



Trans people perceptions of care received from healthcare professionals — A phenomenological study

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ABSTRACT

Introduction: Trans people have unique health needs and turn to the public health system to meet them. Offering them a more inclusive assistance requires health professionals to know these needs and work on cultural competence. Understanding trans people perceptions of service received will improve therapeutic relationships and the assistance provided to them.

Objective: To understand trans patients experiences with health care and their perception of care rendered by the Andalusian Public Health System.

Design: A qualitative phenomenological study according to Ricoeur's hermeneutic approach.

Methodology: 18 in-depth interviews were conducted between January and April 2022 with trans adult users of the Andalusian Public Health System. These interviews were audio recorded, transcribed and analyzed following the steps proposed by Tan. The Consolidated Criteria for Reporting Qualitative Research was used for writing the study report.

Results: Three themes were generated from trans patients experiences in the Andalusian Public Health System related to the assistance provided to them: 1) Positive and negative feelings during their pass through the public health system, 2) The importance of being able to receive the care they need, and 3) Having the chosen identity in official documents in order to utterly complete their transition.

Conclusion: Care rendered by healthcare professionals to trans people was received as positive in mostly cases. However, trans people think these professionals need more training in order to avoid some behaviors they perceive as discriminatory and which they believe tends to pathologize gender identity. They also require more information about the treatments in particular they are about to receive and they demand to end drug shortages. Administrative procedures to change identity are also problematic. So the healthcare system must undergo some modifications in order to become more inclusive.

1. Introduction

Around 33 % of trans people do not go to primary care clinics when they have health issues because they feel uncomfortable, and 48 % of them have felt discriminant or inadequate behaviors from the healthcare professional at some point [1]. The term “trans” includes “transgender”, “transsexual”, “gender-fluid” and other gender forms [2]. Although there is no official statistical data, it is estimated between 0.1 % and 2 % of the worldwide adult population to be identified as trans or non-binary [3]. In the United States of America, a recent study reveals 0.6 % of the population over 13 years of age identify themselves as transgender [4]. In Spain, there are no official statistics and the existing but no recent data emerge from trans people healthcare services demand [5], and reveal 4 % of the population identify themselves as transgender, non-binary/gender non-conforming/gender-fluid, or differently from above and from male or female [6].

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According to the Social Determinants of Health identified by the World Health Organization [7], there are some structural determinants of health inequality due to the socioeconomic and political context of people lives. These non-medical factors drive the unequal distribution of power and resources in society, which is based on certain systems of social categorization, including gender. Inequalities in these axes result in an unequal distribution to get material resources, employment and housing conditions, psychosocial factors, behavioral and biological factors, accessing healthcare systems, and service quality. Removing gender inequalities accessing resources would be one of the most important political steps towards gender equality in health [8].

Trans people usually deal with several health issues, which are mainly three: infection by human immunodeficiency virus [9], mental health issues [10–12], and risk habits, such as substance abuse [13]. Healthcare professionals can perform interventions in educational centers to improve mental health in lesbian, gay, trans, bisexual and intersex people [11,14]. Trans people need to have access to healthcare services in welcoming, positive, clinically appropriate, and culturally competent environments, without the common barriers between trans people and healthcare services [15–17]. These barriers include a lack of knowledge about these people health needs and the discomfort healthcare professionals usually feel when they have to provide care to them [18] together with lesbian, gay and transgender families particular needs [19,20] and the discrimination they have to face because of prejudices and stereotypes of healthcare professionals about their sexual practices, or by ignoring their specific health needs [21].

Different studies have used interventions conducted by nurses aimed to improve their cultural competence and that of the healthcare staff [22,23], their attitudes and knowledge about lesbian, gay, trans, bisexual and intersex people [24–26], and in order to avoid prejudices against them [27]. However, it is not clear that such interventions may help to change their beliefs about lesbian, gay, trans, bisexual and intersex people [28]. Therefore, healthcare study programs should include gender diversity and its specific needs [29].

The theoretical framework of this study is Queer theory [30], which emerged as a process of sexuality questioning as being classified into mutually excluding binary categories. There are many gender identity categories which are constantly changing in order to reflect the different realities that individuals and communities face in an endlessly evolving world.

