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The Experience of Transgender People in the Italian Healthcare Context: A Qualitative Study

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Abstract

Transgender and gender diverse (TGD) people is an umbrella term used to describe members of the multiple societies with gender identities or expressions differing from the gender socially attributed to the sex assigned at birth. TGD people still face denial of services, discrimination, harassment, and even violence by healthcare professionals, causing them to avoid seeking ongoing or preventive healthcare. Thus, TGD people have many barriers to health. Barriers to health play an important role in understanding the causes of disparities and they are important, yet understudied, predictors of health promotion. This article describes the health experiences of TGD people regarding their access and use of Italian healthcare. Material and methods: Semi-structured interviews were conducted using a descriptive phenomenological approach with twenty transgender people between December 2021 and September 2023. The data were analyzed following the method proposed by Colaizzi with the help of the Atlas.ti8 software. Results: Twenty TGD people participated. All Italian regions have been included. TGD people care experiences were divided into three areas: obstacles, training experience, and role of the family. Participants identified negative issues and difficulties with the health system due to healthcare providers’ lack of competence. Discriminatory, authoritarian, and paternalist behaviours are still present and hinder the therapeutic relationship, care, and access to healthcare services. There is an important need for the major inclusion of TGD people and training for healthcare professionals in sexual diversity. Training in sexual and gender diversity should be included in the curricula of university courses in the healthcare professionals.

Keywords: transgender and gender diverse people, Italian healthcare, qualitative study, inclusion, Colaizzi method.

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1. Introduction

Gender and sex are two complex terms to use, today more than ever, as the concept of sex refers to the anatomical and biological characteristics based on which an individual is assigned male or female sex at birth. Gender, however, refers to the socially constructed characteristics of men and women, and therefore includes norms, values, behaviors and roles, status related to being a woman, a man, as well as the interactions that occur between these genders. As socially mediated, gender and genres vary across different societies and cultures (Brickell, 2006), and it may happen that gender and sex are not aligned, and this misalignment occurs in the case of Transgender and gender diverse (TGD) people.

TGD people is an umbrella term used to describe members of the multiple societies with gender identities or expressions differing from the gender socially attributed to the sex assigned at birth (Coleman et al., 2022). From the statistical point of view, it is not easy to have certain information on the TGD people. It is estimated that there are around less than 1% of the worldwide population are TGD, with figures ranging from <0.1% to 0.6% (Coleman et al., 2022), and in Italy around 400.000[1]. This is a population that compared to that general one, has a greater incidence and prevalence of unemployment, poverty, estrangement from family, discrimination, psychological problems, substance abuse, sexually transmitted infections, as well as suicide and violence (Warner and Mehta, 2021). At the same time, TGD people need constant direct contact with the healthcare system and healthcare workers due to the gender affirmation process (Costa, 2023a): from hormonal treatment to the various types of surgeries they require. Therefore, the healthcare context should seek to act on this public health crisis (Warner and Mehta, 2021), as all these aspects mean that TGD people experience real forms of barriers to health. Barriers to health can be defined as all those variables that prevent an individual, a community or an entire population from: 1) accessing health services; and/or 2) achieve optimal health (Costa, 2023b). With regard to TGD people, three types of barriers tend to be identified: healthcare barriers, i.e. barriers that concern the healthcare system from the point of view of both policies and spaces, documents, etc.; social barriers that concern the relational sphere both outside and inside the healthcare context, and individual barriers i.e. those barriers that every single TGD person experiences and internalizes (Costa, 2023 b; Warner and Mehta, 2021). All this, in turn, takes on the characteristics of structural vulnerability. “The concept of structural vulnerability explains how systems of oppression drive health inequities by reducing access to survival resources (e.g. food, housing) for marginalized populations. Indicators of structural

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[1] https://www.quotidianosanita.it/scienza-e-farmaci/articolo.php?articolo_id=80135.

vulnerability such as housing instability, violent victimization and poverty are often interconnected and result from intersectional oppression" (King et al., 2023, p.1).

This represents a real contradiction since in recent years models based on the humanization of care and of a patient centered type have become increasingly fashionable and used by healthcare professionals (Raja et al., 2015). Yet, there is not enough education on TGD health in healthcare contexts to provide capable healthcare professionals able respond to their needs and concerns, resulting in deficiencies in the use of health services (Paradiso and Lally, 2018).

