- Copyright - Il Pensiero Scientifico Editore downloaded by IP 18.97.9.173 Wed, 09 Sep 2026, 12:30:46

Ital J Gender-Specific Med 2019; 5(3): 123-130

Psychosocial issues in transgender health and barriers to healthcare

Olivia Fiorilli[1], Angela Ruocco[2]

[1]Cermes 3, Paris, France; [2]Italian National Institute of Health, Rome, Italy. *Received 31 January 2019; accepted 9 May 2019*

Summary. This article aims to review critical issues in the global health of transgender and gender diverse people with a particular focus on the Italian context. Trans identities and experiences have long been pathologized. Pathologization is a form of structural stigma. In many countries, including Italy, having a trans-related mental health diagnosis is still a requisite for having one gender and name changed in identity documents and for accessing gender-affirming treatments, even though important changes are taking place, with the WHO's International Classification of Diseases - ICD-11 - erasing trans-related diagnosis from the "Mental and behavioral disorders" and substituting them with the category of gender incongruence in the new chapter "Conditions related to sexual health". Trans people face social and familial rejection, as well as discrimination in housing, employment, education, and social services. Those intersecting forms of oppression and discrimination have a negative effect on their health. Trans people often experience overt discrimination and hostility in healthcare settings and face structural and interpersonal barriers in the access to general and gender-affirming healthcare. While trans people are as concerned as their cisgender counterparts by the need for sexual and reproductive health services, they face multiple barriers in accessing them. More research conducted as part of a meaningful collaboration with community stakeholders and organizations is needed on important areas of trans people's general health, as well as on the optimal content and models of service provision.

Key words. Transgender, stigma, social determinants of health, health inequalities, barriers to health.

Problemi psicosociali nella salute dei transgender e ostacoli nell'accesso ai servizi sanitari

Riassunto. Questa review si focalizza sulle criticità concernenti la salute globale delle persone trans in particolare nel contesto italiano. Le identità e esperienze trans sono state a lungo patologizzate. La patologizzazione rappresenta una forma di stigma strutturale. In molti paesi, Italia compresa, avere una diagnosi di salute mentale trans-correlata è ancora oggi necessario per modificare i dati anagrafici e avere accesso ai trattamenti ormonali e chirurgici di affermazione di genere, nonostante importanti cambiamenti potrebbero avere luogo in seguito alle modifiche apportate nella nuova versione dell'International Classification of Diseases (ICD-11) dell'OMS, nel quale le diagnosi trans sono state eliminate dal capitolo riservato alla salute mentale e sostituite dalla categoria "Incongruenza di genere" nel nuovo capitolo consacrato alla salute sessuale. Le persone trans affrontano rifiuto sociale e familiare e discriminazioni in materia di alloggio, lavoro, istruzione, servizi sociali. Stigma e marginalizzazione sociale hanno un effetto negativo sulla salute. Inoltre le persone trans subiscono spesso discriminazione e ostilità nel contesto sanitario e incontrano barriere strutturali e interpersonali nell'accesso ai servizi di salute. Sono necessarie ulteriori ricerche in importanti aree della salute generale delle persone trans, nonché sul contenuto e sui modelli ottimali della fornitura di servizi. È fondamentale che queste ricerche si sviluppino in collaborazione con le persone trans e le loro organizzazioni.

Parole chiave. Transgender, stigma, determinanti sociali di salute, disparità sanitarie, barriere nell'accesso alla salute.

Introduction

This article aims to review critical issues concerning the global health of transgender and gender diverse people — a gender minority who face formidable health inequalities — with particular attention on the Italian setting. We focus on issues concerning adult trans and gender-diverse people. Important issues concerning childhood and adolescence are outside the scope of this brief review. Transgender and trans are umbrella terms used to refer to people whose gender identity differs from the gender they were assigned at birth. People whose lived gender does not differ from the one assigned at birth are referred to as cisgender. Trans and other gender diverse people (i.e. those people who do not identify as male/female or are gender-nonconforming but do not necessarily identify as transgender) express their gender and define their gender identities in a variety of ways: e.g. man, woman, trans man, trans woman, non-binary, gender-queer, gender-fluid, etc. Terminology evolves rapidly and is culturally and geographically contingent. It is important to use a non-pathologizing and gender affirmative language, especially in healthcare contexts. Gender identity is not the same as sexual orientation. Trans people — just like cisgender people — can have any sexual orientation. Some trans and gender-

- Copyright - Il Pensiero Scientifico Editore downloaded by IP 18.97.9.173 Wed, 09 Sep 2026, 12:30:46

diverse people might socially transition (e.g., change name, and/or pronoun and/or gender expression), legally transition (change gender marker/name on identity documentation) and/or medically transition (modify their bodies through 'masculinizing' and 'feminizing' hormonal treatments and/or surgery; all of these procedures are known as gender-affirming treatments*). It is important to note that not all trans people medically transition and some trans people only access hormonal treatments and/or some, but not necessarily all, available gender-affirming surgeries: gender transitions are individual and diverse processes.

