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TRANSIT

Training to Raise Acknowledge NeedS and Inclusion of Transgender

HANDBOOK

Promoting a respectful approach towards transgender, gender-diverse, and intersex clients within healthcare and legal services

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Introduction

Protecting the rights of LGBTQ+ people is a priority of the European Union.

Over the past 25 years, the European Union has actively promoted equality for lesbian, gay, bisexual and transgender people. The EU has included the protection of LGBTI people in fundamental legal documents such as the Treaty of Amsterdam (1997), the Charter of Fundamental Rights (2000) and the anti-discrimination directives.

In 2013, the European Union Agency for Fundamental Rights (FRA) presented the results of the agency's first survey on LGBT people which showed that, across the EU, they suffer discrimination, harassment, hate speech and violence, to the detriment of the full enjoyment of their fundamental rights. In 2020, 7 years later, the second survey on LGBTI people in the EU was presented and the results show little progress.

Discrimination in everyday life persists – at work and at school; at cafés, restaurants, bars and nightclubs; when looking for housing; when accessing healthcare or social services; and in shops. Harassment and physical and sexual attacks also remain concerns. Trans and intersex people especially face challenges, including when having to show identification documents. Even nowadays many people feel the need to conceal being LGBTI to avoid discrimination, hate or even violence.

Among LGBTQ+, transgender and intersex (TI) people are recognised as being more exposed during their lifetime to a higher level of discrimination, physical and psychological violence, harassment and social exclusion. This has serious consequences for the mental health of TI people (Seelman, 2014; Tebbe & Morandi, 2016).

In the health sector, the relationship with public services remains problematic for LGBTQ+ people. There is a strong lack of services able to offer adequate care. Professionals often state that they do not feel comfortable interacting with LGBTQ+ people because they have not received any training on the subject and often provide care based on implicit prejudices and tactless stereotypes (Sedlak, Veney and Doheny 2016). Working with LGBTQ+ people therefore requires specific clinical skills that educational institutions and training centres marginally provide.

Also in the legal field, judges and lawyers are unable to protect them from discrimination and violence in their life contexts (family, social, work) and to adequately follow, for example, transgender clients in the gender reassignment procedure, because they are not adequately trained and updated on LGBTQ+ issues.

So, in order to promote true inclusion of LGBTQ+ people, it is crucial to break down barriers and improve access and quality of both health and legal services.

By intercepting both health and legal training gaps on this issue, the European project TRANSIT aims to provide innovative training for professionals belonging to different professional categories who provide care to LGBTQ+ people in various capacities.

The training is addressed to: health professionals (doctors, nurses, psychologists, psychotherapists), judges and lawyers. This training will allow the target professionals to specialize in their field of work on the topic and to adequately assist LGBTQ+ clients who require health and legal counseling (for more details on the project visit www.....).

This training manual is the first intellectual product produced by the project partnership.

The manual is structured in 3 parts:

Part I Theoretical modules and practical exercises designed for the training of socio-medical and legal professionals. In particular, there are three modules:

- 1st Transversal module designed for all professionals
- 2nd Module specifically for social and health professionals
- 3rd Module specifically for legal professionals

Part II Methodological guidelines addressed to professionals working with transgender people in order to support them in a correct approach that respects the person's dignity

Part III Tools to assess the knowledge and skills learned by professionals through the training course.

PART I

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TRANSVERSAL MODULE

Basic Concepts and Definitions

Gender vs. Sex

Sex typically refers to the biological attributes assigned at birth based on reproductive anatomy, such as male or female. It is primarily determined by physical characteristics such as chromosomes, hormones, and genitalia. On the other hand, gender is a complex social and cultural construct that encompasses the roles, behaviors, identities, and expectations associated with being masculine, feminine, or non-binary. Gender identity is an individual's deeply felt sense of their own gender, which may or may not align with the sex assigned at birth. Gender is viewed as a spectrum that encompasses a wide range of identities beyond the traditional male and female categories. Gender is influenced by a combination of personal identity, societal norms, and cultural factors, making it distinct from the biological determination of sex.

Transgender

The term ***transgender*** refers to individuals whose self-identified gender is different from the sex assigned to them at birth. A person's gender identity is their inner understanding of whether they are male or female, or non-binary (for some, their gender identity doesn't align with the traditional binary options). In the case of transgender and non-binary individuals, their internal sense of gender does not match with the sex they were designated at birth. It is used as an adjective, i.e. transgender woman/man, etc

Trans(gender) Woman – a woman who was born with male sex characteristics, assigned- male-at-birth (**AMAB**) and does not identify with the social role of a man.

Trans(gender) Man – a man who was born with female sex characteristics, was assigned-female-at-birth (**AFAB**) and does not identify with the social role of a woman.

You can also come across abbreviations FtM (female-to-male) and MtF (male-to-female). These are used primarily by the members of the transgender communities to refer to themselves and otherwise are generally limiting in terms of the binary conception of gender identities

Transsexual/ism – The terms "transsexual" or "transsexualism" have gradually fallen out of favor in recent years due to its historical association with a medicalized understanding of transgender identity. The language surrounding transgender issues has evolved over time, reflecting a more inclusive and diverse understanding of gender identity. The term transgender encompasses a

broader range of gender identities and expressions beyond the medical aspect, emphasizing self-identification and affirming gender diversity.

Moreover, using the term "transsexual" can be seen as pathologizing or stigmatizing, as it implies a medical condition or disorder rather than acknowledging transgender identity as a natural variation of human experience. The shift towards more affirming and inclusive language is intended to promote respect, dignity, and acceptance for transgender individuals, while challenging outdated medical frameworks that have historically pathologized their identities.

Cisgender

Cisgender refers to individuals whose gender identity aligns with the sex they were assigned at birth. In other words, cisgender people identify with the gender typically associated with their biological sex.

Gender diversity

In contemporary societies, the understanding and acceptance of diverse gender identities has significantly grown, although it varies widely between different cultures and regions. The term "transgender" is often used as an umbrella term to describe individuals whose gender identity differs from the sex assigned to them at birth. Other terms such as genderqueer, non-binary, and genderfluid also describe identities that do not strictly fit into the binary categories of male or female.

Gender diversity has always been a part of human societies, but the recognition and understanding of it has evolved significantly over time. While historical and cultural examples like these demonstrate the existence of gender diversity across time and cultures, the rights, recognition, and acceptance of transgender and gender-diverse individuals remains an ongoing issue worldwide.

Non-binary, Gender-diverse, or Genderqueer – those whose internal sense of gender falls outside the gender binary (feminine/masculine); Non-binary people are extremely diverse in terms of their identities and may be fluid or fixed in terms of their gender; these may include (but are not limited to):

Bigender – a person whose identity shifts between feminine and mas- culine depending on the context or situation.