In many cases, people reality not only include sexual orientation matters, but also those related to their bodies, along with identity notions [31]. To sum up, Queer theory states that: 1) sexual categories are less stable and unified than we thought, 2) sexual identity can be experienced as transitive and discontinuous, 3) the supposed stability of sexual identity depends on particular social contexts and practices — identity is built day by day—, and 4) the criteria of sexual categories belonging may and must be discussed [30]. This theory can be framed within a nursing model which is the Cultural Competence Model [32]. Cultural competence is a process that must be conducted, and it is the result of cultural awareness (the self-examination of one's own cultural and professional background), cultural knowledge (searching and obtaining process of a solid educational basis about different cultural groups), cultural skill (the ability to gather relevant cultural data related to someone's problem), cultural events (directly participating in intercultural interactions with people of different cultural origins) and a cultural desire (the motivation to participate in the process of being culturally aware and culturally capable of knowing). To develop cultural competence, a cultural humility —openness, self-awareness, ego absence and self-criticism generated after voluntary interactions with people from different cultures— attitude is required [33].

Healthcare professionals can create safe environments and provide respectful and inclusive assistance [34,35], and studies about lesbian, gay, trans, bisexual and intersex people health must be developed, which demands a particular training that should be included in study programs and ongoing training [21]. However, most healthcare professionals do not have the knowledge required and they are not familiarized with trans terminology [36]. Thus, it is very important that they know trans people perception of care received. This knowledge can help to implement actions improving the quality of the rendered care and it may also improve the therapeutic relationship between professionals and patients. Therefore, this study aims to answer the following research question: Which are trans people experiences in the Andalusian Public Healthcare System regarding the rendered care by healthcare professionals? The aim of the study was to understand trans patients experiences with health care and their perception of care rendered by the Andalusian Public Healthcare System.

2. Methodology

2.1. Study design

This was a phenomenological qualitative study based on Ricoeur's hermeneutic approach. Phenomenology is a movement that considers the intentionality and meaning of human behavior [37] which has found applications in Health Sciences generally, and in nursing and its specialties in particular. Understanding the meaning people assign to daily experiences lets us know which of these we should focus on to base the attention and care provided to them [38]. According to Ricoeur's phenomenological approach [39], understanding is reached through explanation. Text is a language that depends on reader's understanding [40]. To this end, a back and forth movement (hermeneutic arc) must be performed between each of the parts of the text and its completeness. In addition, text appropriation (explanation) must occur, and this requires the text and the research question to be related among other aspects [41].

2.2. Subjects and context

The study was carried out in Andalusia, a region located in the south of Spain. Subjects were trans people coming from the eight Andalusian provinces, recruited between November 2021 and February 2022. Andalusian Healthcare System is a public system and includes two trans people care units. One of them is specialized in minor assistance (under 14 years of age). These are cross-functional units (including endocrinologist, psychologist, nurse, surgeon, social worker and administrative staff). The system covers any type of

treatment the person needs. Inclusion criteria were the following: to be an adult trans person, to have received medical assistance in primary and specialized care units of the Andalusian Public Healthcare System, and to be eager to collaborate.

A purposeful sampling and snowball technique were conducted [42]. Contacts was made via social networks and through dissemination performed by different lesbian, gay, trans, bisexual and intersex associations and activists. Appointments were set with the people who responded to this call, in order to gather information. Recruitment was conducted by one of the researchers, who did not have any previous relationship with the subjects.

A total of 60 people was contacted. Five of them did not agree to enter the study because they did not have enough time or they did not want to reveal personal information. Others were excluded for not meeting the inclusion criteria. Eventually, study subjects were 18 people. Their sociodemographic characteristics are featured in Table 1.

2.3. Data collection

A total of 18 in-depth individual interviews were conducted by researchers (Ph.D.) who had experience in qualitative research. The interviews have a duration of 45–50 min. A provisional script was designed including questions leading to respond to the objectives set. This script was tested with three people to verify questions clarity and relevance. The necessary modifications were made; thus, the ultimate script was obtained. The interviews were conducted between March and April 2022 in a public space agreed upon or via video call. No additional people were present in the interviews. Table 2 shows interview protocol.