These situations of health disparity derive from a lack of specific education on TGD health, but also due to poor scientific research and affirmation of global health policies on TGD health (de Vries et al., 2020). In this regard, the study of Whittle et al.(2008), found that 30% of TGD people had healthcare experiences such that even if professionals would have liked to help them, they were not sufficiently trained on their critical issues and from the point of view of healthcare professionals, according to research by Santander-Morillas et al. (2022), 73% declared that they had not received adequate university training in TGD health, and this was clearly identified as an essential barrier during any care relationship.

All this means that TGD people, very often, following negative interactions with healthcare professionals, decide not to use healthcare services. In this regard, data from one of the most recent European-level surveys[2] shows that around 22% of TGD people who go to healthcare facilities have had discriminatory experiences at first contact, and around 30% declared of having received care that was not entirely satisfactory by healthcare professionals.

In Italy, the situation is problematic both for TGD people and for healthcare professionals who do not actually have sufficient training tools available in this regard (Costa, 2023a) and, "Scientific evidence shows the presence of challenges during interactions with health systems that make it difficult to develop and obtain specific care for transgender people in short, discriminatory treatment is evident. Rodriguez et al. identified a statistically significant correlation between being recognized as a transgender person and experiencing discrimination in healthcare settings" (Santander-Morillas et al.,2022, p.3).

However, there are few qualitative data regarding these issues, therefore, this paper starts from a research question: what is the experience of TGD people in national healthcare contexts, and above all their relationship with healthcare professionals?

Thus, the aim of this research is to describe and analyze the experiences of TGD people within the services and realities of the Italian national healthcare system.

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[2] https://fra.europa.eu/en/publication/2014/being-trans-eu-comparative-analysis-eu-lgbt-survey-data.

2. Material and methods

A qualitative study based on face-to-face semi-structured interviews was performed, following the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (O'Brien et al., 2014).

2.1. Study participants

TGD people over 18 years of age who were residents in Italy and who had attended a hospital or private or semi-private Italian healthcare structures in their live were invited to participate.

2.2. Recruitment of participants

Purposive sampling was used to obtain a wide range of TGD people characteristics and hence to ensure a wide range of experiences. This technique is widely performed in qualitative research to identify information-rich cases (Patton 2002). Consecutive TGD people were contacted by means of specific associations for people belonging to the LGBTQA+ world, via email, telephone, and social networks. Subjects were also recruited using social media. Recruitment continued until data saturation, therefore, when no new information or additional perspectives were observed in the data when adding more participants (Guest et al. 2006) was achieved, which was checked after each interview.

2.3. Data collection

Data disclosure was accomplished through semi-structured face-to-face interviews. After the literature evaluation, an interview guide (table 1) with open-ended questions was created in advance and was evaluated by researcher skilled in applying qualitative methods. The duration of each interview was approximately 100 min and was conducted by D.C. with specific training on interview techniques. The interviews were audio-recorded and transcribed verbatim. 14 interviews were conducted online. All interviews were conducted in Italian and occurred between December 2021 and October 2023.

1. At the level of health facilities, did you found it difficult to enter places such as bathrooms, being these distinct only for men and women?
2. If you happened to be hospitalized, which department where you admitted to? With the type of the gender which with you identify yourself? Or with the sex assigned at birth?
3. What effect did it have on you to find your sex and your gender on a document such as a report or a health prescription gender of origin rather than the possibility of choosing the one you perceive?
4. When you came into contact with general practitioners, specialists, nurses... How they seemed in interacting with you? Did you feel embarrassed? Difficulty?
5. Have they managed to use inclusive language (the right pronoun for example)? Or on the contrary you caught transphobic attitudes?
6. What role did your family have and does your family have in your life in general and also in the context of health (Do they come with you for any visits, nights of hospitalization, etc.)?
7. When you came into contact with the healthcare context, how did you feel?
8. What do you think about the training of healthcare professionals regarding the health of TGD people?

Table 1- Questions from the semi-structured interviews

2.4. Data analysis

The data were descriptively and thematically evaluated based on the method by Colaizzi (1978)[3] using Atlas.ti8 software. This methodological approach was chosen because is rigorous and robust, and therefore a qualitative method that ensures the credibility and reliability of its results and allows researchers to reveal emergent themes and their interwoven relationships.

The transcripts were open coded by DC. After evaluating each interview, then, the related codes were compared in order to structure categories and subcategories with an iterative and inductive method. The findings were noted as major themes and represent the starting point for understanding the experience of TGD people in healthcare contests.