Genderfluid - a person whose gender identification shifts or changes

Androgynous – a person whose identity is neither feminine nor mascu- line, presenting a gender either mixed or neutral

Pangender – a person whose identity is made up of all gender identi- ties.

Agender – a person who does not have a personal sense of gender identity

and others….

How Many Transgender and Gender Diverse People Are There?

There is no major consensus on the number of transgender people in population. Accurate statistics are lacking for several reasons, including the fact that many trans people are not out (both pre- and post- transition).

In the past, estimations were primarily based on the data sourced from health professionals indicating the number of people who had undergone sex reassignment surgeries or were undergoing hormone treatment. Other estimations were based on the number of people who had obtained legal gender recognition. However, such estimates fail to take into account the transgender people who do not undergo reassignment surgeries or other health treatments.

According to different surveys, the number of trans people reported are rising, however, not in terms of there being more transgender and gender-diverse persons, but in terms of more people who are coming out about their gender identity.

We now mostly rely on data collected in a nationwide census, such as in Canada (0,2-3%) and in the UK (up to 0,5% of population identifying themselves as gender diverse).

Intersex

Intersex means a person is born with any of a number of biological attributes that do not fit the specific definitions of female or male. Some intersex people experience gender dysphoria and identify as transgender as well, for instance when they have been socialized as one sex and gender and find during puberty (or earlier) that they exhibit attributes of “the other” gender in addition to or instead of those of their assumed sex and socialized gender.

Unfortunately, in many countries, babies with ambiguous genitals are still forced to undergo surgery in order to be legally recognized as either female or male, even though for most, the condition is not life-threatening.

It is crucial not to confuse intersex persons with transgender or non-binary people, intersex persons can be identified as women or men or non-binary as it comes to their gender identity.

More information on the European contest are available from the website of organization OII (Organization Intersex International Europe) at https://www.oiieurope.org/.

Coming Out

Coming out is the process of becoming aware of and articulating one's minority sexual orientation and/or gender identity. We can distinguish two phases of coming out: internal and external. It is not uncommon that some transgender clients spend years or even decades before they decide to come out publicly.

The realization that one is a transgender person can take anywhere from a few moments to several decades. Transgender people usually have inkling early on in their lives that their assigned gender feels out of sync with their social role, or feel physically uncomfortable. The self-realization process is extremely complicated. A gender-questioning person may be triggered into intense denial or, in response to social constraints, ignore the signs pointing toward their transgenderism, whether consciously or unconsciously.

Transgender people vary greatly in choosing whether, when, and how to disclose their transgender status to family, close friends, and others. The prevalence of discrimination and violence against transgender people can make coming out a risky decision. Fear of retaliatory be- havior, such as being banished from the parental home, can influence a transgender person’s decision not to not come out to their families at all, or wait until they have reached independence in adulthood. Parents who are confused or rejecting their transgender child’s newly revealed identity may treat it as a “phase” or attempt to convert their children back to “normal.

Minority stress

On top of the normal stress experienced by the majority population, a minority experiences minority stress due to the fact that their members are often stigmatized, marginalized or discriminated against.

Minority stress factors

General: discrimination, rejection and victimisation based on gender identity, disrespect for gender identity, prejudice and stigma

Personal: identity concealment, internalised homophobia/transphobia, negative expectations of acceptance and the future

Resilience factors: community support, family support, availability of support services

Cisnormativity

This concept is grounded in the belief that individuals assigned male at birth will naturally develop into males, and individuals assigned female at birth will naturally develop into females. However, it serves to reinforce strict gender binaries, reinforcing societal norms and expectations associated with these binary genders. Consequently, it contributes to the perpetuation of discrimination, prejudice, and bias against individuals who do not fit within these traditional gender categories.

Transnegativity

Negative socio-cultural messages are addressed to members of the minority - starting with the family, through the media, the government system, etc.

- Personal level (stereotypes and prejudices);
- Interpersonal level (discrimination, violence);
- Institutional level (legislation, policies, social practices, systemic violence);
- Cultural level (cultural representation)

Internalised trans negativity is the internalisation of this message, self-hatred, low self-esteem, hatred of other trans people.

Transition

Clients who identify as transgender frequently plan to undertake a transition process. This entails adopting the visual traits, physical attributes, and social responsibilities that correspond with their gender identity. This process can be segmented into three distinct components:

Physical – hormone replacement therapy (HRT), surgical changes (sex reassignment surgery – SRS or gender reassignment surgery – GRS).

Legal – change of legal gender marker and legal name.

Social – change of name and pronouns; adjusting one's visual appearance; performing the desired gender role.

Social Transition

The hardest part of transitioning is often the social aspect. The social shift necessitates that an individual undergoing a transgender transformation transition openly and noticeably from one gender role to another. This might result in a change in their societal standing. For instance, trans women might discover a decrease in their professional wages. The expectations of others may also alter. The more advanced in age an individual is and the more societal roles they take on, the more intricate the transition can become. In severe instances, an individual might end up in a state of social isolation. As stated earlier, it is strongly advised that transgender individuals receive ample access to professional psychological help throughout this time.

Physical Transition

This is the most visible part of the transition, and for most people a symbol of or synonym for transition as such, however, often reducing the entire process to physical changes and treatment of trans identity by means of hormonal and surgical interventions, neglecting the needs in terms of psychological wellbeing. Not all trans people are automatically interested in all available surgical interventions – in general, the stronger the dysphoria, the greater the interest in surgeries. Gender Reassignment Surgery (GRS) includes Feminization and Masculinization surgeries. An anatomy that is typically gendered female may require one or a set of feminization surgeries, including orchiectomy, vaginoplasty, feminizing augmentation mammoplasty, facial feminization surgery, reduction thyrochondroplasty (tracheal shave), and voice feminization surgery, among others. An anatomy that is typically gendered male may require one or a set of masculinization surgeries, including chest masculinization surgery (top surgery), hysterectomy, phalloplasty, metoidioplasty, and crotoplasty.

In some countries, a diagnosis and a number of medical examinations (endocrinology, internal, psychologiy, etc.) have to be made prior to HRT or surgery. An integral part of the diagnosis can be the so-called Real-Life Test, in which a person must practice living in the gender role with which they identify for some time before undergoing surgery. This experience may cause trans people additional stress. After HRT, a person starts to change physically (and often mentally), which is associated with frequent coming out experiences and risks such as losing one's job, conflict with family, friends or acquaintances, and more. It is recommended that the person in transition have enough support around themselves (good friends and/or some professional psychological help) during this period.

Legal Transition / Legal Gender Recognition

Each country legislates transition differently depending on their history, healthcare system and legislation. Sadly, in countries like Hungary there is no official process of legal gender recognition – or changing or legal gender marker in documents. Most European countries have already dropped the requirement of sterilization for legal recognition, however, there are still several countries (incl. Czech Republic) that have this condition that goes directly against the rights to health and family. In other countries, The most progressive countries in Europe work with the so-called self-determination or self-identification that allows to change the official gender marker only on the basis of an official declaration without the need to prove the diagnosis or surgical interventions.

