months of hormone therapy .

There was a theme among participants that these criteria are inadequate for trans women because even though the breast tissue growth that they had experienced was deemed ‘sufficient’ by OHIP standards, it was not always enough for them to feel good about their body and/or look feminine.

BMI CUT-OFF

People reported being ineligible for the surgery they needed or wanted due to being over a particular body mass index (BMI).

“ Due to my current weight and my very large torso size I was deemed ineligible for breast enlargement coverage despite being unable to even fit an A-cup bra.

-47, FEMALE

Although researchers and clinicians have questioned its appropriateness as a measure of weight or health, BMI is still commonly used to categorize people as underweight, normal weight, overweight, or obese. Many surgeons have eligibility criteria that includes a BMI of 35 and under. Based on this BMI cut-off, they will not operate on a person over a certain BMI; reasons given include restrictions imposed on them by the facility or concerns around clinical safety and patient outcomes.

Responses from beyond ON found that BMI-related criteria changes from surgeon to surgeon, which created additional difficulties for people as they navigated the process and tried to figure out if they had other options for accessing gender-affirming surgery. People also expressed concerns over the impact on both their mental and physical health of having to lose weight in order to access surgery as this is difficult or unattainable for many people.

WAITING FOR SURGERY

BEING REFERRED FOR SURGERY AND CHOOSING A SURGEON

The vast majority of respondents from ON (83%) did not have any problem getting a referral to a surgeon for gender-affirming surgery.

A majority of respondents in ON (67%) reported that they were able to choose the surgeon they wanted for their surgery. This contrasts to the less than half (41%) of the respondents from other provinces who reported being able to choose their surgeon.

We compared people whose sole source of funding was a government health plan versus people whose sole source of funding was private pay. Most people who paid for surgery entirely out of pocket were able to choose the surgeon they wanted (94%) compared to about half of those who were funded entirely by a government health plan (47%). However, among respondents from other provinces who were funded by government plans, only about a quarter (27%) were able to choose their own surgeon.

WAIT TIMES

Among respondents in ON, the wait time between approval and surgery date was 15 months or less for all of the surgeries, with an average wait time of about 7 months. In comparison, among respondents from other provinces wait times ranged from 5 to 16 months, and the average wait time across all surgeries was over 11 months.

There may be other factors aside from health care system capacity that contributes to the length of time waiting, but the comments given by respondents provided no examples of such factors.

Additionally, at the time they took the survey, people who had secured a surgery date reported an average waiting time of 13 months between assessment and surgery. However, wait times varied greatly, so the averages do not necessarily reflect the majority of experiences with wait times. Half of participants reported a wait time of 9 months or less between assessment and scheduled date of their surgery.

It is worth noting that many people were still waiting to secure a surgery date at the time of taking the survey. These people who had not received a surgery date reported waiting an average of 8 months since their assessment at the time they started the survey. Also, half of such people reported waiting 5 months or less between assessment and when they started the survey.

WAIT TIMES BY SURGERY IN ONTARIO VS REST OF CANADA		
	ONTARIO	REST OF CANADA
Vaginoplasty	6 months	8 months
Orchiectomy	4 months*	10 months
Labiaplasty	6 months*	10 months
Breast augmentation	11 months^	7 months
Facial feminization	3 months	4 months
Tracheal shave	3 months	5 months
Liposuction	1 month	N/A
Phalloplasty	13 months^	9 months
Metoidioplasty	15 months^	12 months
Clitoral release	10 months	9 months
Hysterectomy	7 months*	11 months
Chest surgery	7 months*	16 months

