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Service Gaps in Perinatal Care for Transgender and Non-Conforming Patients: A 16-Clinic Study in New York City

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ABSTRACT

The purpose of this study was to identify gaps in services, staff training, documentation, and inclusive environments in perinatal care for transgender and gender nonconforming (TGNC) people in a sample of clinical facilities in New York City (NYC). Data on facility demographics, reproductive services, training, policies, and the physical environment relevant to transgender pregnancy care were collected through a cross-sectional survey and examined using a mixed-methods approach. Sixty percent of facilities offered gender-affirming reproductive health services, 40% provided structured inclusive care training, and 63% integrated pronouns into electronic health records. However, few offered TGNC-specific perinatal mental health support. NYC facilities demonstrate partial progress toward gender-affirming perinatal care but remain deficient in standardized fertility counseling, affirming physical spaces, and comprehensive TGNC training.

Keywords: gender-affirming care, health care disparities, perinatal care, reproductive health, transgender health

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INTRODUCTION

At the beginning of its second term, the Trump administration made a concerted effort to erase transgender and gender nonconforming (TGNC) identities, as seen in the enforcement of regressive executive orders that recognized only two sexes and restricted federal funding related to gender-affirming care. Such acts have, in turn, found expression in increasing attacks against nonconforming identities (Coelho et al., 2025). These legal barriers have trickled down to state-level entities, leaving significant access and equity gaps in care for transgender and nonconforming patients, with structural effects becoming apparent. Following the Department of Health and Human Services' directive barring hospitals from performing gender-affirming pharmaceutical and surgical procedures on patients under age 18, related facilities across the country are facing widespread closures. Within New York, two major hospital systems have ceased providing such care to youth (Lewis & Heyward, 2026). Such measures deprive TGNC individuals of access to primary care and specialized mental health services, in addition to sexual and reproductive care (Coelho et al., 2025). Beyond barriers to access, mistreatment, misgendering, and care denial, these new policies strip TGNC individuals of protections against discrimination and may cause delays or neglect of health care as a self-protective measure (Coelho et al., 2025). This is cause for concern, especially regarding reproductive health care, as gender transition treatments, including hormone therapy and surgery, can affect fertility in the long term.

Reproductive health care remains rooted in a cisnormative framework, often neglecting TGNC needs for pregnancy care, contraception, and other services. This is exacerbated by provider bias and a lack of clear legal patient protection (Peitzman, 2024). Recent qualitative work shows how this framework operates in practice. In interviews with 14 queer, trans, and nonbinary midwifery clients in Ontario, Canada, Goldberg et al. (2026) found that routine pregnancy surveillance, such as questions about genetic makeup, conception, and paternity, rests on cisheteronormative assumptions that render queer and trans identities and family structures invisible. TGNC individuals may also be unaware of their reproductive options (Sterling & Garcia, 2020), which limits informed decision-making and leads to long-term consequences for reproduction. Fertility preservation and reproductive counseling remain inaccessible for many transgender individuals.

During transition, fertility preservation is rarely addressed owing to limited awareness among providers and insufficient patient counseling (Powers et al., 2024). One study found that only 12.7% of transgender patients were informed about fertility preservation (Campo et al., 2024). These findings emphasize the need for increased cultural competence, improved provider training, and standardized institutional policies to ensure equitable access to reproductive health care for transgender individuals.

The negative psychological impact of inadequate gender-affirming services remains a major challenge in transgender and nonbinary perinatal health care. Studies have shown that non-inclusive care leads to higher rates of postpartum depression, anxiety, and trauma (Pow, 2023). A systematic review found that TGNC individuals experience perinatal

depression and posttraumatic stress disorder (PTSD) at significantly higher rates than their cisgender peers (Greenfield & Darwin, 2020; Kirubarajan et al., 2022). D'Angelo et al. (2021) found that barriers to gender-affirming care led many TGNC individuals to delay or avoid health care visits, increasing the risk of adverse outcomes and psychological distress. Misgendering, stigma, and provider incompetence further discourage care seeking, and some perinatal health care settings feel alienating, exacerbating gender dysphoria and distress (Parker et al., 2022). The lack of TGNC-specific mental health services amplifies these challenges, as providers are often unprepared to meet the psychological needs of TGNC patients (Miller et al., 2024). Navigating a cisnormative system heightens anxiety and depression, especially during and after pregnancy (Miller et al., 2024), underscoring the urgent need for integrated gender-affirming mental health support in perinatal care. Without proactive steps to reduce this gap, disparities in perinatal care will continue to grow.