Other key terms and concepts:

Passing

"Fitting in" from the perspective of the others (society) into the desired gender role (female/male). This concept is tricky in that it imposes stereotypical gender roles on transgender people.

Dysphoria

Distress or discomfort that some individuals may experience when the gender they were assigned at birth does not align with their deeply felt sense of their own gender identity. It is also a key diagnostic criterion for the diagnosis of Gender Incongruence in ICD-11 and a recognized medical diagnosis and is listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Euphoria

Positive and affirming emotional experience that individuals may feel when their gender identity is acknowledged, validated, and aligned with their sense of self.

Misgendering

Referring to or addressing someone using language or pronouns that do not align with their gender identity. It occurs when someone uses incorrect pronouns (such as referring to a transgender woman as "he" instead of "she") or uses gendered terms (such as addressing a non-binary person with gender-specific language like "sir" or "ma'am") that do not correspond to how the individual identifies. This can be unintentional, resulting from ignorance or unfamiliarity with someone's preferred gender identity or pronouns. However, it can also be intentional and used as a form of disrespect, discrimination, or invalidation of a person's gender identity. Regardless of intent, misgendering can have negative effects on individuals, causing emotional distress, reaffirming feelings of gender dysphoria, and undermining their sense of self.

Deadnaming

Using someone's birth or assigned name instead of their chosen name, particularly in reference to transgender individuals. It involves referring to a person by the name they were given at birth, which may not align with their current gender identity. For transgender individuals who have changed their name as part of their transition, deadnaming can be distressing, invalidating, and disrespectful. It undermines their chosen identity and can evoke feelings of dysphoria and emotional discomfort.

Transphobia

Prejudice, discrimination, or hostility directed toward transgender individuals or gender diverse people. It encompasses a range of negative attitudes, beliefs, and actions that target transgender people based on their gender identity. Harassment and violence: Discrimination Exclusion and marginalizationLegal and policy barriers and restrictions to access to legal gender recognition.

Internalized Transphobia

The internalization of negative attitudes, beliefs, or stereotypes about being transgender. It occurs when transgender individuals internalize and adopt society's transphobic messages, resulting in self-doubt, shame, or a negative self-perception related to their gender identity. This can manifest in Negative self-image, conformity to societal roles and disconnection from and devaluation of other trans and gender diverse people.

Glossary of Basic Terms and Definitions related to gender identity

Sex – a strictly biological definition, based on certain sets of physical features, typically separated into the categories of ‘Male’ and ‘Fe- male.’

Sex Assigned at Birth – sex assigned at birth refers to the sex (male or female) attributed to a child at birth by medical personnel based on certain sets of physical features (genitalia, chromosomes, gonads, hormones, etc.). May also be referred to as birth sex, biological sex, or natal sex.

Gender – socially or culturally constructed roles that people in a society identify with based on their gender identity; such roles vary historically and geographically and are associated with certain physical appearances, expressions, and expectations.

Gender Identity – a person’s interpretation and categorization of their own gender, finding a comfortable definition of oneself, expressed through interactions with other people.

Trans(gender) Person – someone whose gender identity is incongruous with the sex they were assigned at birth. The terms ‘trans’ and ‘transgender’ are used exclusively as adjectives.

Trans(gender) Woman – a woman who was born with male sex characteristics, assigned- male-at-birth (**AMAB**) and does not identify with the social role of a man.

Trans(gender) Man – a man who was born with female sex characteristics, was assigned-female-at-birth (**AFAB**) and does not identify with the social role of a woman.

Transsexual – a historical term, today considered outdated, related to the previous medical diagnosis of transsexualism which was replaced by the diagnosis of "gender incongruence".

Transsexualism, transsexuality – a medical diagnosis falling under mental disorders, coded F64.0 in the previous versions of the Inter- national Classification of Diseases (ICD). This diagnosis has been re- placed by that of Gender Incongruence, no longer classified as a men- tal disorder, but a condition related to sexual health.

Gender Incongruence – a medical diagnosis which will replace Transsexualism/Gender Identity Disorder in the ICD as of 2022. It indi- cates the shift in the perspective away from the category of mental disorder and focusing on the social aspect of the transgender condition in addition to the physical one.

Cis(gender) Person – a person whose gender identity aligns with the sex they were assigned at birth – e.g., a person who was assigned male at birth, was raised as a man and considers himself a man.

Intersex – a general term used for a variety of conditions in which a person is born with biological attributes that do not fit the specific def- initions of female or male.

Non-binary, Gender-diverse, or Genderqueer – those whose internal sense of gender falls outside the gender binary (feminine/masculine); Non-binary people are extremely diverse in terms of their identities and may be fluid or fixed in terms of their gender; these may include(agender, bigender, genderfluid, etc.)

Gender Non-conforming – a person whose gender expression does not conform to societal expectations of feminine or masculine.

Two Spirit – a person who fulfills the roles of both genders; traditionally used in Native American cultures, but the term is being also used as an umbrella term for "third genders" in other cultures.

Transvestite, Cross-dresser, Drag Queen/King – falls outside the con- temporary understanding of 'transgender,' as it denotes a person who prefers or the clothing styles and gender expression of another gender or who dresses as another gender for personal enjoyment or performance.

Dysphoria – negative feelings associated with one's physical features, experienced by most trans people to a greater or lesser extent.

Transition – the process of acquiring the visual characteristics, physical features and the social role that is in accordance with a person's gender identity:

- **Physical** – hormone replacement therapy, surgical changes, sex re- assignment surgery – SRS, or gender reassignment surgery – GRS.
- **Legal** – change of legal gender marker and legal name, other gender markers such as digits in national identification numbers indicating gender.
- **Social** – change of name and pronouns; adjusting visual expression; performing the desired gender role.

SRS, GRS – sex reassignment surgery, gender reassignment surgery.

HRT – hormone replacement therapy during transition.

Real-Life Test (RLT), Real-Life Experience (RLE) – common medical requirement for trans clients to prove they are able to live in their authentic gender role. It may range in duration from a couple of months to years. While for many people this practice may be beneficial, for some others it poses unnecessary risk and stress.

Legal Gender Recognition – the official procedure to change a trans person's name and gender identifier in official registries and documents such as their birth certificate, ID card, passport or driving license. In some countries, it's impossible for a transgender person to have their gender recognized by law. In other countries, the procedure can be long, difficult and humiliating.

Passing – being perceived and accepted by other people in a manner consistent with one's own gender identity.

Misgendering – referring to people using the wrong pronouns or gendered language (may happen by mistake, carelessness or seeking confrontation); connected with **Deadnaming** (using someone's old name).