Since no new themes emerged from the data analysis, the researchers considered that data saturation to be reached [43].

2.4. Data analysis

The interviews were audio recorded and subsequently transcribed. Field notes were written down, especially focusing on non-verbal language, and they were incorporated into the data analysis. Subjects were given the opportunity to check interview transcripts in order to verify their accuracy.

An approach based on Ricoeur's hermeneutic phenomenology was used in the data interpretation and analysis processes. According to this approach, understanding is attained through the interpretation and explanation of a text [41]. To this end, three steps were followed. Firstly, a superficial reading was carried out to extract the text general meaning. This reading was done without considering neither the context nor the author, to extract an "explanation" based solely on a literal perception of what the text says. In a second step, a structural analysis was performed to obtain the meaning of the text. Its outcome is what Ricoeur describes as a naive understanding of the text [39]. Then, a thorough interpretation of the text was made [38] by two researchers using codes which were grouped into subthemes and then into themes. Lastly, all the information was presented in a report, analyzing the final result and verifying whether it matches the initial proposition of the study, including some examples extracted from the interviews and relating the analysis to the research objectives and the existing literature. This third step is done by a process of moving back and forth between explanation and understanding. The interpretation of this process is informed by the knowledge, experience and beliefs that researchers bring in this topic. It enhances an in-depth understanding of what the text says. The results were reported to subjects who were asked to verify them.

The software used for the data analysis was ATLAS. ti v7 for Windows (Scientific Software Development GmbH, Berlin, Germany). Table 3 shows some examples of the coding process.

Table 1
Sociodemographic characteristics of the subjects (n = 18).

Subject	Age	Gender	Education level	Year of transition initialization	City
P1	19	Transgender men	Higher	2021	Granada
P2	19	Transgender men	Secondary	2018	Granada
P3	30	Transgender woman	Higher	2021	Seville
P4	23	Transgender men	Secondary	2021	Granada
P5	27	Transgender woman	Higher	2021	Málaga
P6	26	Transgender men	Higher	2019	Jaén
P7	24	Transgender woman	Primary	2019	Sevilla
P8	20	Transgender men	Higher	2020	Granada
P9	23	Transgender men	Higher	2019	Córdoba
P10	22	Transgender men	Higher	2020	Almería
P11	24	Transgender men	Higher	2020	Huelva
P12	25	Transgender men	Higher	2021	Málaga
P13	18	Transgender woman	Secondary	2021	Granada
P14	27	Transgender men	Secondary	2020	Almería
P15	19	Transgender men	Higher	2019	Sevilla
P16	32	Transgender woman	Higher	2021	Sevilla
P17	30	Transgender woman	Higher	2011	Granada
P18	24	Transgender men	Higher	2019	Cádiz

Table 2
Interview protocol.

Stage of the interview	Topic	Question example
Presentation	Reasons Intentions	The idea that their perspective provides knowledge that must be globally known. Conducting a study aiming to show the real situation.
Starting point Development	Starting question Interview script	What was your journey in the Andalusian Public Healthcare System? In what units or services where you treated? How would you rate the behavior of healthcare professionals toward you? How did they make you feel? What about the treatment information they gave you? Tell me your experiences during the treatment you have followed and everything you consider important about it. Tell me about your experiences about the name change process.
Closing	Final question Acknowledgment Offering	Is there anything else you want to tell me? Thank you very much for your collaboration. Your contribution is very useful. I would like to remind you that you can call me or send me an e-mail if you have any questions.

Table 3
Example of the analytical process (from quote to theme).