Although some facilities have adopted gender-inclusive practices, implementation varies widely, with little to no standardization. This can make TGNC individuals feel excluded and uncomfortable, exacerbating anxiety. Research shows that health care models informed by community needs and focused on social justice are critical to ensuring that TGNC individuals receive equitable perinatal care (Julian et al., 2020). Models grounded in social justice, such as those Julian et al. (2020) described in their work with Black birthing communities, offer a framework that can be adapted to improve perinatal care for TGNC individuals. Such models prioritize patient autonomy and cultural humility while addressing the systemic barriers that often hinder access to necessary care. By integrating trauma-informed care, anti-racist approaches, and patient-centered policies, hospitals and clinics can better meet the needs of TGNC individuals and promote reproductive justice in perinatal services (Julian et al., 2020).

Many hospitals and clinics lack standardized gender-affirming care, leading to inconsistencies in practices such as incorporating gender-inclusive language in intake forms, providing clear clinical guidelines, and offering patient education; these inconsistencies further limit TGNC individuals' access to reproductive care (Akerson et al., 2022). Additionally, provider bias and inadequate training often result in mistreatment of transgender patients (Parker et al., 2022). Provider competency is a critical factor in achieving reproductive justice, and clinically and culturally competent care for transgender and nonbinary individuals in perinatal settings is therefore crucial. Recent evidence from the United Kingdom illustrates the training gap. In a survey of obstetric anaesthetists, formal training in the care of transgender and gender-diverse patients was uncommon and few respondents reported departmental policies, although most believed that inclusive language improved care (Turner et al., 2026). Similarly, in interviews with 10 midwives in the National Health Service (NHS), Brown and Swartz (2026) found that participants were eager to learn but called for more education, institutional support, and national and institutional policy.

The National LGBTQIA+ Health Education Center offers training for health care professionals on best practices in related areas, including gender-affirming care for transgender and nonbinary patients. The World Professional Association for Transgender Health (WPATH) provides a certification program for transgender care, and the Mount Sinai Center for Transgender Medicine and Surgery offers comprehensive training on surgeries, hormone therapy, and mental health support. The American College of

Obstetricians and Gynecologists (ACOG) emphasizes inclusive, evidence-based care for TGNC individuals and promotes the use of gender-affirming language and comprehensive fertility counseling. Some obstetrics and gynecology (OB-GYN) residency programs are now incorporating training in transgender medicine; however, in a national survey of OB-GYN residents, only 49.4% reported that their program offered formal didactic education in transgender medicine, and only 14.5% had any surgical training experience with transgender patients, highlighting a significant need for expansion (Burgart et al., 2022).

The lack of inclusive spaces, such as gender-neutral restrooms, affirming imagery, and LGBTQ+ representation in promotional materials, further alienates TGNC individuals and deters them from seeking care (Parker et al., 2022). Experts recommend patient-centered models with shared decision-making and inclusive practices to address these gaps, including community-led birthing centers and midwifery models that provide culturally competent, gender-affirming care (Roosevelt et al., 2021). Adopting justice-focused strategies can further make perinatal care safer and more equitable. Inclusive communication matters beyond the clinic walls as well. A cross-sectional analysis of 178 U.S. hospital obstetrics web resources found that gender-inclusive elements were rare and that gender-exclusive language was common (Coward & Howell, 2026).

Visual representation in perinatal health care settings can have a significant impact on patient comfort and trust. Including diverse gender identities in marketing materials, in-clinic imagery, and educational resources has been shown to help normalize TGNC experiences in reproductive health care (Miller et al., 2024). Health care facilities with visible LGBTQ+ representation were also perceived as more inclusive and safer by transgender patients (Miller et al., 2024). Expanding and standardizing gender-affirming policies to include representation in all patient-facing materials is thus an important step toward an equitable health care environment.