Self-determination – the inherent right to declare one's own gender and make choices to self-identify in one's own authentic way of expression.

Transphobia – the fear or hatred of trans people, often expressed in the form of verbal or physical attacks (insults, confrontation, assault).

Internalized transphobia – transgender individuals themselves internalize negative sociocultural attitudes from their surroundings, society, the system, family, their culture, and so on. As a consequence, they may devalue and undermine their own identity or the identities of other transgender or non-binary individuals.

Cisnormativity – The belief that a normal, natural, and solely acceptable identity (gender expression, physical characteristics, etc.) is either male or female.

Gatekeeping – any requirement which controls access to resources for transgender people; often used in regards to medical and legal transition, where there are strict formal requirements trans clients must fulfill in order for one's transition to be acknowledged medically or legally.

Depathologization – a process involving an official shift in perspective, in which the range of transgender identities are no longer considered pathological conditions/medical disorders in need of healing but acceptable health and behavior choices, in which trans and non-binary people are respected as agents of their own identities.

Gender-questioning – a person who may be questioning or exploring their gender identity and whose gender identity may not align with their sex assigned at birth.

References:

Aragón A. M. et al., Theoretical Background Report, SWITCH, 2020

Pavlica, K. et al. (2018). The Fears and Hopes of Trans People. Pra- gue: Transparent, z. s.

GLAAD (2018). Transgender FAQ. Retrieved November 10, 2020, from https://www.glaad.org/transgender/transfaq

www.oii.org

www.jsmetransparent.cz

SOCIAL, PHYSICAL AND LEGAL TRANSITION

ITALY

Transsexuality is an obsolete term that indicated the condition of those who identify themselves permanently with a gender different from one's biological sex and pursuing the goal of changing one's body, also through medical-surgical interventions.

Transgenderism is the modern term in use that, more generally, also includes the condition of those who deny the binary sexual logic (male/female) and perceive themselves beyond the two genders (male/female), not permanently identifying with either one or in none of them.

A *Transition* or *Gender Affirmation* begins when the need to be oneself becomes urgent and can no longer be postponed. A process is started during which one's body is harmonized through hormonal treatments and cosmetic surgery. Even the outward appearance, including clothing, becomes or can become more consistent with one's self-perception. The transition can never end and can include the sex change operation.

These paths, including hormonal dosages, vary from person to person, especially in non-binary persons. This is already a good reason why it is important to be followed by a specialized team.

Hormones have also moderate side effects which must be followed up by a specialized medical staff.

Some transgender people (but not all) embark on a gender affirmation journey that proceeds through successive stages and may involve hormonal and/or surgical treatment. This is not a mandatory path, and the journey is not the same for everyone. The aim is to adapt the path according to the requests of each person.

There are recommendations (standards of care) proposed by the World Professional Association for Transgender Health and international guidelines that healthcare professionals refer tofor surgical treatment. Those are named Standard of Care (SOC). Actually, the most modern version is the number 8 (SOC-8).

The person who intends to embark on a medical gender affirmation journey must, therefore, turn to specialized centers. www.infotrans.it offers a list of both public and affiliated healthcare facilities, present on the Italian territory, capable of providing this type of service in the "Service Map" section.

Public facilities use two kind of reference protocols: ONIG, named after the Italian... National

Organization on Gender Identity, and WPATH, developed in the USA in a worldwide consensus conference. "They are globally recognizedguidelines for gender dysphoria and transgenderism.

Before embarking on a surgical gender affirmation journey, it is essential that the person is aware that this transition is not mandatory but also is important to remember that it is not a surgery capable of completely obtaining the desired sexual characteristics. In fact, gender affirmation surgeries may involve the removal of present genital organs (uterus and ovaries; testicles and penis) but do not allow for the creation of genital organs of the desired gender (for example, the creation of a uterus in a person with a male assigned sex at birth). Surgical procedures can be reversible or irreversible. Those, for example, that prevent a person from reproducing are irreversible. For this reason, the use of instruments that artificially guarantee the fertility of those who use specific hormones and surgery is required by law.

From a legislative and legal point of view, the constitutional Italian principle of equality establishes that "All citizens have equal social dignity and are equal before the law, without distinction of sex, race, language, religion, political opinions, personal and social conditions" (Article 3, paragraph 1, Constitution). This principle does not expressly mention gender identity or transgender condition, as indeed it appears reasonable, considering that the Constitution was drafted in the 1940s when awareness of the topic was not yet developed. However, there can be no doubt about the "strength" of the principle of equality and the Constitution as a whole as instruments to protect transgender individuals. This is primarily in the name of the "personalistic principle" that places the person, theirneeds, rights, and freedoms at the center of the "constitutional project."

Affirming that "The Republic recognizes and guarantees the inviolable rights of man, both as an individual and in the social formations where his personality is developed, and requires the fulfillment of the indispensable duty of political, economic, and social solidarity" (Article 2, of Italian Constitution) means giving centrality to the person regardless of any personal condition they may have. Moreover, the same principle of equality does not list in an exhaustive and exclusive manner the protected conditions, tothe extent that it closes with an expression – "personal and social conditions" - which can be understood to protect any personal characteristic. Furthermore, the same article assigns to the Republic the task of "removing the economic and social obstacles that, in fact, limit the freedom and equality of citizens, preventing the full development of the human person and the effective participation of all workers in the political, economic, and social organization of the country" (Article 3, paragraph 2 of Italian Constitution), which can certainly be invoked to protect the transgender condition. Article 32 (Italian Constitution) protects health as a fundamental right of every citizen and establishes that no one can be obliged to undergo a certain medical treatment except by law.

Law 14 April 1982, n. 164, "Provisions on the rectification of sex attribution," sets forth the provisions for anatomical and registry sex change (modified in 2011, within the context of the reform of the civil procedure rites, with Legislative Decree 1 September 2011, n. 150, "Supplementary provisions to the code of civil procedure on the reduction and simplification of civil proceedings of cognition,". In particular see Article 31, "Disputes concerning the rectification of sex attribution," in turn amended by the implementing decrees of the “Cirinnà Law”, i.e., Legislative Decree 19 January 2017, n. 5, "Adaptation of the provisions of the civil status system concerning registrations, transcriptions, and annotations, as well as normative modifications and integrations for the regulation of civil unions".