* Wait time in ON is at least 3 months **shorter** than in rest of Canada

^ Wait time in ON is at least 3 months **longer** than in rest of Canada

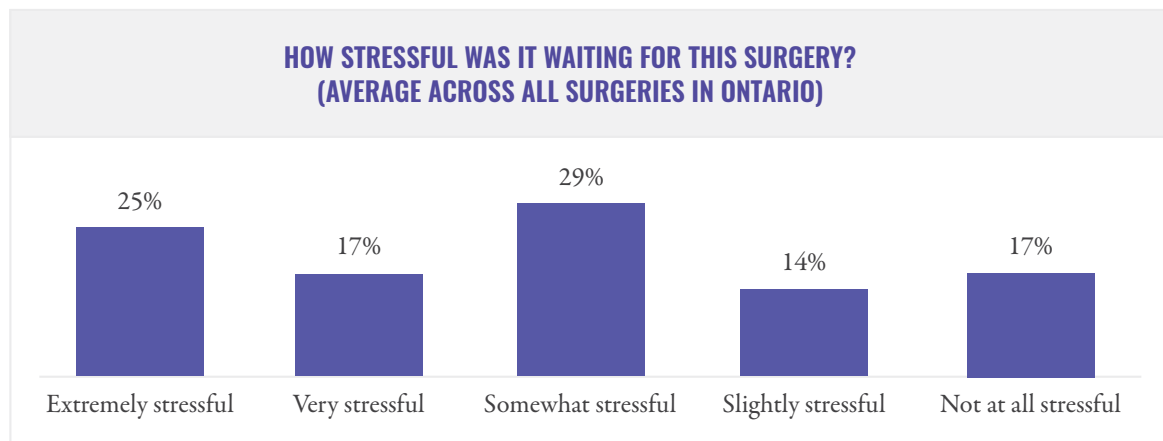
MANAGING STRESS WHILE WAITING

We asked people about their experience during the time that they were waiting for surgery. Respondents who had already had surgery varied greatly in how stressful they found the waiting process. As the graphic below shows, 25% found the experience extremely stressful while 17% found the experience not at all stressful. These numbers also varied greatly depending on what surgery people were waiting for.

In contrast, people who were currently waiting for their surgery (and may or may not have a scheduled surgery date) reported slightly higher stress levels: 31% found this waiting period extremely stressful while only 6% found it not at all stressful. This difference may be explained by the fact that, for those who have already had surgery, the stress of waiting has been dampened by time and distance from that experience, while this stress is very present for those who are currently waiting.

“ [I] had the internet and read a lot of information there, as well as some personal accounts on tumblr.

-20, DEMIBOY



We asked people what resources they had – or wish they had – that are helpful while waiting for surgery. People primarily mentioned:

- Support from peers, friends, or the larger trans community, especially the ability to talk to people who have been through the same surgery.
- Online resources such as blogs, websites with information, YouTube channels, Tumblr pages, etc. While some people knew where/how to access such content, some did not know how to access it or even that it existed, highlighting how online literacies can affect the surgery experience.
- Support from health care providers, including the ability to contact with the surgical centre to answer any questions that arise. Some respondents mentioned feeling abandoned between the assessment and surgery, and that there could be more supports during the wait time to prevent disillusionment with the process.

All these resources point to the need that people expressed for having information as they wait for their surgery. People expressed distress and frustration when they felt like they had little access to information – for example because they could not talk to someone who has had the same surgery, with the same surgeon – and it contributed to making them feel less prepared for the next step.

“ [M]ore social support. Definitely more medical support. Once the assessment is processed for funding it feels like a hard cut of no longer being a problem to the government unless a complication arises that requires more funding. -31, TRANS

PRE-OPERATIVE EXPERIENCE

DISTANCE FROM SURGERY CENTRE

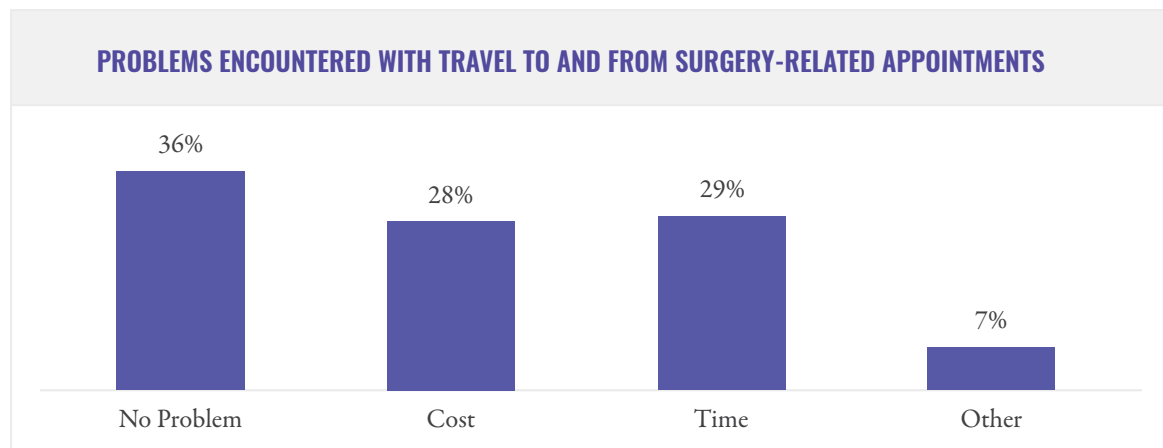
Among respondents in ON, over half (57%) had to travel 2 or more hours to their surgery appointments. This includes many respondents who traveled to Montreal and other locations outside of ON for surgery.