Research indicates that inclusive language, provider training, and visual representation of diverse identities significantly improve patient experiences and health outcomes among TGNC individuals (Roosevelt et al., 2021). Consideration for such individuals must exist in all areas of health care, at both the systemic and the individual level, to ensure equitable reach, particularly at a time when care for TGNC individuals is under attack. Maternal–fetal medicine specialists have likewise argued that all people who can become pregnant and give birth should have access to inclusive, gender-affirming care (Brandt et al., 2026).

Given the barriers TGNC individuals face in reproductive and perinatal health care, implementing gender-affirming practices in these settings is imperative. This study therefore assesses the services available to TGNC individuals in New York City (NYC), an urban center in the northeastern United States, to identify gaps in care and recommend areas for improvement. Data from 16 health care facilities were collected and evaluated for their practices and services.

METHOD

Study Design

This study used a cross-sectional survey to evaluate perinatal care resources for trans-male and nonbinary individuals in NYC. This approach provided a snapshot of services, policies, and provider practices, highlighting care gaps and guiding future improvements for TGNC

populations. The design is particularly suited to identifying gaps in care and informing improvements in health care delivery.

Guiding Framework

The research was guided by ACOG recommendations and best practices in trans-male and nonbinary reproductive care. These guidelines emphasize inclusive care environments, gender-affirming language, staff training, and equitable access to perinatal services. Using these recommendations, the researchers aimed to evaluate adherence to current professional standards among NYC health care facilities and to identify areas needing improvement.

Study Population and Sampling Strategy

Health care facilities that provided perinatal care to trans-male and nonbinary pregnant individuals and were located within NYC were eligible for the study. To ensure diversity among facilities, a purposive sampling strategy was used to cover hospitals, OB-GYN clinics, and specialized reproductive health centers known to serve TGNC populations. A target sample of approximately 20 facilities was selected to provide a broad yet detailed representation of perinatal care practices across NYC.

Survey Instrument

A 48-item survey was developed using a framework based on the ACOG guidelines to ensure relevance and alignment with best practices in perinatal care for trans-male and nonbinary individuals. The survey was structured to collect both quantitative and qualitative data using a combination of Likert-scale, multiple-choice, and open-ended questions.

The survey covered six key domains of trans-inclusive perinatal care: (a) demographic information, (b) available services, (c) staff training and competency, (d) policies and procedures, (e) physical environment and accommodations, and (f) inclusive language and practices.

Data Collection Procedures

A multimodal recruitment strategy was used to maximize participation and to ensure that eligible facilities were aware of the study. Health care providers and administrative staff were contacted by telephone, in-person visits, and e-mail, through which they were introduced to the study and its objectives and invited to participate. The e-mail invitations included survey links hosted on the Qualtrics platform. Invitations were also extended through professional OB-GYN networks, LGBTQ+ health care alliances, and local health department registries to reach a broader set of qualified participants. Two follow-up reminders were sent over a 4-week data collection period to improve the response rate.

Ethical Considerations

The study was approved by the Institutional Review Board (IRB) of York College, City University of New York. Informed consent was obtained from all participants before the survey was administered, with the study's purpose, voluntary participation, and confidentiality measures clearly explained. Data were stored securely on password-protected servers accessible only to authorized research personnel. Results were reported in aggregate form to prevent identification of specific facilities.

Data Analysis

Both quantitative and qualitative methods were used to ensure a comprehensive assessment of the data. Descriptive statistics (frequencies, percentages, and means) summarized key facility characteristics, services, training initiatives, and policy adoption rates. Cross-tabulations were used to analyze categorical data.

RESULTS

Sixteen NYC health care facilities participated in the study, representing a diverse range of perinatal care providers, including hospitals, private OB-GYN clinics, community health centers, and specialized LGBTQ+ reproductive health service centers. Although individual responses remain confidential, the aggregated findings provide a comprehensive overview of trans-inclusive perinatal care in the region. All participating facilities reported providing perinatal care to trans-male and nonbinary pregnant people. Of the sample, 12.5% of facilities were publicly funded and 87.5% were private (see Table 1 for item-level responses by funding type).

