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Sexual Orientation, Gender Identity, and Gynecological Health: An Exploratory Study on the Experiences and Needs of LGBT+ Individuals in Italy

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Abstract

The paper outlines and discusses the main results of a survey aimed at investigating the experiences of LGBT+ individuals concerning their gynaecological health and access to related healthcare services, including their relationship with medical personnel. The study shows that LGBT+ still face some obstacles and, on average, a fair awareness of their own health issues, as well as provides inspiration for future research.

Keywords: healthcare, LGBT+, sexual orientation, gender identity, discrimination.

1. Introduction

Due to the varying cultural competencies (Shetty et al. 2016) and knowledge gaps related to gender identity and sexual orientation (Seay et al. 2018; Lisy et al. 2018), as well as the lack of awareness regarding their health needs (Chapman et al 2013; Sabin et al. 2015; Fisher et al. 2017), many LGBT+ people are unable to exercise their right to health effectively. These are also known to contribute to the inequality between the LGBT+ community and other individuals (Zeeman et al. 2019; McGlynn et al. 2020; Bonvicini 2017).

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The European regional context is no exception. In a survey conducted in 2012 involving 93,000 individuals, approximately one-third of whom were residents of Italy, the European Union Agency for Fundamental Rights revealed that LGBT+ people often feel victimized by discrimination in the field of health (FRA 2012). Although only 8% of respondents residing in Italy reported feeling discriminated against by medical staff in the twelve months prior to the survey, with a higher percentage among transgender respondents (12%), more than half (56%) stated that they had not disclosed being LGBT+ to their treating physician.

The survey was repeated in 2019 on a sample of 140,000 subjects, including, unlike the previous study, also intersex people (FRA 2019). The results showed a deteriorating situation. The deterioration in the situation for LGBT+ individuals in healthcare between 2012 and 2019, can be attributed to several factors, including entrenched biases, inadequate policy implementation, and broader sociopolitical trends affecting attitudes toward LGBT+ people in some parts of Europe. Some possible reasons for this negative shift include the percentage of respondents who felt discriminated against because of sexual orientation, gender identity, or based on sexual characteristics increased to 12%, with a significantly higher percentage for transgender and intersex individuals (27%). Inappropriate curiosity was confirmed to be the main difficulty encountered by LGBTI people in accessing healthcare services, especially for transgender individuals (LGBT+: 12%; T: 20%).

The LGBT+ community is also considered to be a vulnerable group that needs to have access to gynecological health care services. International research revealed seven main themes that pertain to the experiences of individuals when it comes to accessing healthcare in the field of gynecology. These include fear, discrimination, cultural incompetency, gender identity, and accessibility (Ferreira-Filho et al. 2024; Thomas et al. 2023; Wingo et. 2018). Unfortunately, many of them delay their visits due to various factors such as poor treatment and neglect (Macapagal et al. 2016). Research also shows that gynecologists are not confident about treating the LGBT+ community or are not trained to provide specialized care (Unger 2015).

2. The Italian context

Regarding Italy specifically, from a strictly legal perspective, there is no national legislation explicitly prohibiting discrimination in healthcare based on sexual orientation, gender identity and expression, or sexual characteristics. However, given that healthcare in Italy is managed at the regional level, some regional legislative initiatives prohibit any differential treatment based on sexual orientation and gender identity in relation to regional goods and services, including

access to healthcare and health services[1]. The empirical impacts of these legal references, however, are yet to be verified.

Furthermore, despite some ministerial recommendations, there are still no specific guidelines for the management of LGBT+ patients[2] and only since October 1, 2020, has the Agenzia Italiana del Farmaco (Italian Medicines Agency) included hormone replacement therapies in the list of drugs fully covered by public healthcare.

The only national strategy introduced by the Ministry of Health to improve the health conditions of LGBT+ individuals is the "Biennial Action Plan against HIV and AIDS" of 2017. For instance, in the field of vaccinations, those deemed to engage in high-risk sexual behaviors for contracting Hepatitis A or B, including MSM[3] explicitly, can access free administration of the vaccines. Recently, mention has also been made in the implementing guidelines of MSM and transgender women as individuals who could benefit from Pre-Exposure Prophylaxis (PrEP)[4]. LGBT+ associations (e.g. Arcigay), albeit sporadically and with limited resources, have also carried out health promotion interventions, but almost exclusively focused, once again, on the prevention of STDs in general and HIV in particular.