Quote	Code	Unit of meaning	Subtheme	Theme
“He told me he needed to get more information before referring me to another unit. I had to get another appointment.” “In my opinion, they treated trans men better than trans women. They didn’t pressure them to undergo surgery.”	Problems with general practitioners. Delayed appointment. Attention to trans men. Attention to trans women. Equal treatment. Unequal treatment.	Problems in attention and processes at the clinics. Rendered care to trans men is different from that provided to trans women.	All their problems begin in primary care. Perception of a non-egalitarian treatment.	Positive and negative feelings during their pass through the public health system.
“Something as simple as to be called by a name I don’t identify with affects me, because these professionals are supposed to be used to avoiding this mistake.” “They briefly explained two types of treatments to me: the one with injections, which is the one I’m receiving, and that with gel or patches. But I knew there were more treatments, and they didn’t say anything about them.”	Uncomfortable situation. Inappropriate comment. Crying after visiting general practitioner. Feeling helpless. Pharmacological treatment. Lack of information. Course of treatment options.	Undesired situations and experiences that generate discomfort. Information they need about pharmacological and surgical treatments.	Emotional impact of the treatment received. Information as an essential element of care.	The importance of being able to receive the care they need.
“For health card it was very simple: I filled up a paper, sent it, and I got the new card in two weeks. But, for the identity card, it was a lot more difficult.”	Administrative bureaucracy. Health card change. Identity change.	Difficulties or easiness in modifying official documents.		Having the chosen identity in official documents.

2.5. Ethical considerations

The criteria of the Declaration of Helsinki were followed, and permission was obtained from the Ethics Committee of the University of Granada (reference: 2656/CEIH/2022). Data confidentiality and subject’s anonymity was preserved by replacing their names with an alphanumeric code. The data provided by the subjects were kept by the research team and it remained inaccessible to people who did not belong to the project. The study respected Regulation (EU) 2018/1725 of the European Parliament and of the Council of October 23, 2018 on the protection of natural persons with regard to the processing of personal data by the Union institutions, bodies, offices and agencies and on the free movement of such data, and repealing Regulation (EC) No 45/2001 and Decision No 1247/2002/EC.

Subjects were requested to sign an informed consent form before interviews, and they were fully informed about the study, specifying the voluntary nature of their entry, their freedom to leave the study whenever they wished to with no consequences, their anonymity, and their freedom to answer anything they wanted to in the interviews.

2.6. Scientific rigor

To ensure scientific rigor, we followed the criteria of Lincoln and Guba [44]: credibility (subjects had no previous relationship with research team, interviews were created with the contributions of other trans persons who did not enter the study, and transcripts were given back to subjects), transferability (the sociodemographic characteristics of the subjects were provided, as well as a detailed description of the context and of the methodology used), dependability (there is consistency between the study design, the data-collection methodology, and the data analysis conducted), and confirmability (transcripts were given back to confirm the results,

including verbatim quotes provided by subjects).

3. Results

Based on subject's perception, three themes were generated related to their experiences with care received in the Andalusian Public Healthcare System.

3.1. Positive and negative feelings during their pass through the public health system

For trans people, turning to the public health system when they need it is a problematic process. They know about the existence of these problems from previous experiences of other trans people and from information and advice received from associations they attend to request information. However, it is an unpleasant feeling that worsen their experiences when they have to go to the public health system.

3.1.1. All their problems begin in primary care

When subjects decided to go to the clinic in order to be referred by general practitioners to Trans People Care Unit, they continue to perceive a lack of knowledge about the existence of the units which they must be referred to. A trans person has to go through a process before deciding to start the transition. When this happens in primary medical care, is like a prelude of a stage full of problems. Their perceptions denoted the lack of information of healthcare personnel and of general practitioners in particular on how and where to refer trans people to. But this would indicate too that this kind of visit has less importance. This lack of knowledge is mainly related to the specialty unit trans people should to be referred to, depending on whether it is a trans woman or a trans man who requires specialized health care. Consequently, beginning the needed treatment in each case was delayed generating distress in these patients.

"My general practitioner was very lost in these matters. In fact, he didn't know there was a trans unit (...). He told me: 'I'll refer you to this other unit ... and they will tell you what must to be done ...' That made me lose trust in what he was doing." (P11).

3.1.2. Specialized units do not always offer the best care

Once the subjects go to Trans People Care Units —managed by endocrinologists— they usually waited about six months until they could begin the hormonal treatment. This because they have to perform a series of previous complementary tests and visits to other specialty areas. Consequently, the beginning of the intended treatment is delayed. This lapse of time is lived with a mixture of feelings, the joy of doing what they want and the impatience to start treatment as soon as possible. For these patients, the transition period has just started and they would like to accelerate the process to become the person they want to be.