We also asked respondents if they had encountered any problems with travel to and from appointments related to their surgery. Over half (64%) of people reported encountering problems. However, people getting hysterectomies were less likely to encounter problems. As the graph below shows, cost and time were the most commonly reported problems for those respondents who faces challenges.

“ Open up the procedures to surgeons across Canada to be able to be performed so folks don't have to travel to Montreal from all over Canada which is costly and sometimes a huge barrier to having the [surgeries] needed.

-50, TRANSMALE

In the 'Other' section, people commented primarily on difficulties caused by travelling shortly after a major surgery, such as pain, stress, or extreme discomfort. These difficulties can be amplified by disabilities or typical travel inconveniences such as lack of transportation to the surgical centre and the distance between the centre and the where respondents live.



Note: People could select more than one answer.

INFORMATION AND CONSENT

The vast majority of respondents in ON (92%) indicated that they had received all the information they needed to understand what their surgery would involve.

Almost all respondents (86%) indicated that the surgeon met with them before the surgery to answer their questions.

Similarly, the majority of people (87%) indicated that all of their questions about their surgery were answered by the surgeon and their team. Nevertheless, this still leaves a significant minority (13%) who felt that all their questions were not answered.

“ I was rushed and forgotten about during aftercare. [A]lso I didn’t meet the surgeon until 5 minutes before they put me under.

-28, TRANSMAN

Nearly all respondents (93%) indicated that they had signed a consent form prior to surgery. 6% were not sure if they had signed one. The vast majority of people (94%) reported having enough time to review the consent form before signing.

“ The doctor and team at the clinic were very friendly, understanding and professional. I was home the same day of the surgery.

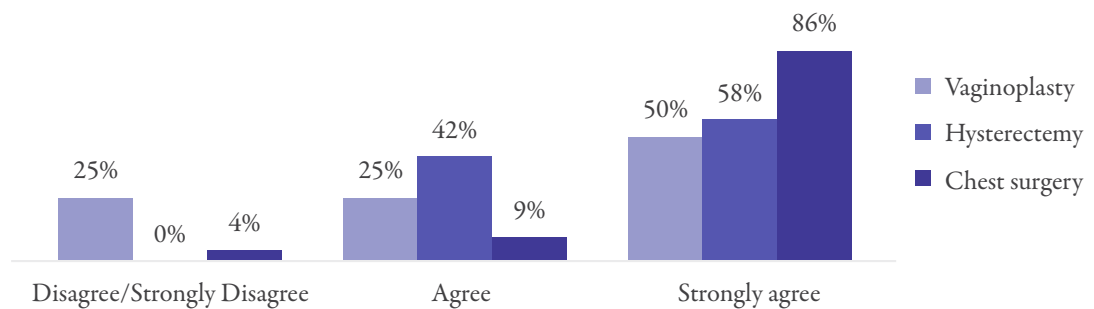
-38, MALE

INTERPERSONAL EXPERIENCES WITH SURGEON AND CLINIC STAFF

We asked respondents to tell us how much they agreed with the following statement: “the surgeon created a space that was safe enough to ask questions and talk about the surgery process.” A large majority of people (84%) said that they agreed or strongly agreed with this statement.

We have included a summary graphic for the three surgeries where we had the most respondents: vaginoplasty, hysterectomy, and chest surgery.