It is also noted that in 2019, the Ministry adopted the "National Plan for the Application and Dissemination of Gender Medicine"[5]. Although it does not specifically focus on LGBT+ individuals, it recommends that in the evaluation and management of diseases, various parameters should be considered, including sexual orientation, to ensure the quality and adequacy of services provided by the National Health Service. Furthermore, a specific paragraph is dedicated to the well-being of transgender individuals who, according to the Plan, while sharing many health needs with the general population, are believed to have special needs. Attention is finally given to intersex status, the correct diagnosis of which is recognized as complex but also necessary for the proper management of the patient and support for the family.

[1] These are the regions: Tuscany (Law of November 15, 2004, No. 63), Liguria (Law of November 10, 2009, No. 52), Marche (Law of February 11, 2010, No. 8), Piedmont (Law of March 23, 2016, No. 5), Umbria (Law of April 11, 2017, No. 3), and Apulia (Law of July 10, 2006, No. 19).

[2] An exception to this is represented by the guidelines developed by the Osservatorio Nazionale sull'Identità di Genere, albeit limited to gender affirmation pathways for transgender individuals.

[3] In international scientific communications on STDs, it has become customary not to use the term "homosexuality" but rather "Men who have sex with men" (MSM) or "Women who have sex with women", because it is a definition that allows for the inclusion of individuals from various sociocultural backgrounds and with different sexual identifications (Young 2005).

[4] Pre-Exposure Prophylaxis (PrEP) involves taking a combination of HIV medications daily or before sexual intercourse to prevent the acquisition of HIV infection.

[5] The first step in this direction dates to January 31, 2018, when Law 3/2018 (*Delega al Governo in materia di sperimentazione clinica di medicinali nonché disposizioni per il riordino delle professioni sanitarie e per la dirigenza sanitaria del Ministero della Salute*) was approved. Article 3 of this law, (*Applicazione e la diffusione della medicina di genere nel Servizio sanitario Nazionale*), called for the creation of a Plan aimed at promoting gender medicine through dissemination, training, and indication of healthcare practices that, in research, prevention, diagnosis, and treatment, take into account gender differences to ensure the quality and appropriateness of services provided by the National Health Service uniformly throughout the national territory. On June 13, 2019, the Minister of Health formally approved the Plan by signing the implementing decree related to Law 3/2018.

In Italy, there is also a clear delay in research on the healthcare needs of LGBT+ individuals. Almost no major past national surveys have included questions about sexual orientation and/or gender identity[6], while the other available studies are still numerically limited (Togni e Viggiani 2022).

Among the few available studies in the field of health, though not strictly related to gynecological health, the following four deserve to be highlighted. The first is "Pazienti non previsti in ospedale" (Unscheduled patients in the hospital), conducted in 2012 on a sample of 3,700 healthcare workers from the provinces of Massa Carrara, Lucca, Pisa, and Livorno (Regione Toscana 2012). The results revealed serious deficiencies in the cultural competencies of the participants: just over half (53.9%) were able to recognize the correct definition of homosexuality, one-fifth (20.2%) considered it a choice of the individual, while a smaller but not insignificant fraction viewed it as a pathological condition of human sexuality (13%), a recessive genetic anomaly (4.4%), and even a family-induced neurosis (0.83%). Furthermore, nearly half of the participants (48.4%) stated that they did not consider the possibility that patients could be LGBT, with 29.1% considering it irrelevant for assessing health status. However, when asked whether homosexual and transgender individuals were more susceptible to contracting certain diseases, just over half of the respondents (51.8%) answered affirmatively, with almost nine out of ten indicating sexually transmitted diseases (STDs).

The second study is a quantitative survey called "MODI DI - Sesso e salute di lesbiche gay e bisessuali oggi in Italia" (WAYS OF - Sex and Health of Lesbians, Gays, and Bisexuals in Italy Today), conducted in 2005 on a sample of approximately 7,000 MSM or WSW subjects distributed across the national territory (Lelleri 2006). When asked whether they agreed or disagreed with the statement "I am afraid of receiving worse treatment because of my sexual orientation when I turn to doctors and nurses", more than three out of ten subjects agreed or strongly agreed (MSM: 32%; WSW: 35%). Consequently, more than two-thirds stated that they had not disclosed their sexual orientation to their general practitioner (MSM: 69%; WSW: 80%). Conversely, when participants were asked whether they had disclosed their sexual orientation to a psychotherapist, if they had one, almost eight out of ten responded affirmatively (MSM: 78%; WSW: 78%), but slightly less than two-thirds (MSM: 64%; WSW: 64%) considered the psychotherapist's attitude towards homosexuality as positive.