Trans identities and experiences have long been pathologized. With the term 'trans pathologization' we refer to the appraisal of trans identities along with the need for gendered body modifications as 'pathological' (http://stp2012.info/). Since the 1960s trans-related diagnoses have been listed in the International Classification of Diseases and Related Health Problems (ICD) and in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Nevertheless, thanks to trans organizations' advocacy, important changes are taking place and the medical community has recognized that gender nonconformity is not a 'disorder'[1]. As shown by a vast amount of literature, pathologization represents a form of structural stigma[2] that has legal, social and health consequences for trans and gender-diverse people[3]. In many countries, including Italy, having a trans-related mental health diagnosis (as well as having undergone some gender-affirming treatments) is still a requisite for having one gender and name changed in identity documents: something that is criticized by trans activists and medical organizations[4] as a breach of trans people's human rights. Furthermore, in order to access gender-affirming treatments, a diagnosis of gender dysphoria is generally required, although this is not the case in a number of different settings and countries[5,6]. Gender dysphoria (GD) is the diagnostic category currently used to refer to the "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth"[1] that might be experienced by some trans people. In an attempt to mitigate trans pathologization, the category of "gender dysphoria" has been included in the DSM-V to replace "gender identity disorder"[7]. Nevertheless, this category (and its inclusion in the DSM) is strongly criticized because it continues to pathologize the need for gendered body modifications in trans people (http://stp2012.info/; https://tgeu.org/)[7]. "Gender identity disorders" have also been removed from the chapter "Mental and behavioral disorders" of the 11th edition of the ICD, approved by the World Health Assembly in 2019. The category of gender incongruence (of adolescence/adulthood and of childhood) substitutes the older diagnoses and is located in a new chapter "Conditions related to sexual health". Although this change is a step forward towards the depathologization of trans identities and expression, important concerns over gender incongruence categories persist (http://stp2012.info/; https://tgeu.org/). More broadly, many practitioners and trans health advocates question the very use of diagnoses in gender transition services. The fact that access to these services depends on diagnostic evaluation is considered part of the broader phenomenon of trans pathologization. Indeed, different models of trans-specific healthcare that do not rely on diagnostic evaluation for initiating treatment, particularly hormonal treatment, such as the 'informed consent model' are now applied in different parts of the world[5,6,8,9]. The 'informed consent model' puts emphasis on the capability of service users to choose their options once they have been informed of their implications, providing the possibility to seek treatment without requiring external evaluation[10].

The general health of transgender people

As consistently shown by international literature, transgender people around the world face multiple and intersecting forms of oppression and discrimination including stigma, pathologization and violence, as well as social and economic marginalization. Trans people face social and familial rejection as well as discrimination in housing, employment, education, social and healthcare services[11,12]. The intersection of transphobia and cisnormativity with other forms of oppression like racism make some segments of the trans and gender-diverse population even more vulnerable to marginalization[11]. As far as Italy is concerned, a study of the European Agency for Fundamental Rights has shown that trans people experience high rates of discrimination in education (23%) and employment (43% when looking for it and 22% in the workplace). Trans people are over-represented in the lowest income quartile (33%). Stigma is also high, 51% of respondents reported discrimination

* In the literature published in English "gender-affirming treatments/surgery" has now almost completely superseded the term "sex/gender-reassignment treatments/surgery", which is considered to be problematic, disrespectful and inaccurate. Indeed, it has now been established that hormonal and surgical treatments do not "reassign" the sex/gender of an individual, rather they help him/her/them to better express, "affirm", his/her/their gender: hence the term "gender-affirming". In Italy, the term "*riassegnazione di genere*" [gender-reassignment] or "*riassegnazione sessuale*" [sexual reassignment] are still commonly used; however, these terms present the same problem as the English equivalent "sex/gender reassignment". In the Italian abstract, we have therefore opted to use the term "*trattamenti di affermazione di genere*" [gender-affirming treatments] as, despite being less familiar to the Italian-speaking public, it renders the above concepts in a more accurate manner.

- Copyright - Il Pensiero Scientifico Editore downloaded by IP 18.97.9.173 Wed, 09 Sep 2026, 12:30:46

or harassment on the grounds of being trans in the 12 months preceding the survey[12]. Marginalization is even stronger for those trans people who experience intersecting forms of stigma and structural oppression such as trans people of color, migrants and sex workers[13]. Italy has the highest number of trans people murdered in the EU. Most of the victims are migrant trans women sex workers[14]. Finally, trans people, are often victims of microaggressions, i.e. subtle forms of discrimination in which brief, daily, behavioral, verbal, or environmental injustices occur[15]. One of the most common forms of microaggression experienced by trans people is 'misgendering' i.e. referring to a person using an incorrect pronoun/name.