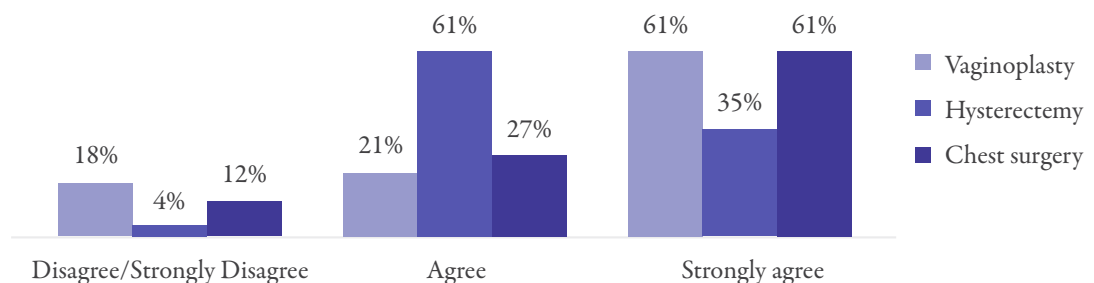
SURGEON CREATED SAFE SPACE TO TALK ABOUT THE SURGERY PROCESS



We also asked respondents how much they agreed with the following statement: “the clinic staff created a space that was safe enough to ask questions and talk about the surgery process.” Roughly the same portion of people (89%) said that they agreed or strongly agreed with this statement.

We have included a summary graphic for the three surgeries where we had the most respondents: vaginoplasty, hysterectomy and chest surgery.

CLINIC STAFF CREATED SAFE SPACE TO TALK ABOUT THE SURGERY PROCESS



“ My surgeons in both cases were amazing, relaxed confident individuals who were not transphobic at all and made me feel very comfortable in their hands.

-27, AGENDER

In comments, people's experiences varied greatly. While some reported excellent interactions with staff, including some surgeons and most nursing staff, many reported feeling rushed through interactions with surgeons and were surprised by how little time they spent meeting, and interacting with, their surgeon. Many people who spent a few nights in recovery facilities were appreciative of the staff there. However, there were still a number of people who experienced instances of misgendering and other upsetting interactions with staff.

COMPLICATIONS

We asked people about their experiences of complications during and after surgery. There are some complications that are commonly associated with any kind of surgery, but there is no systematic data that would allow us to compare typical complication rates for gender-affirming surgery with what the respondents reported. It is also difficult to make comparisons without knowing precisely what procedures people underwent.

“ While [I] was on the operating table, the surgeon's staff were misgendering me. This not only made me extremely uncomfortable but it made me unable to trust the people who were doing my gender affirming surgery.

-34, TRANS MAN

For some surgeries (such as phalloplasty), it is important to remember that only a few respondents provided data. This makes it difficult to be confident our findings represent an accurate estimate of complications and highlights the need for further research.

CONTACT IN CASE OF COMPLICATION

Almost all respondents (95%) indicated that they were given contact information in case of questions or complications. Among those who received this information, just over half (53%) used it. The people most likely to use that contact information were people who had the types of surgeries that were most likely to experience complications, namely vaginoplasty (77%), metoidoplasty (100%), and phalloplasty (100%).

DURING SURGERY OR BEFORE DISCHARGE

We asked people about their experiences with complications during surgery, before they were discharged from the surgery centre, and after they were discharged from the surgery centre. The numbers reported below are based on people's personal understandings of complications; this may lead to over- or under-reporting depending on the circumstances.

Most respondents (85%) did not have any complications during surgery or before they were discharged, meaning that the reported complication rate was 15%.

We classified the severity of complications using the Dindo-Clavien classification. Complications reported by respondents ranged from Type 1, which requires limited medication and health interventions, to Type 2, which requires medication, and Type 3 which requires further surgery or other significant treatments.

Among the people who provided details about their complications during surgery or before discharge, 87% reported experiencing one type of complication, and 11% reported experiencing two types of complications.

A vast majority (82%) of the reported complications were Type 1 complications, while Type 2 represented 7% of reported complications, and Type 3 represented 4% of reported complications. Only 7% reported complications that were deemed 'non-surgical' (such as stitches not dissolving).

AFTER DISCHARGE

Complications after being discharged from the surgery centre were slightly more common. 29% of respondents in ON indicated that they experienced complications after they were discharged.

Well over half (62%) of the reported complications were Type 1 complications, while Type 2 represented 23% of reported complications, and Type 3 represented 13% of reported complications.

People also reported having difficulties with follow-ups due to distance from their surgeon and a lack of available trans competent health care providers in their area.

“ I had extensive complications, post surgery and my doctor in the clinic completely ignored me even when I was calling them from one of two different emergency room visits...

-42, FTM

FACTORS IN COMPLICATIONS

We looked at how distance from home might affect complication rates after someone has been discharged. Complication rates were 20% when the person had to travel less than 2 hours to their surgery appointments, and 46% when the person had to travel more than 2 hours to their surgery appointments.