2.5. Ethical considerations

In this study, the authors initially sought to inform potential participants in detail about the subject and purpose of the research, so that they would feel impartial and free to decide whether to participate in the research process. Thus, the subjects completed a consent form, so

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[3] This methodology requires 7 steps to be followed, and they are: 1. Listen to the tape time and again and transcribe them into transcriptions, then read their words repeatedly combining with the non-verbal communications till feelings resonate; 2. Extract Significant statements which are relevant to the death experience of nursing students from each transcript.; 3. Formulate meanings from significant statements and code them. Codes should be approved by all researchers; 4. Cluster these codes; 5. Confirm findings and identify difference by comparing transcriptions and sub-themes, themes more than once.; 6. Describe the theme and essence of nursing students' experience by their own statements to insure the validity of study; 7. Return each transcript and result to participants to affirm the findings.

that the research was legally secure (Gay et al., 2012) while the researchers created a confidentiality atmosphere with the respondents to avoid feelings of emotional crisis and pressure during the interview. Then, the anonymity of the interviewees and of the identities were secured attributing an alphanumeric code to each participant.

3. Results

20 TGD people were included: 19 MtF (Male-to-Female) and 1 FtM (Female-to-Male). The middle age was 39.2 years (range 26-59 years). All Italian regions have been included. In Table 2 there are summarized socio-demographic data and the synthetic characteristics of the participants.

ID	Age	Gender	Education	Occupation	Region
1	34	MtF	High school	Chef	Valle d'Aosta
2	44	MtF	High school	Employee	Molise
3	32	MtF	Graduation	Freelance	Umbria
4	51	MtF	High school	Employee	Trentino-Alto Adige
5	35	MtF	High school	Employee	Friuli-Venezia Giulia
6	26	MtF	High school	Student	Abruzzo
7	46	MtF	Secondary school	Employee	Marche
8	32	MtF	Secondary school	Sex worker	Liguria
9	44	MtF	High school	Self-employed	Sardegna
10	33	MtF	High school	Self-employed	Toscana
11	42	MtF	High school	Employee	Puglia
12	31	MtF	High school	Employee	Piemonte
13	50	MtF	Secondary school	Sex worker	Emilia-Romagna
14	29	MtF	High school	Student	Sicilia
15	37	MtF	Secondary school	Sex worker	Veneto
16	59	MtF	Graduation	Self-employed	Lombardia
17	34	MtF	Graduation	Employee	Lazio
18	48	MtF	High school	Employee	Basilicata
19	41	MtF	High school	Employee	Calabria
20	35	FtM	Graduation	Freelance	Campania

Table 2- Socio-demographic data of the participants.

Three majors' themes emerged from the analysis: 1) obstacles, 2) role of family in TGD health and 3) training experience. TGD people build their personal formulas to resolve situations in a resolute manner.

3.1. Obstacles

The experiences lived and described by TGD people are defined as a set of difficulties that have often led to the search for alternative strategies, inherent to their health, outside the healthcare system. The majority of interviewees described negative experiences in contact with the healthcare context, regardless of their region of residence. The negative experiences concerned healthcare professionals and administrative staff…, describing these encounters as stigmatizing, dehumanizing, and/or alienating. At the same time, these experiences are intrinsically linked to barriers to health that TGD people encounter in accessing and using health services, and to an almost total lack of knowledge on the subject on the part of healthcare professionals.

> *"A doctor, during a visit, stared at me in a negative way. . . He got very irritated when I started talking…. I didn't feel at ease, on the contrary, I felt judged... Which disappointed me a lot. A health professional should be able to enter into a relationship with anyone, whether man, woman or TGD!" (Participant 6).*
>
> *"Even though the nurse was wearing gloves, it was felt that he could have, would have liked to be somewhere else instead of touching me" (Participant 7).*

While in greatest situations, the participants do not describe this kind of situations as transphobic approach, the emotional impact that this category of unfavorable state occasionally produces could provide to evading seeking new health encounters later on for fear of suffering similar situations of discomfort or even rejection.