The original 164 law was approved with the primary objective of "regularizing" the registry issues of those individuals who had undergone surgery abroad without the possibility of being recognized in their new identity in Italy, and to allow access to surgical intervention within the public health system, without costs. This explains, perhaps, its summary nature in dealing with some issues. Although it was a very innovative law at the time, allowing for the modification of anatomical and registry sex, it now appears to be lacking and in need of updates that have become necessary due to the continuous emergence of new demands. Over the years, there has been questioning about some expressions that are not entirely clear. For example, the law refers to the necessary authorization of the court for the intervention "When a modification of the sexual characteristics is necessary to be achieved through medical-surgical treatment," seeming to admit that surgery is only an occasional step (Article 31, paragraph 4, Legislative Decree 150/2011). It also does not clarify what is meant by "medical-surgical treatment," i.e., whether simple hormone therapy and modification of secondary sexual characteristics may be sufficient. Until 2015, judges mostly considered the modification of sexual characteristics to be necessary, but subsequently, they admitted the lack of necessity, also thanks to two rulings of the Constitutional Court (221/2015) and the Court of Cassazione (15138/2015).

The Legislative Decree of April 11, 2006, No. 198, known as the "Code of Equal Opportunities between Men and Women," is intended to protect people who experience discrimination due to gender identity. This law also respects the rights of the European Union (EU), as described in the "EU Law Protections" section. The law is the only reference to anti-discrimination protections, as there is no clear regulation for gender identity as compared to sexual orientation (Legislative Decree No. 216 of 2003) or other personal conditions.

The Law No. 76 of May 20, 2016, known as the "Cirinnà Law," regulates civil unions between same-sex couples and living together. According to the original 164 law, changing one's name and sex on official documents results in the dissolution of a civil union between same-sex partners. It is actually by the “Cirinnà Law” changed this way: if the partners are married (in Italy marriage is available only for straight couples) their union is automatically converted into a civil union.

The former Law No. 354 of July 26, 1975, known as the "Penitentiary Ordinance," rules on the “penitentiary system and on the execution of privative and limiting measures of freedom", in particular art. Article 1 quoted:

“Treatment and rehabilitation: provides that the treatment of prisoners must be in accordance with humanity and respect the dignity of the person. The law must be impartial, without discrimination based on sex, gender identity, sexual orientation, race, nationality, economic and social conditions, political opinions, and religious beliefs.”

This has been recently amended by the D. lgs 123, which reforms the penitentiary system by extending the protection of art. 3 of the Constitution to the factors of discrimination based on "sex, gender identity and sexual orientation". A transformation that today proves problematic, however, because it widens the dimensions of difference, now also sexual, providing for its protection in the name of equality. (2018) in a very innovative way because it expressly recalls gender identity as a condition that cannot generate discrimination in detention.

The Legislative Decree No. 251 of November 19, 2007, implements Directive 2004/83/EC concerning minimum standards for granting refugee status or protection. This decree considers transgender status as a possible reason for granting a residence permit for humanitarian reasons.
Moreover, Article 8 of the Decree defines "particular social group" as a group that shares an innate characteristic, common history, or a characteristic or belief that is fundamental to a person's identity or consciousness. This group also possesses a distinct identity in the country of origin, perceived as different from the surrounding society. Depending on the situation in the country of origin, a particular social group can be identified based on the common characteristic of sexual orientation, taking into account gender considerations, including gender identity.

It should be noted that some Italian regions have used their margin of maneuver to regulate these issues further. Some regions in Italy have used the margin of maneuver offered by the distribution ofState-Region powers to introduce laws to combat discrimination based on gender identity.
It includes:

- Tuscany Regional Law 63/2004, "Rules against discrimination based on sexual orientation orgender identity"
- Liguria Regional Law 52/2009, "Rules against discrimination based on sexual orientation or gender identity"
- Marche Regional Law 8/2010, "Provisions against discrimination based on sexual orientationor gender identity"
- Piedmont Regional Law 5/2016, "Implementation of the ban on all forms of discrimination and equal treatment in matters of regional competence"
- Piedmont Regional President Decree 6/R/2017, "Regional regulation implementing Regional Law 5/2016 (Implementation of the ban on all forms of discrimination and equal treatment inmatters of regional competence)"
- Umbria Regional Law 3/2017, "Rules against discrimination and violence based on sexual orientation and gender identity"
- Emilia-Romagna Regional Law 15/2019, "Regional law against discrimination and violence based on sexual orientation or gender identity"
- Campania Regional Law 37/2020, "Rules against violence and discrimination based on sexual orientation or gender identity and modifications to Regional Law 14/1977 (Establishment of the Regional Women's Consulta)"
- Tuscany Regional Government Resolution 329/2021, "Agreement between the Tuscany Region and Public Administrations of the Tuscany Region adhering to the RE.A.DY. Network for the promotion of the network, to strengthen collaboration between local Public Administrations and the integration of their policies at the regional level"

Creating social reflection on legislation is certainly a complex process, but every jurist and healthcare operator must have an overall view in order to achieve the objectives. The Transgender population is characterized by specific social aspects and problems that can be found throughout their entire lives.
Stereotypes, experienced as a threat in the context of psychological care, lead the Transgender

population to access public services less than due. This has important repercussions on their quality of life, affecting every aspect such as physical and mental health, work, family, and relationships.
Certainly, aspects such as discriminations on work, family, university, school and peer group and sometimes also LGBTI groups, are all socio-cultural aspects that affect the Transgender person. For example, with regards to work, the problems of those who have undergone or are undergoing a gender transition, both inside and around work, are multiple, from prejudices to difficulties in completing a CV. Hence, the main issue is changing their documents.

In Italy from 2020 in the CCNL for state employees and from 2022 in the CCNL for the health sector and hopefully soon in the CCNL for health managers, an ALIAS regulation is officially provided for this purpose.

Crystallized stereotypes that turn into prejudices, breaking stereotypes give way to inclusion, such as the ALIAS procedure also in schools and universities for students and teaching staff.

When we talk about the workplace rights of transgender people in Italy, we are faced with a fragmented situation. On one hand, several steps forward have been taken on the topic thanks to training and awareness initiatives managed by activists, experts, and dedicated associations. On the other hand, there is still a long way to go to prevent prejudices and discrimination.

Another prejudice is that even today, transgender women are associated with sex work which in turn is an issue subject to prejudice. Those stereotypes unfortunately persist, and that not only violates the person's respect, but also threatens the job selection process and buying or renting a house. This is paradoxically triggering as a possible consequence the need to begin prostitution, resultingfrom the lack of employment.

It is also essential to mention Article 3 of Law 3 of 2018 on Gender Medicine and subsequent decrees, especially the recent National Training Plan for Gender Medicine signed by the Ministry of Health and the Ministry of University and Research.
This innovative subject specifically includes the paths related to the protection of the health of LGBTI people, in particular transgender and intersex people, and sees the Istituto Superiore della Sanità (ISS) as a referent together with the Observatory for Gender Medicine.

Unfortunately in Italy we still use ICD-9 CM instead of the most recent version ICD-11 which invalidates most of the innovative paths provided for transgender people by the international consesus SOC-8.