"I went back to the endocrinologist months later with all the tests done, and she told me that everything was fine, and that we could start the treatment whenever I wanted. I was happy." (P8).

Subjects perceived they did not always receive the most appropriate care in these specialized units, although in some cases the specialist displayed a friendly behavior, calling the subjects by the name they chose, as well as good coordination and continuity of care. In these cases, they perceive they are receiving the care they need and the healthcare professionals adapt to their circumstances in an integral way. For a trans person, it is of great importance for healthcare professionals to see them as the person they want to be, not who they are at that moment.

"I was treated by a female doctor and she started asking me about my chosen name. So, she was the first person referring to me by my new name." (P16).

However, there were situations where general practitioners or specialists' behavior was considered distant or unpleasant. Although subjects were unable to identify if it was routine behavior or was only specially related to trans people: "*I felt respected, but I consider they were tactless and cold to me.*" (P13). Healthcare professionals even asked questions related to the pre-existing stigma about trans people —sexual relationships and practices, hobbies, and childhood experiences— which subjects found inappropriate. In these cases, trans people feel stigmatized in a health environment by professionals who must have the necessary training in order to avoid such situations.

"How many sexual relationships do you have every month? I don't understand why he asked me that and why he needed to know that ... Does it influence anything for the hormonal treatment that I wanted to do?" (P3).

In addition to Trans People Care Unit, other specialists which interviewed subjects referred to were gynecologists, urologists and mental health specialists. Subjects perceived these specialists tried to treat them properly, although they attended in a rush, either out of fear of doing or saying something offensive, or due to a lack of knowledge. However, their behavior was friendly and they named subjects by their chosen names. These are positive experiences for trans people in their transition process and they enhanced them to experience different and better quality of service.

"So, perhaps they are more careful with a trans person, because they might not know how to address us and they may make a mistake. It's understandable." (P15).

Subjects perceived healthcare professionals did not have enough information about the health needs of trans population. When

visiting these specialized units, they hope for the best information due to professional background in this field: *“I consider that they don't have enough knowledge and they lack a bit of professionalism, a bit of tact.”* (P13). In fact, they stated that this topic should be included in Health Science degrees, as well as healthcare professional's communication skills should improve. For trans people, a better knowledge and better communication skills would be useful for both professional and personal activity.

“I don't know if they devoted time to these things. But ... it would be good to have a course about sexuality and gender diversity, or something like that ...” (P8).

Nevertheless, younger healthcare professionals have a more suitable education in this topic, both technical and social knowledge, and communication skills. This fact was highlighted by trans people and brought them joy and tranquility when going to appointments. While it is obvious these professionals provided important services to subjects, it is potentially problematic these services rely on the age and the level of continuous training of a small number of professionals.

“Current generations are better prepared ...” (P17).

3.1.3. Perception of a non-egalitarian treatment

Subjects also perceived healthcare professional in these units do not render the same care to trans men than to trans women. From the interviews, it is understood that transgender men are treated with an attitude of consensus, but transgender women are treated with a more patronizing attitude: *“With trans men, they usually treat them differently ..., I don't know ..., as if they don't try to impose things on them ...”* Subjects also expressed the specialists tried to force them to undergo surgical or drug treatments when they did not want to, which they considered an interventionist attitude. For trans people, this fact reveals the gender gap existing in the treatment they received and the preconceived idea among health personnel of all trans people to want and desire surgically modify their genitals in order to feel their body fully suits the gender which they identify with. One more time, it was highlighted the stigma or false belief of trans people to want to modify their genitals to feel they have completed their transition, even among healthcare professionals.

“He treated trans men better than trans women. He tried to convince me to get a vaginoplasty, and I remember they even put me on the waiting list. I went to the appointment, but I said I didn't want to do it.” (P17).

3.2. The importance of being able to receive the care they need

Trans people perceived their health needs are often different from those of cisgender people. Not being able to satisfy these health needs in the public health system causes a series of emotions similar to those that people who have any other physical or mental health problem would feel. Hence the importance of the right response to health problems.