> *"One of the things that most traumatizes a TGD person like me is the correct use of pronouns... It may seem trivial for cisgender people, but for those who have struggled since birth with an unsuitable body, and pronoun, it is devastating! And this opens the door to transphobia, even if unintentionally" (Participant 5).*
>
> *"Situations of this type pushed me, and I am the only one, to say "Well I won't go to hospital anymore, I will ask other people or go on the internet" (Participant 4).*
>
> *"A nurse clearly told me to stop acting like a man, because I was a woman... It really humiliated me!" (Participant 20).*

In all interviewees, the highly pathologized perception of the condition of being a TGD person is evident. What emerges, therefore, is a stigmatizing experience, in which the terminology used by healthcare professionals is almost always of a clinical nature.

> *“The real problem, and it is not only in Italy, because I know many Spanish and Eastern European TGD friends, concerns the fact that most healthcare professionals interpret our condition as an illness that requires an anamnesis, a diagnosis and even pharmacological treatment. It is not clear that we need psychological support, because of the traumas caused by society, and its binary vision, and not because being a TGD person is an illness. A TGD person is the same as all the others, we are like everyone else! We have some health and health "peculiarities", otherwise we are like EVERYONE!” (Participant 18).*

> *“I remember when I spoke to my primary care doctor about my transition journey and he, still calling me by my first name, said "Are you sick? I know a good psychiatrist who could treat your situation!” (Participant 16).*

In addition to the correct use of pronouns, TGD people highlighted, in totality, the problem of documentation from the identity card, health card, and the medical record itself, etc. not being able to take into account the "third gender". This translates into a constant request from healthcare personnel to keep their first name, and that of TGD people who would like to be called by the chosen name. Even if inside, some companies tend to write the name in brackets without any inconvenience, but in most cases, this happens in vain, since either the healthcare staff ignores the chosen name or gets confused and you end up using both names.

> *“It constantly happens to me in any health facility reception area (having many pathologies) that when I show my identity card, and my first name is in the male form, and seeing me dressed as a woman, there are shocked faces or restrained smiles, etc. It is a dehumanizing feeling not to be able to have a document that is immediately appropriate to the person's perceived gender!” (Participant 4).*

> *“The truth is this: health workers only see what is on a card, they don't care if you wear women's clothes, but if on the card you are a man, you are in everything and they treat you as such” (Participant 1).*

Furthermore, the interviewees described, with a certain similarity, the situation whereby, when they declared to the health professional, physician, nurse or other, that they were TGD people, creating a real situation and atmosphere of embarrassment and annoyance that is maintained for the entire duration of a visit, consultation, etc. This resulted, in some cases, in a real situation of anxiety and uncertainty, since the interviewees were unable to predict what the reaction of the doctor on duty could be.

> *“Every time I have to go to a doctor, I ask myself “will they be able to be friendly towards me?” Asking myself this question is real violence, because having anxiety about meeting a doctor is common to everyone but living in uncertainty as to whether or not I can be accepted for my gender identity is something truly painful” (Participant 2).*

Another type of difficulty, which is in fact experienced as a barrier, is represented by the frequent questions from healthcare professionals on issues relating to possible sex change in health situations. Although in some cases they are grateful for the interest shown by healthcare personnel in transgender issues, there is a certain degree of discomfort in having to explain or answers about their condition when the reason for the consultation is completely unrelated and distant from the topic. This form of "curiosity" was experienced by some interviewees as a real violation of privacy.

> *“I went for blood tests, because they had discovered hereditary hypercholesterolemia, and so all the children went for the test to see if we had it too. I went to a private laboratory to get the results quickly, and the nurse, seeing me dressed as a woman, with a man's identity document, without thinking asked me "Haven't you had the operation yet? Do you still have a penis?"... And 'It was mortifying, because she must have thought she was being inclusive and making me feel at ease, but instead the whole workshop fell on me out of shame” (Participant 9).*

Finally, with respect to this first section, the interviewees underlined the presence of a typically paternalistic behavior, in which the doctor does not place the TGD patient on an equal footing in the care and therapeutic relationship, but as a result of prejudices and poor training, according to participants, they make a TGD patient not feel understood. The initial evaluation of the patient may suffer if a proper history and physical examination are not performed. Above all, a TGD person, who already experiences his own body with conflict, in a less than inclusive situation, tends to feel his self-esteem reduced and experience various forms of discomfort.