All these factors are social determinants of ill health[16] that negatively affect the general health of trans people. An Italian study[17] showed that social status is the primary determinant of premature mortality. The most relevant social aspects related to premature mortality are availability of a work and a family network, level of education and material resources; as we have seen, access to these resources is restricted for trans people. Not surprisingly, trans people worldwide are burdened by substantial adverse health indicators, as consistently shown in the literature[18]. As shown in a review by White Hugtho and colleagues, stigma – be it structural, interpersonal or individual (see the glossary at the end of the article) – is a fundamental cause of ill health in the trans population, firstly, because it directly induces stress (a key driver for morbidity and mortality), and secondly, because it restricts access to health protection resources[2]. Surprisingly, though, there is a dearth of literature that examines the link between social exclusion, anti-transgender stigma and trans people health[18]. Literature has shown the negative effects of stigma on mental health through the mobilization of the minority stress model[19,20]. Recent studies in Italy found that discrimination and internalized stigma are associated with negative mental health outcomes like depression, anxiety, and suicidal ideation[21,22]. Another area where the link between stigma and adverse health has been explored is research on HIV. Literature consistently shows that trans people, particularly those in the feminine spectrum, carry a significantly higher burden of HIV infection and other sexually-transmitted infections[23]. Stigma, marginalization and lack of gender affirmation that can lead to HIV-related vulnerabilities (e.g. risk behavior as coping mechanisms) are core drivers of HIV risk for trans people[24]. Trans people continue to be a highly stigmatized and under-resourced population both in clinical care and HIV prevention services[24], as well as in research. The dearth of literature on interactions between antiretrovirals and hormone regimens used in gender transitions is one example[25]. In general, research is lacking on the interaction between gender affirming treatments and other medical treatments. Finally, research is starting to delve into the physical health implications of transitioning-related stress[26], but the psychobiological link between minority stress and physical health is still an understudied area.

Indeed, recent reviews suggest that the general health of trans people is still the least researched area in transgender health[19,27]. Historically, transgender health has only been considered through the prism of pathologization. Not surprisingly, literature has over-focused on gender affirming treatments and mental health[27], whereas crucial areas such as cancer, cardiovascular, metabolic and degenerative diseases and others have remained under-researched[19].

Barriers to healthcare

Trans people face enormous barriers in accessing appropriate and equitable health care and are a medically-underserved population in both primary and tertiary care settings. Trans people experience more unmet health care needs than their cisgender counterparts[28,29]. Barriers to healthcare are multifactorial and have social, interpersonal and structural dimensions[30]. Trans people often experience overt discrimination and hostility in healthcare settings[31]. Experiences of discrimination or fear of victimization can lead trans people to avoid or postpone care[32]. As regards Italy, a recent study found out that 17% of respondents had experienced discrimination by healthcare personnel in the previous 12 months[13]. Facing inappropriate curiosity, having one's specific needs ignored and being pressured/forced to undergo medical or psychological tests were the most commonly reported experiences[13]. Previous research on European countries including Italy reported that 25% of respondents had been refused care because a practitioner did not approve of gender transition[33]. Though treating trans patients does not require specialization, providers often lack basic knowledge about trans people and their needs. In actual fact, the lack of sensitive and knowledgeable health providers and of information on trans service users' specific needs are often cited as fundamental barriers to healthcare for trans people[34,35] even by practitioners themselves[36]. International studies have shown a lack of LGBT-related curricular content in medical schools[37]. In Italy, trans health issues aren't generally addressed in medical curricula except under the heading of 'gender dysphoria'. This might foster the misleading idea that being trans is a health problem *per se* or that any health problem experienced by trans people is related to their trans status[35]. As a consequence, many health professionals are not informed about trans health issues. This creates a barrier in the access to care for trans service users: research has shown that even in contexts of universal health coverage