Most facilities (94%) served White patients, followed by Black or African American patients (81%). Asian patients were also widely served (75%), while "Other" racial groups accounted for 69% of the populations served. However, fewer facilities provided services to American Indian, Alaska Native, Native Hawaiian, or Pacific Islander populations, each at 31%. These findings highlight potential disparities in perinatal health care access for underrepresented racial and ethnic groups.

Only 60% of facilities provided gender-affirming reproductive health services tailored to trans-male and nonbinary individuals. Only 38% of facilities (6 of 16) discussed fertility options with transgender and nonbinary patients, although about 69% could refer patients to a fertility specialist. Only 25% made patients aware of options such as cryopreservation of sperm and oocytes, and just 13% discussed fertility and parenting desires early in the transition process, before hormone therapy or gender-affirmation surgery. Gender-affirming termination of pregnancy was available on request in 38% of facilities. Hormone management was integrated with perinatal care in about 40% of facilities, indicating a need for improved coordination between endocrinologists and OB-GYN providers. While some facilities offered dedicated trans-affirming pregnancy support programs, others relied on general reproductive health services that may not fully meet the needs of transgender patients (Table 1).

Findings indicate major gaps in staff training for trans-inclusive perinatal care. While 69% of facilities reported that staff had received appropriate training to work with the trans-

male pregnant population and 81% for the nonbinary pregnant population, the frequency and comprehensiveness of these programs varied significantly. Only 40% of facilities had structured training sessions covering inclusive language, pronoun usage, and best practices in transgender reproductive health. Encouragingly, 94% of facilities trained intake staff to ask patients about their pronouns, demonstrating a shift toward inclusivity at the first point of contact. However, only 31% reported that front desk, nursing, and other patient-facing staff ask about preferred pronouns appropriately, and specialized gender-affirming care liaisons were available in fewer than 40% of surveyed facilities, indicating that many still lacked dedicated personnel to support trans and nonbinary patients.

While most facilities (over 70%) had nondiscrimination policies in place, only 6% displayed signs stating the nondiscrimination policy, and only 63% (10 of 16) systematically included gender markers and preferred pronouns in patient records. The lack of standardized documentation posed a significant barrier to affirming and consistent health care experiences.

Several facilities faced institutional limitations, with respondents citing a lack of funding and administrative support as key barriers to implementing gender-affirming modifications. Although 75% of facilities had a protocol for gender-inclusive terminology in patient interactions (e.g., "birthing parent" and "chest feeding"), only 31% used gender-inclusive language in promotional materials, and only 63% ensured documentation of preferred names, gender markers, and pronouns in electronic health records (EHRs). These gaps highlight the need for standardized policies to ensure inclusive documentation and reduce misgendering errors in clinical settings.

Most facilities (63%) referred trans-male and nonbinary patients to mental health professionals during the postpartum period, acknowledging the psychosocial challenges these individuals face. Additionally, 63% of facilities counseled patients on contraception options and reproductive life planning (and 69% included a conversation about reliable contraception in postpartum care), and 63% routinely screened for intimate partner violence, depression, substance use, cancer, and sexually transmitted diseases. However, only a small subset of facilities offered mental health services tailored specifically to transgender reproductive experiences, indicating an unmet need for specialized psychological support during pregnancy and postpartum care.

Table 1: Affirmative Item Responses by Facility Funding Type (Percent)

Facility Policy	Public (%)	Private (%)	Overall (%)
Do you have a protocol in place that helps alter verbiage for gender nontraditional mothers, for example, referring to mothers using the gender-neutral term "birthing parent" or using terms like "chest feeding" instead of "breastfeeding"?	50	79	75
Are your restrooms labeled using gender-neutral terms?	100	71	75
Are your changing rooms labeled using gender-neutral terms?	100	79	81