In the Health sector, mention should be made of the AIFA 2019 determination on the use of triptorelin in persistent Gender Variant adolescents; the AIFA determination of 2020 for the free triptorelin and cross sex hormones in gender variant people and finally the AIFA 2022 determination for the free PREP as a prevention of particularly serious HIV risk or in transgender people who are Sex Workers.

Also, in the legal-health field, in the future we foresee the need of adaptations in protocols or PDTA that will be necessary as well as a certain degree of adaptation of health personnel to prepare for

the affirmative reception and inclusion of transgender people both as patients and as health personnel.

References:

SOC-8: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9553112/

Other references are the laws indicated in the text

CZECH REPUBLIC

Transition (or gender affirmative process) is defined as a process undergone by some trans-identified or gender diverse persons to live authentically in their desired gender role. This process may include changing one's appearance, name, taking hormones, undergoing surgery and/or changing official documents to reflect the true gender identity. In most countries, including Czech Republic, there are officially only two binary gender options (male and female) and a third category is not yet existing.

SOCIAL TRANSITION

In Czechia, transition is often perceived as equalling medical / physical transition including hormones and surgeries. However, the most important and primary part of the process of transition is the social one because it provides:

Identity affirmation: Social transition is the process by which individuals start living in their self-identified gender in their daily lives. This can include changing their name, pronouns, clothing, and appearance to match their gender identity. This affirmation can be incredibly empowering and crucial for their mental and emotional well-being.
Better public acceptance: Social transition affects how people interact with the transitioning individual. It's about being recognized and treated in accordance with their true gender identity by family, friends, coworkers, and society at large.
Accessibility and non-invasiveness: Social transition doesn't require medical intervention, making it more accessible to a wider range of people. It can be a necessary first step, especially for those who, due to financial, health, or personal reasons, may not want or be able to pursue hormonal or surgical transition.
Better mental health: Studies have shown that social transition significantly reduces dysphoria and improves mental health outcomes in transgender individuals. Being recognized and treated as their true gender can alleviate feelings of distress and improve self-esteem and overall life satisfaction.

Social transition in Czechia is widely respected and relatively safe if one is conforming to socially stereotypical binary gender roles. People who are visibly trans and gender-diverse. njlguz

Name change

In Czechia, you can use your new name and gender immediately - you don't have to wait for the official gender change to be approved (some people don't want or are not entitled to it). You can make an unofficial name change first, e.g. on social media, to your family, friends or co-workers. You

can also (temporarily) choose a neutral name (Danny, Niky, Alex) that will not be so new to others. The official change then takes place as part of the official transition process, after a diagnosis has been obtained and on medical advice at the registry office. However, the name can only be changed to a neutral form before the official gender change.

Change of pronouns / grammatical gender

This might be difficult in Czechia as the official process of transition is lengthy and the gender marker and name can only be changed after several years including hormonal treatment and surgery. That is why there is often a mismatch between the official name and gender marker in documents which may cause confusion related to pronouns. Regarding non-binary and gender-diverse persons, appropriate way of addressing and use of pronouns is extremely difficult in Czechia, as there is no gender-neutral pronoun in the Czech language, as well as no verb form. Some refer to themselves using the masculine or feminine, some alternate between these two, others use the „it“ pronoun, or the newly discovered pronoun "one".

MEDICAL/PHYSICAL TRANSITION

Each transition process is unique and individual. Each person has a different goal and idea of how far they want to go in their transition. In order to answer this question satisfactorily and simply, we are describing the process of official transition in the CR. If you don't want to undergo any of this process for whatever reason, it doesn't mean you are not "trans enough" or "non-binary enough". Each*one*of*us*is*unique*with*unique*needs and it is up to us how we live our lives.

The first step is to visit a sexologist who deals with the topic of transgender and non-binary people. All you have to do is make an appointment, you don't need an application or a referral. However, every clinic has a different and specific approach to trans and non-binary people, which is mostly based on outdated professional knowledge. Most sexologists in the country also fail to accommodate non-binary people and so reject them. But there are fortunately a few exceptions. You can find out about the care within a given clinic on FB groups for trans and non-binary people, for example. In any case, sexology should treat you with dignity, not force you into unnecessary and degrading examinations such as arousal testing (plethysmograph), naked body examination by sight or touch and other uncomfortable tasks, accommodate your individual situation and give you the choice and time you need for your transition.

You will attend your sexology appointment regularly after your first interview. During these visits, you will be given several requests for labs and endocrinology tests to determine if your planned hormone therapy will work for you. This stage may already give you more courage to gradually make those around you aware that you are transgender or non-binary.

After a few months of regular check-ups, you will be asked to see a clinical psychologist to assess whether you are 'really' trans - to confirm the sexologist's proposed diagnosis. At the same time, you will receive a referral from Sexology, which will allow the registry office to change your name to neutral. You can then apply for a new ID card and other documents with a neutral name.

If the treating psychologist considers that you are comfortable living in your chosen role and your endocrinology tests are in order, you will progress to the hormone treatment phase. Hormonal preparations are used to make you feel better in your own body and in relation to your surroundings.

Trans men and masculine people take the hormone testosterone. It makes the female hormone estrogen disappear from the body, deepens the voice, grows a beard, stops the menstrual cycle, changes the distribution of fat and muscle mass, and balding may begin to occur. It is usually given in injections, but there are also testosterone pills, gels and patches.

Trans women and feminine people take the hormone estrogen plus a testosterone blocker. With these two drugs, the male hormone testosterone stops working in the body, breasts get bigger, fat and muscle mass distribution changes, semen production stops and erectile dysfunction can occur. It is administered in tablets, injections, sprays, gels and patches.

All physical changes due to hormones occur gradually over a period of months to years, and are largely an individual matter. If you decide to have surgical changes, you will be referred to the MHCR Sexology Committee, which approves insurance-covered surgical procedures for trans people, including sex reassignment surgery, one year after you start hormone treatment.

If the MHCR committee, which consists of sexologists, representatives of the Ministry and lawyers and is more or less a formality in the process, approves your request, you can make an appointment directly at the surgery for transition surgery (mastectomy - i.e. Breast removal, hysterectomy - removal of the uterus and subsequent phalloplasty if necessary for trans men and trans masculine people, orchiectomy and vaginoplasty for trans women and trans feminine people) which are covered by your insurance.

LEGAL TRANSITION – LEGAL GENDER RECOGNITION

Legal gender recognition - change of gender marker in documents - is available in the Czech Republic under specific conditions that have to be met. It is linked to medical transition, i.e. the legal gender recognition is only available to those with medical diagnosis and 1 year of hormone treatment and surgical castration.

The process of legal transition is governed by Act 89/2012 (29) Coll. of the Civil Code and Act 373/2011 Coll. on Specific Health Services. However, the whole procedure is associated with discriminatory and degrading requirements both in legal and healthcare terms. The most blatant violations of transgender people's rights are the requirement of castration (surgical treatment) and divorce as a condition for legal tender recognition embedded in law.