- Copyright - Il Pensiero Scientifico Editore downloaded by IP 18.97.9.173 Wed, 09 Sep 2026, 12:30:46

trans people are less likely to have a regular family physician or report discomfort when discussing trans specific issues with practitioners[38]. The lack of knowledge regarding trans issues combined with the assumption that such knowledge does not exist was described by Bauer and colleagues as a form of informational erasure[35]. A similar kind of erasure of trans needs and specificities is mirrored at an institutional level, where policies to accommodate trans patients are non-existent[35]. In Italy, as in other countries, this kind of institutional erasure takes different forms. For instance, healthcare facilities do not usually recognize trans people's gender identity on intake forms and hospitalization policies (e.g. transmen and transmasculine people are often hospitalized in women wards and vice versa, intake forms do not allow service users to self-identify), in spite of the evidence that gender affirmation is a crucial determinant of health for trans people[24]. Furthermore, institutional erasure is evident in the fact that medical record and billing/coding systems are designed in a way that does not consider trans people's genders and embodiments, as they assume a concordance between a given gender and a certain set of body parts. As a consequence, access to consultations and tests that are considered 'gender-specific' (e.g. gynecological or urological consultations) is barred for some trans people. In a similar way, trans people who have changed their legal gender are excluded from screening for diseases that are coded as 'gender-specific' (e.g. prostate cancer screening for transfeminine people or cervical cancer screening for transmasculine people).

Barriers to gender-affirming healthcare

Trans people also face a number of barriers even with regard to access to gender-affirming treatments. This is particularly alarming given that international literature shows that structural and social barriers which impede or delay access to transition-related care can have a negative impact on physical and mental health for trans people. Conversely, access to transition-related care when needed is a protective factor for health risks[40] and is associated with decreases in suicide and self-harm risk[39,41,42].

Barriers to gender-affirming healthcare are structural and interpersonal[30]. A dearth of knowledgeable providers willing to provide affirmative care has been documented in many European countries, including Italy[10,12,33]. General practitioners are among the least knowledgeable and sensitive providers in this domain[12]. This is particularly concerning given that hormone treatments are best undertaken in the context of primary care[1]. In many countries, trans people are less likely to have health insurance and many insurance policies do not cover trans-related healthcare[29]. Financial barriers can exist even in countries that provide universal coverage and where public healthcare is free of charge at the point of service. For instance, in Italy, hormonal treatments are prescribed off-label and refunded only in a few Regions/facilities. A dearth of knowledgeable providers and geographical inequalities are also a financial barrier to trans healthcare in Italy. Furthermore, while gender-affirming surgery is covered by the NHS, accessing it actually has a cost for trans service users. Based on Law 164/82, access to gender-affirming surgery must be authorized by a court of law on the basis of solid medical and psychological documentation that can have a considerable cost. This represents a strong financial burden, especially for a population that suffers from economic marginalization. Furthermore, the fact that access to gender-affirming surgery requires authorization by a judge increases waiting times for surgery. The long waiting times for surgery in the public sector (e.g. 12 months or more) is also due to institutional constraints and a dearth of experienced surgeons trained for trans-specific genital surgery. Few are willing to practice non trans-specific surgeries like oophorectomy, hysterectomy or bilateral mastectomy on trans patients for the purpose of gender affirmation. Furthermore, there is anecdotal evidence that service users face difficulties in finding post-surgical care in the presence of complications, which are frequent in gender-affirming genital surgery[43,44].

Despite the burgeoning literature on trans experience of general health services, there is a dearth of research on trans people's experiences with transition-related services. Existing literature provides alarming data. A UK study on trans experiences with gender identity services showed that 46% of the respondents experienced difficulties obtaining the treatment/assistance needed[45]. Barriers to quality care might also arise from the way trans healthcare is organized[46]. Some trans organizations, service users and health professionals question the fact that access to gender affirming procedures in many countries is conditional to authorization by a mental health professional and in some cases (as in some centers in Italy) on psychotherapy[8-10]. Mental health professionals' 'gatekeeping' is questioned for a number of reasons, including the fact that it limits service users' autonomy while not granting a better care outcome, as shown in a 2011 study[47]. Furthermore, it might represent an obstacle to a trusting therapeutic relationship and have a negative impact on service users' health and on their ability to receive care. Research on trans people's experience of gender identity services in the UK has shown that 62% of the respondents reported feeling emotionally distressed or worried about their mental health whilst attending a gender identity clinic and 53% felt that they were not able to discuss these concerns for fear of jeopardizing access to gender-affirming treatments and some had lied or withheld information for the same reason[41,45].

- Copyright - Il Pensiero Scientifico Editore downloaded by IP 18.97.9.173 Wed, 09 Sep 2026, 12:30:46