Facility Policy	Public (%)	Private (%)	Overall (%)
Are there images around the office showcasing birthing people of various genders?	0	7	6
Have the staff members received appropriate training to work with the trans-male pregnant population?	50	71	69
Have the staff members received appropriate training to work with the nonbinary pregnant population?	50	86	81
In the case that staff voice objections to treating the trans-male and nonbinary population, is your facility prepared to deal with these objections to provide care that ensures equality and inclusion for the trans-male and nonbinary population?	50	86	81
Are intake staff trained to ask patients for their pronouns during the initial screening process?	100	93	94
Do the promotional materials distributed by your facility include gender-inclusive imagery?	50	7	13
Do the promotional materials distributed by your facility include gender-inclusive language?	100	21	31
Do you allow patients to decide what they would like their anatomical reproductive organs to be referred to as?	0	64	56
Is it standard for birthing people to choose how they would like to be addressed?	50	36	38
Does your organization discuss fertility options with transgender and nonbinary patients?	0	43	38
Are you able to refer your patients to a fertility specialist for further advice and care?	0	76	69
Are your patients made aware of options such as cryopreservation of sperm and oocytes?	0	29	25
Does postpartum care include a conversation about reliable contraception?	0	78	69
When requested, are you able to offer gender-affirming termination of pregnancy?	0	43	38
Do the front desk staff, nursing staff, and others who interact with patients ask them about preferred pronouns appropriately?	0	36	31
Does the clinic/office space have images, signage, educational materials, and artwork that represent all individuals' genders?	0	7	6
Does the clinic/office have signs with the nondiscrimination policy?	0	7	6

Facility Policy	Public (%)	Private (%)	Overall (%)
Does the clinic/office have at least one restroom that is gender neutral and accessible to all patients?	0	64	56
Do patient forms include check boxes for all gender and sexual orientation options, including blanks for patients to write their responses?	0	64	56
Are preferred names, gender markers, and pronouns fed into the electronic health record system used by the clinic/office?	0	71	63
Are patient pronouns documented in the patient chart?	0	71	63
Are fertility and parenting desires discussed early in the process of transition, before the initiation of hormone therapy or gender-affirmation surgery?	0	14	13
Are patients counseled on current contraception options and their future reproductive life plan?	0	71	63
Are patients referred to mental health care professionals during the postpartum period?	0	71	63
Are patients routinely screened for intimate partner violence, depression, substance use, cancer, and sexually transmitted diseases?	0	71	63

Note. This table compares the percentage of affirmative responses to gender-inclusive perinatal care practices between publicly funded ($n = 2$) and privately funded ($n = 14$) facilities in NYC. Overall percentages were calculated from facility counts across all 16 facilities and rounded to the nearest whole number. †The reported private-facility value (76%) does not correspond to a whole number of the 14 private facilities; the overall value assumes 11 of 14 and is approximate.

DISCUSSION

This study highlights both progress and persistent challenges in providing gender-affirming perinatal care to trans-male and nonbinary individuals in NYC. While most facilities (60%) reported offering some form of gender-affirming reproductive health services, significant gaps remain in the standardization of fertility counseling, hormone management, and comprehensive perinatal care. Only 13% of facilities discussed fertility and parenting desires early in the transition process, and only 38% discussed fertility options with transgender and nonbinary patients at all, underscoring the need for providers to integrate reproductive planning into transgender health care, particularly for individuals undergoing medical transition. These findings align with previous research showing that transgender individuals often receive inadequate information about fertility preservation options and face systemic barriers to reproductive health care (Campo et al., 2024; Powers et al., 2024).

This study also identifies inconsistency in staff training regarding gender-affirming care. Although 69% of facilities reported that staff had been trained to work with trans-

male patients and 81% with nonbinary patients, only 40% provided structured education on pronoun usage, inclusive communication, and transgender reproductive health needs, and only 31% reported that patient-facing staff ask about pronouns appropriately. This finding is consistent with prior studies that emphasize how a lack of provider knowledge contributes to disparities in perinatal care for transgender patients (Roosevelt et al., 2021). It also parallels national evidence from residency training, where only 49.4% of OB-GYN residents reported formal didactic education in transgender medicine and 51.1% perceived barriers to training in their programs (Burgart et al., 2022), as well as recent international evidence: Turner et al. (2026) reported that formal training was uncommon among obstetric anaesthetists in the United Kingdom, and Brown and Swartz (2026) found that NHS midwives wanted more education and institutional support to care safely for TGNC patients. Without robust and ongoing education, health care staff may fail to deliver affirming care, increasing the risk of misgendering, discomfort, and medical mistrust among transgender patients. Expanding mandatory training programs and establishing gender-affirming care liaisons in clinical settings could help mitigate these challenges and foster a more inclusive health care environment.