> *“Even in the way a nurse wears personal protective equipment, I can detect appreciation or, as often happens, contempt and annoyance at having to come into contact with my body. Those who, since birth, live an experience of non-acceptance have an infallible clinical eye in detecting non-acceptance!” (Participant 17).*

> *“I have many moles, and since my mother had a melanoma, I should have frequent check-ups... believe me, I only did it once... because the cold and unempathetic request "undress" was followed by a long moment made up of glances with the nurse, of silences, as if I were some sort of bizarre creature, some sort of freak... It was embarrassing... but it wasn't the only time…” (Participant 3).*

3.2. The role of family in TGD health

The role of the family, in general, has a central role in the health of each individual, and therefore it would also have this in the case of TGD people, indeed perhaps more so, due to the well-known health needs. All participants recognized a central role in TGD health pathways.

> *“I think that having your parents and siblings close to you is essential to feeling good... I would have liked to have a united and present family…” (Participant 19).*
>
> *“The family, for a TGD person, should be the first home of health protection, I really like reading, and I know well the role that parents have, unfortunately not all families are able to understand all this. And this is the origin of all the barriers and obstacles that we encounter even outside the family context” (Participant 10).*

Some of the participants, however, underlined a total state of estrangement from the family of origin: either moving away or being removed from home, attributing to this situation a negative role on the economic management of TGD health, which requires a series of expenses and the support of healthcare costs that are not always easily accessible.

> *“When I said I felt like a woman, my father looked at me and turning to my mother saying “This being must leave my house IMMEDIATELY”... In less than two days I was removed from the house... and I started working as a sex worker to be able to support myself... This clearly made it difficult to manage my health from an economic point of view...Being a TGD person is a luxury” (Participant 8).*
>
> *“My family? There never was... I told my parents to feel like a woman with a letter that I left on the kitchen table the day I left... Since then, I have never heard from or seen them again... This resulted in a series of choices... like that of becoming a sex worker... I am aware that this job is also dangerous for my health... but how could I live? Nobody gave me work…” (Participant 10).*

Other interviewees, however, declared that they live in families that immediately accepted their choice. Giving them a central role in their life and health journeys.

> *"My father chose my name as a woman... They have always been there for every operation... My parents' embrace soothes every pain after an operation, even the bloodiest... And then they are the ones who pay the costs visits, travel, etc. I'm lucky…" (Participant 13).*
>
> *"My mother never abandoned me... she was there and always is... She even worked two jobs to help me financially to cover the healthcare costs for my transition" (Participant 14).*

3.3. Training experience

The poor training of healthcare professionals has been identified as the main cause not only of negative and unpleasant situations but also of real forms of aggression towards TGD people. These behaviors combined with the disinterest shown by some healthcare professionals, cause additional stress and anxiety in TGD people.

> *"When I went to a surgeon for the first time for preliminary assessments relating to gender reassignment, in addition to a generic hello, he only gave me a generic hello, and then gave me a pile of questionnaires to fill out, without explaining anything to me... It was embarrassing" (Participant 4).*
>
> *"When I asked for more details on the hormonal treatment, the somewhat annoyed doctor replied, "Everything you need to know is in the information brochure in your hand!"..." (Participant 2).*

Thus, poor relational competence on a social level impacts the health of TGD people and the development and maintenance of the care relationship. This involves, as stated by some participants, the progressive distancing from healthcare contexts, also opting for DIY solutions.

> *"These attitudes are a clear manifestation of the fact that they are not prepared regarding TGD health" (Participant 1).*
>
> *"It has often happened to me that for other health reasons, healthcare professionals have seen my genitals operated on, without even understanding the type of operation to which I had been subjected... It is clear that there is no training, let's say medical or psychosocial…" (Participant 12).*
>
> *"After a series of negative experiences, honestly for small things I prefer to go to Google and try to solve my problems... I'm tired of having to give too many explanations" (Participant 4).*

Due to situations of this kind, TGD people would prefer a patient-centered approach, in which they are an active part in the treatment process.

> *"It is preferable that they ask me direct questions... I would like to be asked what happened, who I am, etc. Rather than treat me coldly or distantly…" (Participant 12).*

Finally, all interviewees attributed the level of training of healthcare personnel regarding TGD health to be poor or even absent.