Sexual and reproductive health

Trans people's sexual and reproductive health is an area of particular concern. Despite a relatively vast amount of research on HIV and STIs, sexual and reproductive health has been relatively marginal in medical literature on transgender health[27]. Although trans people are as concerned as their cisgender counterparts by the need for sexual and reproductive health services including contraception, abortion, screening for STI and reproductive diseases, they face multiple barriers to accessing them[48-50]. Barriers arise from a lack of consideration of the specificities of trans embodiments and also from the fact that sexual and reproductive health services are often not ready to offer gender affirmative care for their trans users. Nevertheless, many recommendations exist that can help providers to offer more trans-inclusive services[48,51-53]. Sex education rarely acknowledge trans people's specificities. Existing information on sexual health for trans people is not easily available[54]. Although trans people, like anyone else, can have or desire to have children either before or after transitioning, for a long time sterility has been considered as the 'price to pay' for transitioning[55,56]. In many countries, sterilization is considered a requisite for legal gender change. Nevertheless, in 2017, the European Court of Human Rights ruled that requiring sterilization for legal gender recognition violates human rights. In Italy, for a long time jurisprudence considered sterilizing genital surgeries as a requisite for gender recognition. In 2015, the Supreme Court and the Constitutional Court ruled that surgery cannot be a requisite for gender recognition; nevertheless, the translation of this verdict into jurisprudence is still non-homogeneous. Most gender affirming genital surgeries (e.g. vaginoplasty, phalloplasty) have a sterilizing effect[57]. Nevertheless, some sterilizing surgery routinely practiced within the frame of medical transitions might be undertaken for reasons other than gender affirmation. A US-based study published in 2010 showed that for the majority of participants who underwent hysterectomy and oophorectomy, prevention was the 'number one reason'[58], despite the fact that there is no evidence that gender-affirming hormonal treatments increase reproductive cancer risk[59]. Fertility can also be affected by hormonal treatments[58]. Masculinizing hormonal treatments usually provoke reversible amenorrhea, but unplanned pregnancies cannot be ruled out. Increased androgen levels might affect 'follicle' growth[58]. Nevertheless, trans men and transmasculine people could get pregnant regardless of prior testosterone use[53-60, 61]. Even the effects of estrogens on fertility are reversible, but research has reported a poor 'semen' quality due to feminizing hormonal treatments[58]. Furthermore, interrupting hormonal treatment in order to re-establish fertility can be a painful experience for some trans people. The standards of care of the WPATH recommend that providers discuss fertility options with clients before the commencement of hormonal treatments[1]. Of the current fertility-preservation options, gamete cryopreservation is well established[62]. Embryo cryopreservation requires a partner or donor and gonadal tissue preservation is more experimental. In Italy, the possibility to cryopreserve gametes is available to some services users (especially transfeminine people), but geographical inequalities are significant. Data on trans people's access to assisted reproductive technologies in Italy are lacking. It is worth remembering that under Law 40/2008, ARTs are available only to heterosexual couples in Italy. This prevents some trans people (as well as some cisgender people) from the possibility to access them. Finally, little literature is concerned with the health service experiences of trans men, transmasculine and other gender-nonconforming people who go through pregnancy and birth. While pregnancy might be anathema to some transmasculine people, others might want or need to undergo it in order to have a genetically-related child. Existing literature shows that trans people who undergo pregnancy might feel particularly isolated and have difficult experiences with providers including misgendering, discrimination and rude treatment, through to being denied treatment[61]. Some publications provide suggestions for the provision of affirming and inclusive care[53,61].

Conclusion

Trans and gender diverse people face a multitude of discriminations that adversely affect their health. These include a range of structural and interpersonal barriers that restrict trans people's access to care, both general and related to gender affirmation. More research is needed on important areas of trans people's general health, as well as on the optimal models and content of service provision. A better understanding of the mechanisms that put trans people at risk of or protect them from adverse health — including legal and social policies[63] — would lead to more meaningful interventions on trans people's health. As suggested by many trans advocates and health researchers, research on trans health should be grounded, from inception to dissemination, in a meaningful collaboration with community stakeholders[64], in order to ensure that health-related research and interventions are responsive to trans people's real-life issues[65]. Participatory population perspectives and community-based participatory research approaches that aim at working *with* and not *on* trans people and their organizations are already being implemented with important results[18,28,32,35,38]. As recently reported by Reisner and colleagues in the *Lancet*, against the backdrop of widespread social and economic exclusion "community empowerment is essential for clinical

- Copyright - Il Pensiero Scientifico Editore downloaded by IP 18.97.9.173 Wed, 09 Sep 2026, 12:30:46

services, public health programs, and human rights efforts that seek to design and implement effective services and population-level interventions to improve the health and wellbeing of transgender people"[65].

Glossary

Cisnormativity: the expectation that every person is cisgender and that who were assigned male or female at birth, will identify themselves as men and women, respectively. This assumption is so pervasive and dominant that it is not easily recognizable as such and it shapes the entire society.

Gender identity: gender identity refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the gender assigned at birth.

Transphobia: term referred to a repulsion, hatred, discrimination and physical and verbal aggression vis-à-vis transgender and gender non-conforming individuals.

Stigma: psychosocial process through which people belonging to a majority group attribute a negative and disqualifying feature to an individual or to an entire group of individuals in order to lead the entire group to a lower social rank.