Institutional policies supporting transgender reproductive care were present in over 70% of facilities, yet the implementation of gender-inclusive documentation practices remained inconsistent. Despite growing recognition of the importance of integrating gender markers and pronouns into patient records, only 63% of facilities reported doing so, highlighting an ongoing administrative gap. Standardized EHR modifications that include chosen names, gender identities, and pronoun preferences should be prioritized to ensure consistency in care delivery. Communication that assumes a cisgender patient can also operate as a form of exclusion: Coward and Howell (2026) found that U.S. hospital obstetric web resources rarely used gender-inclusive content, and Goldberg et al. (2026) showed how routine pregnancy surveillance can render trans and nonbinary parents invisible. Additionally, the physical environment of health care settings plays a crucial role in fostering inclusivity. While 56% of facilities had at least one gender-neutral restroom accessible to all patients, only 6% had images, signage, educational materials, and artwork representing all genders, and only 13% used gender-inclusive imagery in promotional materials. Increasing trans-affirming visibility in clinical settings is an important area for improvement (Miller et al., 2024).

The study also reveals partly encouraging trends in mental health support, with 63% of facilities referring transgender patients to mental health professionals during the postpartum period and 63% offering contraceptive counseling and reproductive life planning. However, the lack of specialized mental health services tailored specifically to transgender reproductive experiences remains a concern. Given the higher prevalence of perinatal anxiety, depression, and psychological distress among transgender individuals due to systemic discrimination (Greenfield & Darwin, 2020; Kirubarajan et al., 2022; Pow, 2023), integrating gender-affirming psychological care within perinatal services is critical to improving patient well-being.

Limitations

While this study provides valuable insights into transgender-inclusive perinatal care in NYC, several limitations must be acknowledged. The sample of 16 facilities (from a target

of approximately 20), though diverse, may not fully capture the breadth of perinatal care experiences across all health care institutions. The reliance on self-reported responses introduces the possibility of social desirability bias, in which participants may have overstated the inclusivity of their services. The study assesses institutional practices but does not include firsthand accounts from trans-male and nonbinary individuals receiving perinatal care, limiting insight into patient satisfaction and lived experiences.

Implications

The findings carry several practical implications. While 60% of facilities provide gender-affirming reproductive health services, many lack standardized protocols for fertility counseling and hormone management; only 13% discuss fertility and parenting desires early in the transition process, and only 25% make patients aware of options such as cryopreservation. Staff training is inconsistent, with 69% to 81% of facilities reporting some gender-affirming care training but only 40% ensuring structured training on pronouns and inclusive communication. Although over 70% of facilities have nondiscrimination policies, only 63% incorporate gender markers and pronouns in medical records. Gender-neutral restrooms exist in 56% of facilities, but only 6% display images, signage, and artwork representing all genders. These findings underscore the urgent need for enhanced health care provider education, policy standardization, and improved environments to support trans-male and nonbinary individuals during the perinatal period. Expanding gender-affirming training, integrating inclusive documentation, prioritizing early fertility counseling, and increasing trans-affirming mental health support are critical for equitable access to reproductive care.

CONCLUSIONS

This study highlights persistent gaps in equitable, gender-affirming perinatal care for trans-male and nonbinary individuals in NYC. The findings suggest that while many facilities offer mental health referral and reproductive counseling, systemic barriers remain, such as limited staff training, non-inclusive documentation, and a lack of trans-affirming environments. To address these gaps, health care institutions must prioritize provider education, inclusive policies, and visibility in patient-facing materials. Standardized EHRs, expanded mental health services, and accessible fertility preservation counseling are also key. Future research should explore patient experiences and institutional accountability to advance reproductive justice for transgender communities.

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☐ None

x☐ Some sections, with minimal or no editing

☐ Some sections, with extensive editing

☐ Entire work, with minimal or no editing
☐ Entire work, with extensive editing

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