3.2.1. Emotional impact of the treatment received

The fact that trans and cis people are treated differently could be justified by the difference between health needs of each other. However, this should not result in a gap between how to attend and deal with trans and cis people: *“When I enter the doctor's office, they already assume I'm different because I'm trans. I'm not like any other young person, they have to know this.”* (P10). However, subjects perceived healthcare professionals continue to have prejudices which cause a discriminant behavior. This behavior still surprises and saddens trans people dealing with it. They think that due to the fact that they are specialized professionals in caring for trans people, they should have been got rid of prejudices and they have should developed the necessary cultural competence. Cultural competence appears to be a powerful tool for healthcare professionals that would help to provide a better and less discriminant care: *“Yes, I believe so, because, in the end, that prejudice is there.”* (P11).

Therefore, many subjects stated that they cried after attending a doctor's office at some point: *“That day, I cried immediately after I left the doctor's office.”* (P8). All this set of experiences with healthcare professionals can also affect trans people's emotions, making them feeling like they were sick. This is another stigma that trans people had until transsexuality was depathologized. Feeling sick people is a setback in a way that has been a lot of difficulties to be overcome: *“The nurse told me that we're very weak people.”* (P11). Considering that, trans people implement defensive mechanisms that prevent them from being emotionally affected by these comments, except in the case of disrespect. However, they stressed these situations should not occur because to a greater or lesser extent they affect their emotions. Attention should be paid to the emotional level of both trans and cisgender people. To do it, healthcare professionals have to keep an eye to the things they say or do. If not, trans people will perceive it as situations that not happen to patients who have other health problems.

“At the beginning, I was affected by everything they said to me, but now I don't care anymore. As long as they treat me politely.” (P2).

3.2.2. Information as an essential element in care

The information provided in the doctor's office about the pharmacological and surgical treatments available, as well as the different options, is usually considered complete. Nevertheless, subjects claimed they should receive more face-to-face information, instead of a document to read at home: *“He gave me a lot of papers about things that could happen, so I would read them.”* (P8). Trans people place greater value on information transmitted personally and verbally because it allows them to clear up doubts and questions about

treatments. Moreover, when information came from healthcare professionals, it generates a feeling of safety and a sense of peace of mind. They also perceive the care they are being offered is the most appropriate and it is customized to meet their needs. But they require more information about treatments sides effects and waiting lists. These are two of the aspects they appeared to have more doubts about and they consider them as very relevant in their transition process:

“They explained the types of treatments to me. They explained the puncture, the gel, and the patches. But I know there’s more, and they didn’t tell me anything else.” (P2).

Consequently, subjects asked other trans people who had already gone through that process, in order to know their experience and the treatments they had received. Trans people who have already had these experiences, as well as associations of trans people or the lesbian, gay, trans, bisexual and intersex group, are benchmarks for those who want to receive information. Trans people starting the process have the perception that these examples are very important and they really appreciated them. Previous experiences of other people allow them to get an approximate idea of the time required to complete the treatment, and bring the opportunity to anticipate problems that may occur in the process.

“I received more information from other people than from my endocrinologist in the healthcare system. There were things about which nobody informed me.” (P10).

Once the pharmacological treatment started, drug shortage may occur. If this happens, new problems arise in trying to contact the endocrinologist to ask about an alternative. These situations of not knowing what to do are very stressful and cause a lot of doubts that need to be solved as soon as possible. According to subjects’ opinions, the existence of a telephone number to get immediate assistance without an appointment would be very useful in order to rapidly solve these situations.

“There has been a shortage on several occasions, and if you can’t contact the endocrinologist when this happens, this affects you, because it seems that the entire process stops. This is very scary.” (P10).

In the same way, these situations can generate hormonal imbalance and anxiety which are perceived as a step backwards regarding the objective pursued: *“The next month I got my period. I got worried and I didn’t know what to do.”* (P8).