Individual stigma: term used to indicate both the feelings and the emotions that the stigmatized individuals feel toward themselves and what they believe others think about them (perceived stigma).

Interpersonal stigma: it manifests itself with various forms of discrimination, including verbal, physical or even sexual abuse, due to the visibility of most transgender people, visibility that exposes them to a greater risk of stigmatization.

Structural stigma: it pertains to all those social conditions, cultural norms, and institutional policies that restrict the opportunities, resources and well-being of stigmatized people. It is a type of stigma used by majority groups in order to exclude and marginalize groups that deviate from what is perceived as 'the norm'.

Key messages

- Trans people face intersecting forms of oppression that have a negative effect on their health.
- Trans people face structural and interpersonal barriers in the access to general and gender-affirming healthcare.
- Tackling the barriers that affect trans people's access to healthcare is fundamental in order to improve trans health.
- An improved understanding of the social determinants of trans people's health is needed.
- Research should be grounded in a meaningful collaboration with community stakeholders in order to assure that health-related interventions are responsive to the real-life issues faced by trans people.

References

1. Coleman E, Bockting W, Botzer M, Cohen-Kettenis P, DeCuypere G, Feldman J, et al. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, Version 7. Int J Transgend. 2012;13(4): 165-232.
2. White Hughto JM, Reisner SL, Pachankis JE. Transgender stigma and health: a critical review of stigma determinants, mechanisms, and interventions. Soc Sci Med. 2015;147: 222-31.
3. Suess A, Espineira K, Walters PC. Depathologization, TSQ. 2014;1-2:73-6.
4. WPATH [Internet]. Identity recognition statement. Available from: https://www.wpath.org/media/cms/Documents/Web%20Transfer/Policies/WPATH%20Identity%20Recognition%20Statement%2011.15.17.pdf
5. Deutsch M. Use of the informed consent model in the provision of cross-sex hormone therapy: a survey of the practices of selected clinics. Int J Transgend. 2011;13(3):140-6.
6. Ministerio de salud, Argentina [Internet]. Atención de la salud integral de personas trans: guía para equipos de salud. 2015. Available from: http://www.msal.gob.ar/images/stories/bes/graficos/0000000696cnt-guia-equipos-atencion-Salud%20integral-personas-trans.pdf
7. Davy Z, Toze M. What is gender dysphoria? A critical systematic narrative review. Transgend Health. 2018;3(1):159-69.
8. Schulz SL. The informed consent model of transgender care: an alternative to the diagnosis of gender dysphoria. J Humanist Psychol. 2018;58(1):72-92.
9. Cavanaugh T, Hopwood R, Lambert C. Informed consent in the medical care of transgender and gender-nonconforming patients. AMA J Ethics. 2016;18(11):1147-55.
10. Transgender Europe [Internet]. Overdiagnosed but underserved. 2017. Available from: https://tgeu.org/healthcare/
11. Grant JM, Mottet L, Tanis J [Internet]. Injustice at every turn: a report of the national transgender discrimination survey. Available from: https://static1.squarespace.com/static/566c7f0c2399a3bdabb57553/t/566cbf2c57eb8de92a5392e6/1449967404768/ntds_full.pdf
12. Fundamental Rights Agency [Internet]. Being trans in the European Union. Available from: https://fra.europa.eu/en/publication/2014/being-trans-eu-comparative-analysis-eu-lgbt-survey-data
13. Botti F, D'Ippoliti C. Sex work among trans people: evidence from the Southern Italy. Fem Econ. 2017;23(3):77-109.
14. Fedorko B, Berredo L [Internet]. The vicious circle of violence: trans and gender-diverse people, migration and sex work. TGEU. 2017. Available from: https://transrespect.org/wp-content/uploads/2018/01/TvT-PS-Vol16-2017.pdf
15. Sue DW, Capodilupo CM, Torino GC, Bucceri JM, Holder AM, Nadal KL, et al. Racial microaggressions in everyday life: implications for clinical practice. Am Psychol. 2007; 62(4):271-86. doi: 10.1037/0003-066X.62.4.271.
16. Diderichsen E, Whitehead M. The social basis of disparities in health. In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, editors. Challenging inequities in health: from ethics to action. New York: Oxford University Press; 2001.