> *"The level of preparation of the healthcare professionals I met? In my opinion it is really low... But I realize that the training in this regard is also poor... I am a medical student and unfortunately in the study plan there is not a single exam on this dimension" (Participant 6).*

4. Discussion

The research evaluated the experience of TGD people within healthcare contexts. The results obtained are perfectly in line with current international literature, in which contact between TGD people and healthcare contexts appears to be negative, resulting in traumatic experiences which sometimes determine real barriers to health (Santander-Morillas et al., 2022). What was said so far forms the basis of health inequalities and inequities, caused by a lack of training of healthcare professionals in the area of TGD health, negatively impacting both the health of TGD people and the related the quality of healthcare services and their results. The interaction between TGD people and healthcare professionals was felt by participants as stigmatizing and not inclusive at all, posing important barriers to access to healthcare (Khozah and Nunu, 2023). In healthcare there are quite often several inequalities, and the results obtained seem to confirm these issues. In fact, Donisi et al. (2020) demonstrated that TGD people, and more in general, patients who fall within the LGBTQA+ world suffer greater health inequalities. Furthermore, Khalili et al. (2015) showed how in centers where education on health TGDs was performed, the number of cases of discrimination, relational difficulties, etc. was significantly lower. Furthermore, negative attitudes can even impact both the health status of TGD people and the quality of health services (Della Pelle et al., 2018).

The situation of being stigmatized, even in healthcare services, leads for TGD people to the feeling of mistrust towards healthcare services which make they think that sufficient and adequate provision has not been made treatments (Cannon et al., 2017), which is very harmful both in terms of research and treatment in this context, but the real risk of resorting to an informal network of non-validated and even dangerous treatments, as declared by the participants and others (Dubin et al., 2018).

All the participants included in this research claimed the issue the current healthcare pathways are lacking specific training on the issues relating to gender diversity and TGD health, favors forms of stigmatization, discrimination, and poor acceptance, partly also mediated by a society that is not sufficiently inclusive in this regard. Nevertheless, despite having been underlined by the Istituto Superiore di Sanità, the necessity of starting ad hoc training courses, in addition to a distance course, unfortunately nothing else has been done in Italy (https://www.iss.it/comunicatistampa//asset_publisher/fjTKmjJgSgdK/content/id/7190609, 24/01/2024).

This highlights the importance that new models of inclusion and protection of the health of TGD people are necessary. At this regard, a new model developed for the TGD health is related with the “Human Rights in Patient Care (HRPC) framework” and it refers to

“(…) the application of human rights principles to the context of patient care […]. HRPC builds up on international human rights law, as established in several international covenants, conventions, and charters, supporting rights that are relevant in the health care context, such as the right to liberty and security of person, the right to privacy and confidentiality, the right to information, the right to bodily integrity, the right to life, the right to the highest attainable standard of health, the right to freedom from torture and cruel, inhuman and degrading treatment, the right to participation in public policy, the right to non-discrimination and equality, and the right to remedy. HRPC establishes differences from a consumer-oriented patients’ rights approach and defines itself as complementary to bioethical perspectives focusing on “universal, legally recognized human rights principles, protecting both patients and providers The HRPC framework can be related to the Human Rights Based Approach to Health Care developed by WHO that aims at realizing the right to health and other health-related human rights (Suess Schwend, 2020, p.3).

Thus, the HRPC should be considered as an important reference for the TDG health (Suess Schwend, 2020).

Another issue stressed by the respondents concerned the paternalistic attitude especially of doctors, which has a negative impact on access to healthcare. In fact, it should be remembered that we speak of paternalism when a doctor prevails on a matter medical decision with respect to the patient's wishes for the sake of his well-being and safety (Dubin et al., 2018). Furthermore, an excessive paternalistic attitude has negative effects on access to care, and as already underlined, limits a patient centered vision, and above all the autonomy and choice of the TGD person (Coleman et al., 2022). This issue may be attributable to the reason why these behaviors based on paternalism are characteristic of a healthcare system that attributes total power to physicians, excluding patients not only in the treatment process but also excluding the possibility that they can provide his knowledge and experience, albeit profane, in the healthcare context (Santander-Morillas et al., 2022).

The results related to the perception of the level of training of healthcare personnel by TGD people, is in line both with the present quantitative research but also with FELGTBI +(Casas-Ramírez et al., 2023) study in which a very similar question was asked and 75.3% attributed a very low level of preparation. The shortage education on TGD health is not only evident from the present study conducted, but also from other studies and in other contexts and beyond (Casas-Ramírez et al., 2023).

Furthermore, education, as already highlighted, represents one of the main tools for reducing the barriers encountered by the TGD population (Coleman et al., 2022).