The third available study takes a qualitative approach and was conducted between March 2015 and November 2016 on a sample of 65 healthcare professionals. Unlike the previous two, it focused on the perception of intersex people by professionals (Prandelli et al. 2021). Although

[6] Only in the last decade's population census were questions about sexual identity included. Even then, 10.2% of homosexual/bisexual respondents reported feeling discriminated against by a doctor, nurse, or other healthcare personnel when accessing health-related services (ISTAT 2012).

most of the interviewed healthcare workers reported having had at least one work experience with an intersex person, many of them used outdated terminology (e.g., pseudo-hermaphroditism) or showed little sensitivity towards the self-determination of the intersex minor in favor of a more "normalizing" approach based on corrective surgical interventions.

A fourth and final study with mixed methods investigated the attitudes of medical students at the University of Brescia, in Italy, and some national experts towards LGBTI individuals and their knowledge of the specific healthcare needs of the LGBTI community (Togni e Viggiani 2022). The results showed a mostly positive attitude of the participants towards LGBTI individuals and, on average, a fair knowledge of issues concerning their health. Nevertheless, the authors called for additional empirical research.

All that being said, in the following pages, the main findings of a new exploratory survey aimed at investigating the experiences of LGBT+ individuals concerning their gynecological health and access to related healthcare services, including their relationship with medical personnel, will be presented and discussed[7].

3. Methodology

The goal of this study was to find out what kinds of LGBT+ individuals face when it comes to accessing and seeking gynecological care. The survey also explored the experiences of LGBT+ people with healthcare professionals, including their perceptions of discrimination and prejudice, as well as the level of satisfaction they have with the services they receive. In addition to gaining a deeper understanding of the services they receive, the study's goal is to gather suggestions on how to improve them. The survey also looked into how informed participants were about various gynecological health issues. In addition, it explored how their gender identity and sexual orientation affected their preventive health behaviors.

The survey adopted a quantitative approach, particularly relying on an online questionnaire administered to individuals self-identifying LGBT+. The questionnaire's distribution online was chosen due to the target population's specificity, which is partly invisible and stigmatized, which prevented the creation of a definitive list for probabilistic sampling. Due to the challenge in identifying the research's reference population, the NGO Coming-Aut LGBTI+ Community Center was utilized as an access hub to engage the target population. Unlike the paper version, the

[7] The research was promoted by the Coming-Aut LGBTI+ Community Center. The activity was carried out in relation to the TODES! - Territorio, Opportunità, Diritti, Eguaglianza, Solidarietà - Centro contro le discriminazioni per orientamento sessuale e identità di genere, realized with the contribution of the Consiglio dei Ministri - Dipartimento per le Pari Opportunità - Ufficio Nazionale Antidiscriminazioni Razziali. For more information, please visit www.coming-aut.it (consulted the 28th February 2024).

online questionnaire also allowed participants to express themselves more honestly and freely, because it provided greater anonymity and privacy. When completing a questionnaire online, participants can feel less judged and may experience less pressure from an in-person presence, which can sometimes inhibit honest responses, especially on sensitive topics like health, sexuality, or personal experiences. Online formats also allow participants to complete the questionnaire in their own space and at their own pace, which can reduce anxiety and lead to more thoughtful and open answers. Simultaneously, this approach facilitated national coverage. Finally, the non-probabilistic sampling procedure used - convenience sampling - allowed us to reach a sample with a good size.

The scientific validation of the questionnaire was conducted following the criteria proposed by the literature (Lynn 1986; Polit e Beck 2006), involving several experts in the field of LGBT+ studies and/or representatives from the field of research. Each expert assessed the consistency of the questions, their comprehensibility, the completeness of classifications, the appropriateness of language used, and, where possible, the presence of biases in the questions. The questionnaire administration took place between April and September 2023.

2,928 individuals agreed to participate in the gynecological-related survey, but only 1,078 ultimately completed the questionnaire, resulting in a dropout rate of 63.19%. Only the 1078 completed questionnaires were considered valid and subjected to analysis.