- Copyright - Il Pensiero Scientifico Editore downloaded by IP 18.97.9.173 Wed, 09 Sep 2026, 12:30:46

17. Rasulo D, Spadea T, Demaria M, Onorati R, Costa G. Conta di più da chi nasci o dove arrivi? Determinanti di salute nel corso di vita. In: Costa G, Stroscia M, Zengarini N, Demaria M. 40 anni di salute a Torino. Milano: Inferenze; 2017.
18. Reisner SL, Poteat T, Keatley J, Cabral M, Mothopeng T, Dunham E, et al. Global health burden and needs of transgender populations: a review. Lancet. 2016,388:412-36.
19. Bockting WO, Miner MH, Swinburne Romine RE, Hamilton A, Coleman E. Stigma, mental health, and resilience in an online sample of the US transgender population. Am J Public Health 2013; 103(5):943-51.
20. Valentine S, Shipherd J. A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. Clin Psychol Rev. 2018;66:24-38.
21. Scandurra C, Amodeo AL, Valerio P, Bochicchio V, Frost DM. Minority stress, resilience, and mental health: a study of Italian transgender people. J Soc Issues. 2017;73:563-85.
22. Scandurra C, Bochicchio V, Amodeo AL, Esposito C, Valerio P, Maldonato NM. Internalized transphobia, resilience, and mental health: applying the psychological mediation framework to Italian transgender individuals. Int J Environ Res Public Health. 2018;15:508.
23. Poteat T, Malik M, Scheim A, Elliot A. HIV prevention among transgender populations: knowledge gaps and evidence for action. Curr HIV/AIDS Rep. 2017;14(4):141-52.
24. Reisner SL, Radix A, Deutsch MB. Integrated and gender-affirming transgender clinical care and research. J Acquir Immune Defic Syndr. 2016;15(72):235-42.
25. Radix A, Sevelius J, Deutsch MB. Transgender women, hormonal therapy and HIV treatment: a comprehensive review of the literature and recommendations for best practices. J Int AIDS Soc. 2016;19(3 Suppl 2):20810.
26. DuBois LZ, Powers S, Everett BG, Juster RP. Stigma and diurnal cortisol among transitioning transgender men. Psychoneuroendocrinology. 2017;82:59-66.
27. Wanta JW, Unger CA. Review of the transgender literature: where do we go from here? Trangend Health. 2017;2(1): 119-28.
28. Giblon R, Bauer G. Health care availability, quality, and unmet need: a comparison of transgender and cisgender residents of Ontario, Canada. BMC Health Serv Res. 2017; 17:283.
29. Gonzales G, Henning-Smith C. Barriers to care among transgender and gender nonconforming adults. Milbank Q. 2017;95(4):726-48.
30. Roberts TK, Fantz CR. Barriers to quality health care for the transgender population. Clin Biochem. 2014;47(10-11):983-7.
31. Bradford J, Reisner SL, Honnold J, Xavier J. Experiences of transgender-related discrimination and implications for health: results from the Virginia transgender health initiative study. Am J Public Health. 2013;103(10):1820-9.
32. Bauer GR, Scheim AI, Deutsch MB, Massarella C. Reported emergency department avoidance, use, and experiences of transgender persons in Ontario, Canada: results from a respondent-driven sampling survey. Ann Emerg Med. 2014;63(6):713-20.
33. Whittle S, Turner L, Combs R, Rhodes S. Transgender Eurostudy [Internet]. Legal survey and focus on the transgender experience of healthcare. 2008. Available from: https://tgeu.org/wp-content/uploads/2009/11/transgender_web.pdf
34. Safer J, Coleman E, Feldman J, Garofalo R, Hembree W, Radix A, et al. Barriers to health care for transgender individuals. Curr Opin Endocrinol Diabetes Obes. 2016;23(2): 168-71.
35. Bauer GR, Hammond R, Travers R, Kaay M, Hohenadel KM, Boyce M. "I don't think this is theoretical; this is our lives": how erasure impacts health care for transgender people. J Assoc Nurses AIDS Care. 2009;20(5):348-61.
36. Snelgrove JW, Jasudavisius AM, Rowe BW, Head EM, Bauer GR. "Completely out-at-sea" with "two-gender medicine": a qualitative analysis of physician-side barriers to providing healthcare for transgender patients. BMC Health Serv Res. 2012;12:110.
37. Korpaisarn S, Safer JD. Gaps in transgender medical education among healthcare providers: a major barrier to care for transgender persons. Rev Endocr Metab Disord. 2018;19(3):271-5.
38. Bauer GR, Zong X, Scheim AI, Hammond R, Thind A. Factors impacting transgender patients' discomfort with their family physicians: a respondent-driven sampling survey. PLoS One. 2015;10(12):e0145046.
39. Bauer GR, Scheim AI, Pyne J, Travers R, Hammond R. Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada. BMC Public Health. 2015;15:525.
40. Wilson EC, Chen YH, Arayasirikul S, Wenzel C, Raymond HF. Connecting the dots: examining transgender women's utilization of transition-related medical care and associations with mental health, substance use, and HIV. J Urban Health 2015;92(1):182-92.
41. McNeil J, Bailey L, Ellis S, Morton J, Regan M [Internet]. Trans mental health and emotional wellbeing study. 2012. Available from: https://www.gires.org.uk/wp-content/uploads/2014/08/trans_mh_study.pdf
42. Bailey L, Ellis S, McNeil J. Suicide risk in the UK trans population and the role of gender transition in decreasing suicidal ideation and suicide attempt. Ment Health Rev J. 2014,19(4):209-20.
43. Dreher PC, Edwards D, Hager S, Dennis M, Belkoff A, Mora J, et al. Complications of the neovagina in male-to-female transgender surgery: a systematic review and meta-analysis with discussion of management. Clin Anat. 2018;31(2):191-9.
44. Santucci RA. Urethral complications after transgender phalloplasty: strategies to treat them and minimize their occurrence. Clin Anat. 2018;31(2):187-90.
45. Ellis S, Bailey L, McNeal J. Trans people's experiences of mental health and gender identity services: a UK study. J Gay Lesbian Ment Health. 2015;19(1):1-17.
46. Carvalho IP. Transsexualidade, vivência do processo de transição no contexto dos serviços de saúde. Acta Med Port. 2010;23:1001-10.
47. Pimenoff V, Pfäfflin F. Transsexualism: treatment outcome of compliant and noncompliant patients. Int J Transgend. 2011;13(1):37-44.