3.3. Having the chosen identity in official documents in order to utterly complete their transition

Changing name in the healthcare system card is easy, and subjects had a good experience in this regard. Being able to have an identity health card that matches their gender by completing a simple bureaucratic procedure gives trans people great joy and is perceived as another step towards being recognized as the people they feel they are. It represents an important milestone in the transition process. So, they think having their personal documents with their chosen identity should be a right.

“For the healthcare card, this was very simple. I just filled up a paper, sent it, and I got my new card two weeks after.” (P13).

Changing name in the National Identification Document was a different thing and usually a negative one due to the excessive paperwork and the time required [*“... it can take up to four months or even longer, because a lot of documents are needed, and gathering them takes a very long time.”* (P13)], since civil workers do not address them by their chosen names according to the gender they identify with [*“They never treated me well; I always came out crying...”* (P7)], and because some documents still show a “disorder” diagnosis which makes them feel that they are sick people [*“... the documents still say that I have a disorder.”* (P15)]. This is one of the great barriers to face in order to have the identity they want to have, and it occurs when obtaining the official document which recognizes them as a natural person with rights and obligations.

4. Discussion

This study aimed to understand trans people perception regarding care received from healthcare professionals of the Andalusian Public Healthcare System. Results show a generally positive perception, although it could be improved, especially focusing in professional training in terms of gender diversity. Subjects also stated healthcare staff should provide more information and display a friendly behavior that respects their identity. Moreover, subjects highlighted the long wait before treatments and the excessive paperwork after making the decision of undergoing the transition. All of the above have a negative impact on trans people.

First barrier is primary care which is the first step for trans people to access the specialized units. Healthcare professionals lack the necessary information about where to refer trans patients to, which has also been reported in a different study conducted with Andalusian healthcare professionals [45]. However, this region has specific guidelines for medical care to trans people [46,47]. This care must begin in primary care which is the gateway to the rest of the system and it can be provided regardless of the primary care model too [48].

Next step is beginning treatments. It is need approximately 6 months since a trans patient visits Trans People Care Unit for the first time until they get a specific treatment. This period matches the one indicated in the study of Castillo and Cuadrado [45]. In these specialized units, although care received from healthcare professional is mainly perceived as courteous, respecting both the name and the pronouns the patient chooses, they are still asked questions that stigmatize them. This aspect agrees with findings reported by the FELGTBI+ (State Federation of Lesbians, Gays, Trans, Bisexuals, Intersex and plus) [1], which also pointed out trans people had to answer questions related to their sexual orientation, their sexual practices and the potential existence of childhood trauma.

Similarly, in these specialized units, subjects perceived a different behavior from healthcare professionals regarding trans people who wish to undergo sex reassignment surgery and those who prefer not to do it. In fact, 31.7 % of trans people have been pressured to do surgery at some point [1]. The decision of not undergoing surgery is aligned to other studies results, in which one third of trans people did not want to undergo sex reassignment surgery [49–51]. There may be barriers of availability and accessibility to this surgical technique and social pressure not to do it, as well as personal considerations which are not vital to recognize oneself with the felt gender [52].

Identically, healthcare professionals who work in these specialized units continue to have prejudices boosting discriminant behaviors, despite the fact that younger professionals use to have better training [53]. However, literature reveals discrimination has also been perceived in primary care [54,55]. These behaviors make young trans people to face feelings of gender incongruence, fear and vulnerability accessing health care [56], as well as emotional affectation and mental health problems, according to subjects of this and other studies [57,58].

When trans people turn to specialized doctors, they observe a rush in attention, possibly because there is a lack of information among the healthcare professionals. This fact was highlighted in a study conducted with nurses, who recognized they felt uncomfortable when they had to assist trans people since they did not know the pronoun to use when talking to them, the restroom to use or even what exactly a trans person is [18]. The lack of information among healthcare professionals about the right care to trans people and their health needs has been reported in different studies [20,59–61]. However, younger generations of healthcare professionals show greater knowledge in this regard [1], although differences persist among university curricula [53]. A mistrust towards healthcare system and its professionals might be generated [62] due to this disinformation, as well as a negative impact on the physical and mental health of lesbian, gay, trans, bisexual and intersex people, especially in those who are younger, since it is perceived as a disrespectful behavior that underestimates their ability to self-define at a young age [63].