Of the participants, 77.18% identified as cisgender women, 7.05% as transgender men, 1.02% as transgender women, and the remaining 14.75% as 'Other'. Although a minority compared to the general sample, the percentage of respondents who identified as transgender men (N=76) appears particularly significant, considering that, to date, international literature estimates the prevalence of this social group to range between 1 in 30,400 and 1 in 200,000 (unlike transgender women, estimated between 1 in 11,900 and 1 in 45,000). Regarding the 14.75% (N=159) of 'Other' responses, participants were asked to qualitatively specify their identification. The majority (>80%) declared themselves as non-binary/genderfluid, a few (<4%) as agender, while the remaining few did not fully understand the question, either declaring a pre-defined category (e.g., cisgender woman) or indicating a sexual orientation (e.g., lesbian) instead of a gender identity.

The sexual orientation of the sample was therefore well distributed, not only ensuring good representativeness but also enabling bivariate analysis. The substantial number of asexual respondents (N=50) is noteworthy, estimated at <1% of the general population and often challenging to capture. Regarding the 3.15% (N=34) of respondents who chose 'Other', the freely provided responses were highly diverse, making it impossible to group them subsequently into defined categories. In general, it can be stated that the qualitative responses of the field "Other" fall between predefined answers (e.g., curious heterosexual, polysexual, homosexually

flexible), highlight romantic orientation (e.g., demisexual, biromantic) rather than sexual orientation, or reject a clear definition (e.g., queer).

In terms of age, the sample appeared quite young, likely a result of the questionnaire's dissemination primarily through the web and social media. 67.07% fell within the 19-34 age range, 26.81% within the 35-50 range, 3.90% were over 50, and the remaining 2.23% were under 18[8].

In terms of relationship status, 60.58% of participants are in a monogamous couple, 31.17% are single, 3.99% are in a non-monogamous couple, 2.88% are in a polyamorous relationship, while the remaining 1.39% chose the 'Other' category. Once again, there is a notable number of individuals in less common relationship statuses, such as non-monogamous (N=43) and polyamorous (N=31). The open-ended responses in the 'Other' category, however, are less noteworthy as they mostly appear as specifications of predefined responses.

Regarding the highest educational attainment, 37.20% of participants have a high school diploma, 25.51% have an undergraduate degree, 23.93% have a master's degree, 5.84% have a doctorate or specialization diploma, 4.73% have a middle school diploma, 0.19% have no degree, while 2.60% chose the 'Other' category. The sample appears to be well-educated, with a higher level of education than the general population in Italy, where only 26.8% hold a tertiary education degree (higher technical diploma, academic diploma, bachelor's, or doctorate). Once again, the responses in the 'Other' category are less noteworthy, aligning mostly with predefined responses (e.g., old system degree) or being specifications of them (e.g., I have a diploma, but I am a graduate student). An exception is a minority of respondents (N=6) who stated having a master's degree level I or II, a title not commonly accounted for in standardized responses.

In terms of geographical distribution, the sample is predominantly located in Northern Italy (69.94%), with the remaining respondents evenly distributed between Central Italy (14.56%) and Southern Italy and Islands (15.49%). This represents a clear limitation of the sample. However, a positive aspect is that 54.27% of the sample resides in urban areas, while 45.73% live elsewhere, allowing for a potential comparison between these two contexts. Urban areas typically offer a broader range of gynecological services (both public and private), which might differ from those in non-urban settings.

Finally, participants were asked some questions regarding their sexual lives, provided that gynecological health is closely linked to sexual health. A relative majority (39.89%) of the sample reported having had sexual intercourse in the seven days prior to the survey, followed by a considerable number of individuals (24.40%) who reported having had sex more than sixty days before completing the questionnaire. The remaining participants reported their last sexual

[8] Since the survey was fully anonymous and posed minimal risk to participants, responses from minors without parental consent were allowed, provided that no personally identifiable information was collected.

encounter within 8-14 days (13.54%), within 15-30 days (9.28%), within 31-60 days (5.10%), or never (7.79%)

In relation to the type and number of partners encountered, participants were asked to complete a predefined grid detailing the number of sexual partners on one side and standardized categories on the other (Cisgender Man, Cisgender Woman, Transgender Man, Transgender Woman), covering the 12 months preceding the survey. The number of encountered partners, in general, appeared rather low, with less than 10% of the sample reporting more than one partner in the last 12 months, albeit with some variations based on the partner's identity. Cisgender men and cisgender women were the most frequently encountered partners, with a mere 0.74% difference between the two. Additionally, the vast majority of participants had not engaged in sexual intercourse with a transgender man (96.94%) or a transgender woman (98.42%).