- Copyright - Il Pensiero Scientifico Editore downloaded by IP 18.97.9.173 Wed, 09 Sep 2026, 12:30:46

48. National center for transgender equality [Internet]. Transgender sexual and reproductive health: unmet needs and barriers to care. 2012. Available from: https://transequality.org/issues/resources/transgender-sexual-and-reproductive-health-unmet-needs-and-barriers-to-care
49. Gatos K. Cervical cancer screening in transgender men. Nurs Womens Health. 2018;22(1):52-62.
50. Light A, Wang LF, Zeymo A, Gomez-Lobo V. Family planning and contraception use in transgender men. Contraception. 2018;98(4):266-9.
51. Potter J, Peitzmeier SM, Bernstein I, Reisner SL, Alizaga NM, Agénor M, et al. Cervical cancer screening for patients on the female-to-male spectrum: a narrative review and guide for clinicians. J Gen Intern Med. 2015;30(12):1857-64.
52. College of obstetricians. Committee opinion no. 512: health care for transgender individuals. Obstet Gynecol. 2011;118(6):1454-8.
53. Hoffkling A, Obedin-Maliver J, Sevelius J. From erasure to opportunity: a qualitative study of the experiences of transgender men around pregnancy and recommendations for providers. BMC Pregnancy Childbirth. 2017;17(suppl 2):332.
54. Erickson-Schroth L. Trans bodies trans selves. Oxford: Oxford University Press; 2014. p. 649.
55. Strangio C. Can reproductive trans bodies exist? CUNY Law Review. 2016;19(2):223-45.
56. Nixon L. The right to trans parent. A reproductive justice approach to reproductive rights, fertility and family-building issues facing transgender people. William & Mary Journal of Women and the Law; 20(1): 73-103.
57. De Roo C, Tilleman K, T'Sjoen G, De Sutter P. Fertility options in transgender people. Int Rev Psychiatry. 2016;28(1):112-9.
58. Rachlin K, Hansbury G, Pardo ST. Hysterectomy and oophorectomy experiences of female-to-male transgender individuals. Int J Transgend. 2010;12(3):155-166.
59. Joint R, Chen ZE, Cameron S. Breast and reproductive cancers in the transgender population: a systematic review. BJOG. 2018;125(12):1505-12.
60. Light A, Obedin-Maliver J, Sevelius JM, Kerns JL. Transgender men who experienced pregnancy after female-to-male gender transitioning. Obstet Gynecol. 2014;124:1120-7.
61. Obedin-Maliver J, Makadon HJ. Transgender men and pregnancy. Obstet Med. 2016;9(1):4-8.
62. Chen D, Simons L, Johnson EK, Lockart BA, Finlayson C. Fertility preservation for transgender adolescents. J Adolesc Health. 2017;61(1):120-23.
63. Winter S, Settle E, Wylie K, Reisner S. Cabral M, Knudson G, et al. Synergies in health and human rights: a call to action to improve transgender health. Lancet. 2016;388:318-20.
64. Adams N, Pearce R, Veale R, Radix A, Castro D, Sarkar A, et al. Guidance and ethical considerations for undertaking transgender health research and institutional review boards adjudicating this research. Transgend Health. 2017;2(1):165-75.
65. Reisner S, Keatley J, Baral S. Transgender community voices: a participatory population perspective. Lancet. 2016;388(10042):327-30.

Conflict of interest statement: the Authors declare no conflicts of interest.

Correspondence to:
Olivia Fiorilli
Cermes3, Paris, France
email: rogerfiorilli@gmail.com