We also looked at how sources of funding might impact complication rates. When surgeries were funded only through a government health plan, 17% reported complications before discharge and over twice as many (37%) reported complications after discharge. When surgeries were funded solely out of pocket, only 5% reported complications before discharge and 13% reported complications after discharge.

POST-OPERATIVE EXPERIENCES

RECOVERY

We asked people if their surgeon had talked to them after their surgery. The majority of them (71%) said yes.

A majority people (89%) also indicated that they were given post-op care instructions in writing, but only 71% of respondents felt that the post-op care instructions were clearly explained and that all questions were answered before they were discharged.

Although we did not ask specific questions about post-operative recovery centres, many people who had spent time in these centres after surgery before heading home shared positive stories about places where they could recover surrounded by both medical staff and other trans people who had just gone through major surgeries as well.

“ [The] surgeons were fantastic, very skilled, caring and respectful... I knew what to do to prepare and how to care for myself afterwards so that I would get the best outcome possible.

-41, PANGENDER

SOCIAL SUPPORT

We used an established social support scale to measure how much support people had while they were recovering from surgery. We specifically asked people if they had someone who could take them to the doctor, help change their bandages, help them with daily chores, listen to them, and get their mind off things.

On average, people scored a 7 out of 10 on that support scale, meaning that they had quite a bit of support available to them.

REVISIONS

About two thirds of respondents (69%) indicated that they were told about the possibility of surgery revisions.

The vast majority of respondents (86%) had not had any surgery revisions. The only surgery that had a much higher rate of revisions was phalloplasty. About a quarter of respondents (26%) indicated that they would like to have (further) surgery revisions, with another 37% indicating that they were not sure if they wanted revisions.

PERCENTAGE OF PEOPLE WHO HAD SURGERY REVISIONS	
Vaginoplasty	7%
Orchiectomy	17%
Facial feminization*	20%
Tracheal shave*	33%
Liposuction*	0%
Phalloplasty	57%
Metoidoplasty	50%
Chest surgery	7%

* Not publicly funded by OHIP.

Conclusion

When asked to reflect on positive aspects of the surgery process, people primarily emphasized their satisfaction with the result of the surgery and how much it meant to them to have been able to access surgery: they felt happier, more comfortable in their body, and able to live their lives more fully.

“**My chest surgery completely changed my life and my experience was wonderful. I couldn’t imagine not having been able to have the chest surgery.**

-26, NON-BINARY TRANS MALE

When they had good experiences with the clinical and surgical staff along the way, they praised them generously; and it was clear that having the experience of knowledgeable, supportive medical team could make all the difference in the person’s experience of navigating their access to gender-affirming surgery, even when other elements (such as lengthy wait times) were difficult.

However, some important disparities exist when people seek out gender-affirming surgery.

“**In the past month since surgery, I’ve been healing well, and the results are exactly like I requested from the surgeon. The experience was fairly positive overall.**

-21, MALE

We pointed out wide differences in terms of wait times, their ability to choose one’s surgeon, whether or not people felt properly informed before they had surgery, their interactions with surgeons and their staff, whether they experienced complications or not, and how supported they were during their recovery. Some of these disparities are influenced by where people live, how far they have to travel to their surgery, whether they are able to pay out of pocket for certain or all expenses, and what surgeries they want to have.

These negative experiences rarely represented the majority of our sample, but they were frequent enough that they point to recurring issues and gaps in the current model of access to gender-affirming surgery.

“**[The clinic] and the aftercare centre made my experience hellish. They failed to provide a week of pain medication, failed to contact my doctor about this, failed to tell me about this until 30 minutes before I left, and then repeatedly failed to respond to questions I had after returning home. The aftercare centre in particular turned what was meant to be a painful but joyous experience into Hell.**

-26, FEMALE

Recommendations

We asked people what recommendations they had both for the surgery readiness assessment and for gender-affirming surgery in general. We have summarized these recommendations here, along with our own recommendations based on the data presented in this report.