The Czech system of transition includes standard and routine practices that entail stressful and degrading diagnostic methods and treatment of transgender clients in care environments and lead to over-medicalisation and pathologisation of the transgender situation.

Intersex persons as such are not explicitly protected by Czech legislation and their situation remains unexplored. Unofficial information from intersex persons indicates the practice of genital surgery in early childhood performed on some intersex persons leading to trauma and health complications in adolescence and adulthood.

List of conditions to be met if applying for legal gender recognition in the Czech Republic:

- Be 18 years of age and over
- Obtain medical diagnosis
- Get divorced/end existing civil partnership
- Obtain an approval from a committee
- Get castrated
- Not available for non-binary persons

Legal gender recognition in the Czech Republic is not available to non-binary and gender diverse persons who do not fit in binary gender roles.

Currently there are attempts and a bill prepared by the Ministry of Justice to abolish the requirement of surgery for official change of legal gender marker in documents. Legal gender recognition should be available only based on medical diagnosis.

References:

Transparent, Průvodce tranzicí pro trans lidi, 2020

Czech Civil Code: Act No. 89/2012 Coll.

Law on Special Health Services: Act No. 373/2011 Coll.

SLOVAK REPUBLIC

Transition, in the context of transgender individuals, refers to the process through which a person aligns their gender identity with their assigned sex at birth. It is an individualised and personal journey that involves various social, medical, and legal steps, often pursued by transgender people to live authentically and alleviate gender dysphoria.

Transitioning may include social, medical, and legal aspects, but not all transgender individuals undergo every step or in the same order (in Slovakia, the legal transition is conditioned by the medical transition which is conditioned by the social transition and is only allowed for people above the age of 18). The following are some common elements involved in the transition process:

1. **Social Transition:** This involves changing one's name, pronouns, clothing, and overall presentation to align with their gender identity. It may include coming out to family, friends, and colleagues, and establishing new social networks.

2. **Medical Transition**: Medical interventions are available to assist individuals in aligning their physical characteristics with their gender identity. These interventions vary depending on the individual's needs and may include hormone replacement therapy (HRT) and gender-affirming surgeries. Hormone therapy can help induce secondary sexual characteristics consistent with the individual's gender identity, such as the development of breasts or facial hair. *Only possible to people above the age of 18 and there are no "standards of care" for transgender youth.*

3. **Legal Transition**: This refers to changing legal documents such as identification cards, passports, and birth certificates to reflect the individual's affirmed gender. The processes and requirements for legal transition vary by jurisdiction. *Only possible to people above the age of 18*

It is essential to note that not all transgender individuals choose or have access to medical interventions or surgeries, as transitioning is a deeply personal decision. Transitioning is a unique process for each individual, and the steps taken and the timeline for transition may differ based on personal circumstances, resources, and individual preferences. The support and understanding of healthcare professionals, therapists, friends, and family can play a crucial role in facilitating a successful transition.

In most countries, including the Slovak Republic, there are officially only two binary gender options (male and female) and a third category does not exist. Non-binary people are not recognized by the legislation either.

SOCIAL TRANSITION IN SLOVAKIA

Social transitioning, which involves publicly expressing one's gender identity and living in alignment with that identity, is challenging in Slovakia for several reasons:

1. **Societal Attitudes and Prejudice**: Social transitioning often challenges deeply ingrained societal norms and expectations regarding gender (which is not a widely accepted concept in Slovakia) and sex. Most of Slovakia have conservative or traditional views of gender roles, and deviating from these norms can lead to discrimination, prejudice, and social ostracism. Fear of rejection, judgement, and potential harm can make social transitioning difficult.

2. **Lack of Understanding and Education**: Gender identity and transgender issues are still not widely understood by the general public. Many people may lack awareness or knowledge about what it means to be transgender and the experiences transgender individuals face. This lack of understanding can lead to misconceptions, stereotypes, and resistance to accepting and supporting social transitions. In Slovak schools, comprehensive sexual education (CSE) in which these concepts are mentioned is not objectively implemented in the curriculum.

3. **Fear of Loss**: Social transitioning often involves changing one's appearance, name, pronouns, and social interactions. This can cause anxiety and fear of losing personal relationships, including family, friends, or colleagues, who may struggle to understand or accept the transition. Fear of rejection and the potential for strained relationships can make social transitioning difficult emotionally.

4. **Safety Concerns**: Transgender individuals, particularly trans women and non-binary individuals, face a disproportionate risk of discrimination, harassment, and violence. The fear of becoming targets of verbal or physical abuse can make social transitioning daunting, as it exposes individuals to potential harm. Safety concerns are a significant factor in deciding when and how to socially transition.
5. **Professional and Legal Implications**: Transgender individuals face challenges in the workplace, such as discrimination, bias, or difficulty accessing appropriate restroom facilities. Additionally, legal aspects, such as name and gender marker changes on official documents, can involve bureaucratic processes that can potentially lead to further issues and obstacles.

6. **Emotional and Psychological Impact**: Social transitioning can be emotionally and psychologically challenging. It requires self-acceptance, courage, and resilience in the face of potential adversity. Dealing with the reactions and judgments of others can contribute to stress, anxiety, and mental health issues during the transition process.

Despite the difficulties, social transitioning is reportedly still one of the most important parts of the transition process because as trans people begin to live in their affirmed identity, improvement of mental health is widely recognized. It is crucial to have a supportive network, access to resources, and proper education to navigate these challenges successfully.

NAME CHANGE

Many transgender people in Slovakia use nicknames for identification as it is more accepted than coming out as a trans person. People in Slovakia usually start calling trans people by their nickname but would assume what gender you are (what sex you are) by using the gendered language in verbs and adjectives.

According to the current legislation, a male person cannot be given a female name and vice versa, i.e. a person designated as male cannot be given a female-connoted name and a person designated as female cannot be given a male-connoted name. To change the name from e.g. Jan (male version, equivalent of John) to Jana (female version, equivalent to Jane), it is therefore necessary to change the gender marker in the documents, which also means changing the person's birth number, a Slovakian form of social security number which is distinguishable by gender. Many countries have legislation on names that is more permissible and open. A transgender person can thus only change their name to a neutral one during the transition process as this is the only possible option before the change of their birth certificate number. A neutral name does not clearly communicate the gender of the person in question, so it is unisex. The law says that when a neutral name is chosen, the goal is that it should not be clear from the name whether the person is male or female. The change of a person's first and surname to a neutral one must be authorised by the registry office on the basis of their application and a statement from the psychiatrist by whom the "sex change" is being carried out. The real name change is a part of the legal transition.