A cisnormative approach is usually use in healthcare systems design, so lesbian, gay, trans, bisexual and intersex people perceive healthcare spaces to be exclusive. To prevent it, this people search, create, use and share information through new technologies [64]. However, the design can be changed, as shown in Health4LGBTI study [65] and project QI [66] results, and may help healthcare professionals to improve their cultural competence and to promote inclusive care. Guaranteeing safe and inclusive healthcare services will encourage trans people to use them [35]. Healthcare professionals must be warm, honest, respectful and trustworthy, and they are required to develop the necessary cultural competence to provide a holistic response to trans people needs and their families [67].

Subjects claimed they should receive more face-to-face information about hormonal treatments. And is this very lack of information which lead them to asked associations or other people who have undergone the process, as was reported by the FELGTBI + [1]. The shortage of hormonal treatments has also been reported in previous studies [68,69], and it is considered by the European Court of Human Rights as a way of discrimination, according to the Legislative Proposal for the Real and Effective Equality of Trans Persons and for the Guarantee of the Rights of Lesbian, Gay, Trans, Bisexual and Intersex Persons (LGTBI), which is currently being processed in Spain [70]. In addition to all the above-mentioned barriers, COVID-19 pandemic has also had an impact and has hindered access to treatments for gender modification, mental health and even the medical assistance related to COVID-19 itself [71].

Administrative paperwork for trans people to modify their identity documents is one of the negative experiences highlighted in the study, especially the process related to identity card. Eradicating this problem is another objective of the previously mentioned legislative proposal [70]. According to the World Health Organization [72], not having access to identity documents with the chosen gender is a way of inequality that may cause health problems, as well as a way of discrimination according to the United Nations [73]. Thus, there is a relationship between not having identity documents with the chosen gender and mental health problems, such as suicidal ideation and other mental disorders [74,75].

By means of education, research and cultural competence nurses and healthcare professionals may help clinics to become more inclusive so trans people consider healthcare system as a reliable health resource adapted to their health needs, and to ensure that healthcare professionals feel more confident to provide culturally adapted and inclusive attention and care.

This study shows a solid methodological congruence between objective, study design and data analysis. Subjects from the entire region of Andalusia were included, and all of them were treated in the public health system exclusively (both primary care and specialized care). Except for one, all of them started their transition in the last five years and the process still continues. So, it is a hard and recent experience of life for them.

5. Limitations

The first limitation of the study is that it was conducted in the region of Andalusia (Spain), specifically in the public hospitals of the Andalusian Health System. However, the results show coherence with studies carried out in other geographical areas. The second limitation is subjects age bias, all around 30 years of age or below; however, they provide more recent insights of health care received by trans people who have started their transition process in the last years. Each subject was only interviewed once. Conducting interviews with each subject at different moments of the process could have deliver different results. The project will continue focusing on different professional categories, since there are no specific studies in this regard about the Andalusian Public Healthcare System.

6. Conclusion

Trans people experiences about care received from healthcare professionals of the Andalusian Public Healthcare System, both in primary and specialized care, are mostly positive, although they believe these professionals need further training about trans people health needs in order to display a friendlier behavior and to attain a comfortable doctor-patient relationship, as well as to eradicate

gender identity pathologizing. Trans people demand healthcare professionals to give them all the information they need about the potential course of treatments they can follow, since they are supposed to be people specifically trained to do so. In addition, delays before initiating the pharmacological treatment and drug shortages generate concern and are experienced as going backwards in the process. The Andalusian Public Healthcare System easily provides a mechanism to change name in health cards, but this is not the case when dealing with public administrations, resulting in long and tedious processes which have an emotional impact on patients.

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Data availability statement

The data that has been used is confidential. Data associated with this study hasn't been deposited into a publicly available repository.

CRedit authorship contribution statement

Margarita Casas-Ramírez: Writing - review & editing, Writing - original draft, Visualization, Validation, Software, Resources, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Jose Manuel Martínez-Linares:** Writing - review & editing, Writing - original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Olga María López-Entrambasaguas:** Writing - review & editing, Writing - original draft, Visualization, Software, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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