4. Results and analysis

The first group of items investigated the behaviors and actions of the participants in relation to their gynecological health.

With the first question, participants were asked about their most recent gynecological visit, choosing from predefined periods. The relative majority of the sample (37.57%) reported having had their last visit over 12 months before the survey, while a similar percentage had it within 7-12 months (19.57%) and within 3 months (19.67%). A smaller portion had it within 4-6 months (12.24%) or had never had one (10.95%).

The data indicating that the relative majority hasn't undergone routine gynecological visits in the last year (as generally recommended) might find a possible explanation when correlated with the relationship status of the sample, where 60.58% are involved in a monogamous relationship. The bivariate analysis supported this interpretation: among those who chose the timeframe of over 12 months, over half are simultaneously in a monogamous couple. However, no significant fluctuations were observed related to the participants' sexual orientation or gender identity, except for trans men, the majority of whom had a gynecological visit over 12 months ago (N=38) or had never had one (N=18). The small size of this subgroup (N=76) prevents establishing a direct causal correlation between the two variables.

Later, participants were asked about their preferred type of gynecological visit, choosing among Private Practice, Health Center, Hospital, Clinic, and Other. Surprisingly, 63.54% of the sample indicated a preference for private practice, despite gynecological visits in Italy being potentially covered by the national health system (with co-payment). The reason behind this

choice is at least partially explained by the open-ended responses to the 'Other' option. Some respondents emphasized the importance of the doctor's identity over the mode of access (e.g., "The location does not matter to me, it is about the doctors we encounter"; "empathy and availability") or highlighted a certain conservatism still prevalent in public healthcare settings ("Unfortunately, there is still the concept of virginity, and I have never felt comfortable in hospital clinics")[9].

In support of this interpretation, the data from the following question where participants were asked how they had chosen or would choose the gynecologist (up to 4 answers were possible) is reassuring.

As evident, a substantial segment of the sample indicated that their choice was influenced by recommendations from friends and family (N=629), while less than 30% mentioned the cost of the service (N=316) or the gender of the doctor (N=280). This underscores that the trust relationship between the doctor and patient is the most important factor for the LGBT+ individuals involved in the research. It cannot be ruled out that non-LGBT+ individuals would have a different outcome, at least partially.

The reasons why participants seek or would seek a gynecologist vary considerably (up to 4 answers were possible), although the most common are regular check-ups or screenings (Pap test, internal ultrasound, breast ultrasound, mammogram, etc.).

However, it is worth noting that among those who chose "Other," a recurring response relates to pre-hormonal and surgical treatment, almost exclusively within the transgender subgroup.

The participants were then asked two questions regarding whether the gynecologist they consult with is aware of their gender identity and sexual orientation, respectively. The results indicate that the respondents' gender identity is more frequently known by the gynecologist than their sexual orientation (65.86% vs. 46.10%), possibly explained by the greater ease in concealing the latter compared to the former.

A subsequent set of items was aimed at investigating aspects related to the Human Papillomavirus (HPV) vaccine, which is responsible for the majority of cervical cancer cases and other genital tumors. Research can so highlight any barriers individuals face in receiving the HPV vaccine, such as access to healthcare services, stigmatization, or lack of information.

From this perspective, it was observed that only 42.30% of the participants received the HPV vaccine, while just over 2% either do not know or do not remember. There do not seem to be any particular correlations with sexual orientation or gender identity. However, there is a notable difference among trans men, where the number who received the vaccine is quite similar to

[9] This is an unsurprising result, as women in Italy (regardless of their sexual orientation and other characteristics) have always preferred to seek visits with private specialists for this area rather than turning to public facilities, including family planning clinics.

those who did not. Instead, a significant variation based on age was observed: the number of individuals in the 35-50 age group who were not vaccinated is nine times higher (N=257) than those who were vaccinated in the same age bracket (N=28). Conversely, this trend is somewhat reversed in the 19-34 age group, though less significantly (N=409 vaccinated vs N=295 not vaccinated). This is not surprising, considering that in Italy the vaccination has only been recommended for young people (both female and male) in recent years. Among those who received the vaccine (N=491), 59.2% did so free of charge through the National Vaccination Prevention Plan.