SURGERY READINESS ASSESSMENTS

- **Trans competency training for assessors:** Respondents mentioned the assessors sometimes held limited, narrow understandings about the experiences of trans people's lives that did not always reflect the people trying to access surgery. These responses were common among non-binary people and people who may have socially transitioned many years before having surgery. They expressed feeling like the assessments were designed to fit a single "type" of trans person rather than allow for a breadth and diversity of trans experiences.
- **Transparent, streamlined assessment process, with reduced wait times:** People should have a clear sense of next steps and how long each step might take (this includes a clear idea of wait times between the referral and the assessment, and between the assessment and surgery). The priority should be on significantly reducing wait times by training more assessors in communities throughout the province, as well as on creating a streamlined process from referral to surgery.

“ [M]any improvements have been made to the system but there is still a long way to go especially when it comes to people with multiple health care need[s] like transpeople with Autism, Borderline personality, or other disabilities and non-binary people getting shafted with assessments often taking 2–4 times longer than the average person.

-38, ANYTHING OTHER THEN CIS-FEMALE

- **More consistency in the assessment process:** Our research suggests the assessment process is not helpful for many people. There are discrepancies in terms of what information people are able to obtain on the assessment process, and who can perform assessments. People also do not obtain enough consistent, helpful information during the assessment. When people did find their assessment(s) helpful, it was because they were able to obtain information on next steps, on different surgical procedures and outcomes, and on the healing process. There needs to be more systematic training of assessors in order to ensure more consistency across practitioners regarding assessment practices – what should happen, and what should not happen, in an assessment.

“ Informed consent, or at the very least fewer restrictions with respect to RLE, would likely help a lot of trans people get the care they need faster.

-21, MALE

- **Informed consent:** The assessment process was useful when it helped people plan for surgery and aftercare and gave them a space to explore fears, questions, and concerns without feeling like this might jeopardize their chance to access surgery. Emphasizing a patient-centered, informed consent model would ensure that people have all the information they need to make the best decision for themselves.
- **Cost coverage:** If assessments remain mandatory, their costs should be fully covered by government health plans to avoid disparities between those who are able to pay out of pocket for services, and those who cannot.

GENDER-AFFIRMING SURGERY

- **Greater number of trans-competent local primary care providers:** Having trained and well-informed health care providers that are accessible locally would help people navigate the process of getting gender-affirming surgery and would help with aftercare for surgeries performed out of province/out of country.
- **Transparent, streamlined path to surgery, with reduced wait times:** As with assessments, people need to have easy access to a clear outline of the different pathways to surgery. Clearly understanding next steps and expected wait times would help people better plan and manage their stress. Additionally, because waiting is often a time of high stress, wait times should be reduced as much as possible by increasing the numbers of surgeons available to perform surgeries.

“ I think it would have helped to have a more accurate estimate of the total length of time involved. In the end it proved rather daunting to realize that end-to-end, the process between referral and the surgery itself would be measured in years. I suppose I should have realized...

-63, FEMALE

- **Clearer pathway to surgery for people with a high BMI:** Given that gender-affirming surgery is medically necessary for many people, there should be work done to improve the experience for patients with higher BMIs so that they have a clear sense of their options for care. Ways to remove barriers to surgery due to BMI should be explored so that those who are able to safely access surgery can do so.
- **Increased choice of surgical options:** People's lack of ability to choose their surgeon when their surgery is funded through a government health plan is a concern. People need to have access to more trained surgeons locally for those surgeries that can currently only be performed out of province or out of country. Finding ways to have care be closer to where people live would help address some of the concerns and issues that arose from having to travel large distances (such as higher complications rates, which may be linked to difficulties with follow-up and reduced support). This would likely reduce wait times as well.
- **Coverage for travel and aftercare costs:** This will reduce inequities between those who can afford to pay for care out of pocket, and those who cannot. This is especially true when people have surgeries performed outside of Ontario. Coverage of travel costs for a companion would

also ensure that patients have proper care during the surgery and immediately after during recovery, including someone to advocate for them.



... we really need more centres to be able to perform these procedures as the waiting lists are far too long and the process is far too stressful. I am fortunate in having secure housing and employment and I found it too stressful so I've no idea how less fortunate people cope with this.

-61, FEMALE

- **Broader access to surgeries that facilitate participation in society:** Some procedures that are still considered primarily cosmetic (such as tracheal shave, electrolysis, facial feminization, etc.) are sometimes key for people to feel like they can more happily, confidently, and safely navigate everyday life. These surgeries should also be covered to increase access for those who need them. This includes changing existing policies for covered surgeries, for instance breast augmentation, that respondents mentioned specifically does not take into account the experiences of trans people.