Likewise, different authors advocate the inclusion of specific training on the health of transgender people, as well as on the LGBTI population in general, in the educational system, with special emphasis on the curricula of university health sciences degrees. Improvements in the training of healthcare professionals at the university level should be linked to the review of issues related to the LGBTIQA+ community, aspects of sex education, gender identity, and assessment of the needs of groups at greater risk of suffering discrimination, as is the case for transgender people. In this manner, universities could be spaces in which to acquire a critical view of the social and normative context that questions concepts as deeply rooted as heteronormativity and the pathologization of all identities that do not comply with established social norms, in addition to condemning transphobic attitudes that, unfortunately, are too often repeated in the healthcare environment (Santander-Morillas et al., 2022, p.10).

Finally, the role of the family in TGD health should be discussed. Generally, Family has an important role in people's health, and it’s no coincidence that it is a founding element of the concept of bonding social capital (Costa, 2022), and “consists of networks, norms, relationships, values, and informal sanctions that shape the quantity and cooperative quality of a society's social interactions” (Aldridge et al. 2002, p.5). The present study is in line with those proposed in the qualitative study by von Doussa et al. (2015) which stressed the concern regarding the judgment of the family, regarding the perceived gender identity, and because the role of the family, in some cases, has led to abandoning the transition path; these authors also show that health and well-being of TGD people depends on positive relationships support from and for families experiencing gender transition of a family member. Another study is in line with the results of the present study, such as Singh and McKleroy (2011) in which the interviewees attributed a central role on the health and resilience capabilities of TGD people. Moreover, these authors highlighted the central role of family in the financial support necessary for the gender transition process. Some of the respondents in the present research highlighted how, without the support of their family members, they found themselves forced to face socioeconomic challenges such as: finding a home, being able to support themselves, etc. and without family financial support, sex work can offer a means of economic survival (Klein, 1999). Being a sex worker in turn exposes them to the risk of further health and social problems. Therefore, it is necessary to implement training on the path of acceptance, psychological, social and health needs also of the family members of TGD people (Bartholomaeus and Riggs, 2017).

4.1. Strengths and limitations of the study

This study has several limitations that should be acknowledged. First, it may be possible that some TGD people who were interested in taking part in the study did not accept to participate for the fear that it could negatively impact on the subsequent care they could receive from their healthcare professionals. To prevent this situation, it was clarified that the confidentiality of the data was ensured throughout the research process and that the personal data of the participants would be modified to guarantee anonymity. The type of sampling used could have included activist participants, and the data obtained may not reflect all TGD realities. Another limitation concerned the fact that it was only possible to include one FtM in the sample. Even so, an attempt was made to diversify the inclusion of participants as much as possible to reduce this limitation. Finally, the data obtained cannot be generalized, but they can be transferred to similar sociocultural contexts, which is the main characteristic of the methodology used.

5. Conclusions

This research underlines the need to act on the low satisfaction and health needs within different healthcare contexts experienced by TGD people. The experiences of this population regarding access to and use of the healthcare system led to a perception of inequality and discomfort, especially in the interaction with healthcare professionals. Furthermore, the healthcare system should be ameliorated in understanding and treating the peculiar and specific needs of TGD people to provide better healthcare services in the name of equity, quality, personalization and respect through an integration not only of knowledge but also of people. Thus, better education and training on TGD health is necessary to be provided first and foremost at university level, in order to act on the social dimension, and also in familiar contexts. In fact, the lack of adequate knowledge on TGD health on the part of healthcare workers causes barriers to health. Further research, development of care protocols guidelines, and training of healthcare personnel will be able to better perceive the reality of TGD people and adopt specific interventions to change and improve the care delivered to this population.

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Supplementary material 1

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	1
Credentials	2	What were the researcher’s credentials? E.g. PhD, MD	1
Occupation	3	What was their occupation at the time of the study?	1
Gender	4	Was the researcher male or female?	1
Experience and training	5	What experience or training did the researcher have?	5
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	N.A.
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	4
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	5
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	4-5
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	4
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	4
Sample size	12	How many participants were in the study?	7
Non-participation	13	How many people refused to participate or dropped out? Reasons?	N.A.

Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	4-5
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	NO
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	4-5
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	5
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	N-A.
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	5
Field notes	20	Were field notes made during and/or after the inter view or focus group?	N.A.
Duration	21	What was the duration of the inter views or focus group?	5
Data saturation	22	Was data saturation discussed?	5
Transcripts returned	23	Were transcripts returned to participants for comment?	N.A.