The high number of unvaccinated individuals in the sample could be attributed to the behavior of their gynecologists. Surprisingly, only 25.32% of the participants recall being offered the HPV vaccine by their gynecologist. This correlates with the age factor mentioned earlier: among participants in the 35-50 age bracket, the number of those who were never offered the vaccine is five times higher than those who were offered it.

Among the subgroup that received the HPV vaccine (N=463), they were asked about the reasons through a standardized range of options, resulting in responses that were not strongly polarized:

Furthermore, as evident, there is a significant portion of participants who chose the 'Other' option (N=126) and consequently provided an open-ended response. In this case, respondents mentioned factors such as misinformation ("I have no idea what it is"), discouragement ("They said it was not necessary"), impediments ("My father prevented me because he is bigoted and closed-minded"; "I was young and my mother did not allow it"), age ("I was told it is pointless after a certain age"), or sexual behavior ("I have a "cautious" sexual life").

The second set of questions aimed to investigate the attitudes, beliefs, and opinions of the participants concerning their relationship with the gynecologist.

The participants were asked, through a first item, how much discomfort they experienced when consulting a gynecologist, using a scale from 0 (no discomfort) to 5 (maximum discomfort). Only 25.88% of the sample reported experiencing no discomfort (score of 0), while the rest of the participants were fairly evenly distributed across the scale. The sum of scores 4-5 (28.02%) slightly surpasses those who reported no discomfort, although not by much.

With a second question, attempts were made to understand the causes of this discomfort using a series of standardized responses, offering the possibility to select up to four choices. The most frequently cited cause of discomfort, not surprisingly, was the invasive nature of the visit (43.04%). This is understandable, especially considering that the subgroup of cisgender homosexual women might not engage in frequent penetrative sexual activity, leading to a heightened perception of invasiveness during gynecological examinations. Other notable causes were ignorance about LGBT+ issues among healthcare staff (31.54%), fear of encountering an

LGBT+-phobic specialist (31.08%), followed by fear of instruments or procedures (20.50%). Less frequent was the fear of having to come out (16.42%), although this was more common in the transgender subgroup. As explained by a participant who chose the 'Other' option for an open-ended response, "I am a trans man with an outward appearance and a male tax code; it would only be coming out for scheduling the visit".

With two subsequent questions, participants were asked how important they consider it for the gynecologist to be aware of their gender identity and their sexual orientation, respectively, on a scale from 0 (not important at all) to 5 (very important). The results indicate that knowledge of gender identity is generally considered more important than sexual orientation:

	How important do you consider it for the gynecologist to know the gender identity of the patient?	*How important do you consider it for the gynecologist to know the sexual orientation of the patient?*
0	98 (9,09%)	205 (19,02%)
1	33 (3,06%)	82 (7,61%)
2	62 (5,75%)	116 (10,76%)
3	162 (15,03%)	182 (16,88%)
4	186 (17,25%)	168 (15,58%)
5	537 (49,81%)	325 (30,15%)

The data aligns with a previous question discussed earlier, where participants were asked whether their gynecologist was aware of their gender identity and/or sexual orientation, with gender identity being more frequently known than sexual orientation (65.86% vs 46.10%).

With a subsequent question, the sample was asked to rate the perceived usefulness of regularly visiting a gynecologist for predefined categories of individuals, on a scale from 1 (not very useful) to 5 (very useful). Overall, the absolute majority of respondents assigned a score of 5 to all types of individuals, indicating that they find it very useful to regularly visit a gynecologist regardless of personal characteristics. However, some fluctuations were observed – cisgender heterosexual women (81.66%), cisgender lesbian/bi/pan/omni/+ women (79.36%), pre-testosterone transgender men (77.71%), testosterone-using transgender men (77.76%), post-hysterectomy transgender men (72.54%) – suggesting a decreasing perception of usefulness as the gender affirmation process (from biological woman to transgender man) progresses.

The third and final set of items investigated how often participants experienced any instances of discrimination in accessing gynecological health services. The participants were presented with several scenarios of discrimination and asked to respond regarding how often these scenarios

occurred in the last 12 months, using the following scale: Always, Often, Sometimes, Rarely, Never. Not sure/Do not remember was also an available response option.

Preliminarily, it can be observed that the sample does not perceive frequent instances of discrimination, although the rate of "Not sure/Do not remember" responses was quite high (>40%) across nearly all these items. This could indicate that participants perceive behaviors that could be defined as discriminatory as "normalized". Additionally, it is essential to consider that within this group are those who have never undergone a gynecological visit, comprising 10.95% of the total.

For instance, in response to the question regarding how often the gynecologist refused gynecological exams solely because the respondent was LGBT+, only a minority responded Always (0.37%), Often (2.23%), or Sometimes (3.06%). However, this minority is quite well-defined, predominantly composed of transgender men who likely face challenges booking visits within a healthcare system geared toward individuals assigned female at birth. Slightly more frequent are experiences of deadnaming/misgendering (Always: 3.71%, Often: 3.15%, Sometimes: 3.06%), with a slight increase (+2%) for non-medical staff (e.g., appointment desk staff), who typically serve as the initial point of contact within the healthcare system.

The behavior of being judgmental from the gynecologist was not very common either: only 1.11% of the participants reported that the doctor always expressed judgments about sexual practices, 2.32% stated it happened often, and 9.74% mentioned it happened sometimes.

A very small minority reported being denied access to the service/studio/clinic because they were LGBT+ individuals (N=22), or having visits scheduled after hours to avoid encountering other patients (N=11), at least sometimes. However, this remains predominantly associated with participants who self-identify as transgender.

A separate case is the responses to the question "As an LGBT+ person, how often do you feel your privacy has been respected in accessing gynecological health services?" Here, the data indicates a less-than-optimal situation: only 20.96% responded that their privacy was always respected. While there were no significant variations based on sexual orientation or age, there is an increased perception of privacy violation related to gender identity, particularly among transgender individuals.

8.81% (N=95) of the sample provided an open-ended response when asked if they believed they had experienced other instances of discrimination related to gynecological health services that were not covered by the previously suggested scenarios. As expected, the responses were highly diverse but were thematically grouped into experiences involving: fatphobia ("Once, a doctor refused to examine me because I am overweight"), body shaming ("A male gynecologist commented on my small labia, offering plastic surgery to reduce them because "women like to have it tidy", even though to him "not as a doctor, but as a man looking at a woman, I think you

are fine as you are""), inappropriate comments about sexual life ("I was verbally attacked because of the waxing I had done, too much shaved. And various references that by 40 I would regret it and rush to try to have children"), heteronormativity ("The gynecologist assumed my partner was a man"; "as a lesbian, it was assumed I was not pregnant"), denial of sexual orientation ("But you really do not want to try sleeping with a man?"; "During a hospital stay, they sent a priest to my room"), ignorance about sexual relations between women ("They assume I am a virgin because they do not conceive that homosexual relations between women involve penetration"), denial of care ("Trans men with corrected documents do not have access to gynecological screenings; Exclusion from Pap tests as a cis lesbian woman"), and invalidation of pain ("Refusal of internal ultrasound to investigate the cause of debilitating menstrual pain until I had penetration with a cis man/boy").

5. Concluding remarks

The study contributes to understanding some of these mechanisms and demonstrates the need for further investigations into factors that promote or hinder access to gynecological health services, especially those that might cause significant diagnostic delays. The study content could also serve as educational material for medical students and trainee physicians (McCann et al. 2018; Dubin et al. 2018; Sanchez et al. 2006) or as a professional development opportunity for practicing physicians through continued education (Donisi et al. 2020; Ardis et al. 2007).

Results show that healthcare providers must prioritize sensitivity and inclusivity when treating LGBT+ patients. They should make the environment they work in feel welcoming regardless of one's sexual preference or gender identity.

Providing patients with the necessary education about their sexual and reproductive health is very important. It empowers them to make informed decisions and advocate for more inclusive practices and policies within institutions. For the same reason, gynecological healthcare should be comprehensive, with an emphasis on fertility options, preventive screenings, sexual health, and more. Communication should be positive and affirming, and open-ended questions should be asked to gain a deeper understanding of patients' needs.

Moreover, the confidentiality of patients' information must be maintained throughout their medical journey. This ensures that their privacy is protected and that their treatment is not influenced by prejudice. Specialists must also be aware of the diverse community of LGBT+ individuals, which includes varying gender expressions and identities.

In future studies, it might be beneficial to reconsider the sample composition, focusing specifically on the transgender subgroup or attempting to overcome the territorial limitation to Northern Italian regions, thus allowing for greater representativeness of results across the entire national territory. Additionally, it could be valuable to delve deeper into the survey results through qualitative interviews or focus groups.

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