GENDERED LANGUAGE

Trans people, but especially nonbinary and gender diverse individuals, can face challenges in gendered languages due to the inherent binary nature of such languages. Gendered languages, like Slovak, assign grammatical gender to nouns, pronouns, and adjectives, typically categorising them as masculine or feminine. This binary system can create difficulties for those who do not identify strictly as male or female as the absence of neutral or non-gendered pronouns or descriptors can make it challenging for nonbinary and gender diverse people to express their identities accurately. It also creates an opportunity for misgendering them. Some nonbinary people like to refer to themselves in third gramatical neutral gender and use "it" instead of "he" or "she". There have been attempts to create other linguistic choices, such as those proposed in "Nebinárna príručka" by Vic Vargic or "Bezrod" by Sely.

MEDICAL TRANSITION

In Slovakia, the process of medical transition is currently governed by the recently approved "Standard Procedure for the Diagnosis and Comprehensive Management of Healthcare for an Adult with Transsexualism" (**REF;** henceforth referred to as the Standard). The Standard, officially adapted on March 3, 2023, serves as a "standards of care" and clinical guidelines document aimed at unifying treatment and medical care associated with transition.

The introduction of the Standard was prompted by calls for standardization and optimization of transition-related medical care, both from the medical profession and the transgender community. Prior to its implementation, experiences of transition-related healthcare varied greatly depending on the medical provider. Without standardized guidelines, each provider had their own set of treatments

and procedures for trans individuals, resulting in significant discrepancies. This meant that every trans person seeking medical care for transition had a fundamentally different experience based on factors such as region, available providers, requirements, and approaches. The recent adoption of the Standard, after years of discussion, public debate, and attempts to discredit it by anti-trans movements, is thus considered a significant step forward in improving trans healthcare in Slovakia. However, it's important to note that the Standard still faces challenges due to pressure and opposition from anti-trans groups, who seek its repeal, cessation of effect, or complete withdrawal for ideological and political reasons.

Despite the existence of the newer 11th revision of the International Classification of Diseases (ICD), the Standard is still based on the outdated ICD-10 understanding that considers being trans a mental and behavioural disorder categorised under "gender identity disorders" as "transsexualism." This is because Slovakia is currently in the process of implementing the new ICD revision, which is being translated into Slovakian for national use. However, the Standard acknowledges the different conceptualization of trans-related health issues as defined by the ICD-11 ("gender incongruence") and the DSM-5 ("gender dysphoria"). It also recommends auditing and revising the Standard after the implementation of ICD-11 in Slovakia.

The Standard places great emphasis on an individualised approach, centred around each trans person's specific needs, in overall treatment planning and care management. It advocates for a "gender neutral" approach, open and honest dialogue, the establishment of trust and a good therapeutic relationship, the use of chosen pronouns and name, and professional non-judgmental and non-moralizing attitudes from all healthcare professionals involved in the care. Informed consent is also highlighted as crucial, with medical professionals required to provide comprehensive information on the risks and benefits of all procedures included in the treatment plan. Multiple written consent forms, signed by the trans person at various points of care, serve as evidence of this consent.

It's important to note that the Standard applies only to legal adults over the age of 18, as they are the only ones currently eligible for a diagnosis of transsexualism in Slovakia. Unfortunately, there are no options for trans youth to access gender-affirming healthcare in the country at present. While the Standard defines the minimum duration of different treatment phases, it does not specify a maximum time limit for any phase, as this depends on the individual needs of the person undergoing treatment.

Overall, the Standard is seen as a more unified and transparent approach to the management of trans-related healthcare. It outlines three distinct phases of treatment: diagnostic, intervention, and follow-up.

1. **Diagnostic phase**

The diagnostic phase represents the initial stage of treatment for individuals seeking medical transition. Its primary objective is to confirm the diagnosis of F64 Transsexualism, establish the presence of psychiatric and somatic comorbidities, including their potential impact on and contraindications for transition-related medical care, and determine the individual's needs and readiness to begin medical transition and live in their affirmed gender for the rest of their life embark on the lifelong journey of living in their affirmed gender. The minimum duration of this phase is one year, although it may be longer depending on individual circumstances.

The treatment process begins with an appointment with a psychiatrist, who becomes the coordinating medical provider for the individual's medical transition. This initial psychiatric

examination, which can be scheduled either with or without a referral from a general practitioner (GP), is focused on comprehensive assessment, particularly in relation to the F64.0 diagnostic criteria, as well as the evaluation of possible accompanying psychopathologies. A detailed sexological history and anamnesis are obtained for the purpose of this evaluation. Subsequently, an individualised treatment plan is developed, which includes further examinations divided into two diagnostic paths: psychiatric and somatic. To progress from the diagnostic phase to the intervention phase and receive a confirmed diagnosis of transsexualism, it is necessary to diligently follow both of these paths and complete all prescribed examinations without exemption.

The psychiatric diagnostic path involves ongoing psychiatric monitoring, which entails a minimum of four check-up appointments per year with the primary psychiatrist. Additionally, it includes differential diagnosis of psychiatric comorbidities and a referral for a comprehensive psychological examination and assessment conducted by an independent clinical psychologist over a minimum of two sessions.

The somatic diagnostic path comprises several mandatory specialist examinations, which are accessed through referrals from the coordinating psychiatrist. These examinations encompass genetic screening (with a focus on karyotype analysis), gynaecological or urological screening (with an emphasis on detecting comorbidities in those respective areas and providing information on the benefits and potential complications of various medical transition interventions, including their effects on fertility and reproduction), and endocrinological examination (aimed at assessing endocrinological conditions, diagnosing and treating potential concurrent endocrinopathies, and evaluating the suitability for planned transition-related endocrinological interventions).

Once all the aforementioned examinations have been completed and any comorbidities have been stabilised, the individual returns to their coordinating psychiatrist for a final psychiatric examination. This assessment involves a comprehensive analysis of all the results and findings obtained during the above diagnostic procedures, evaluated in accordance with the ICD-10 diagnostic criteria for category F64.0. If the criteria are met, the psychiatrist confirms the diagnosis and discusses further possibilities for medical care and interventions, as well as the medical and non-medical risks associated with these interventions. The psychiatrist also provides information regarding legal name change options available at this stage, such the use of a gender-neutral name. Finally, a definitive individualised treatment plan is established in collaboration with the individual, and their signatures are obtained as evidence of their informed consent with the outlined plan.

2. Intervention phase

The intervention phase aims to enable the trans person undergoing medical transition to live congruently with their gender identity and facilitate, to the highest degree possible, adjustment to the new role, so that the individual can achieve better quality of life and satisfactory integration into society. This phase encompasses a range of gender-affirming medical interventions, which can be categorised into two groups:

a. *partially reversible:* endocrinological interventions, i.e., gender affirming hormone therapy;
b. *irreversible:* surgical operative procedures, such as aesthetic surgical procedures aimed at adapting body characteristics, genital reconstructive surgery as well as surgical interventions

resulting in permanent loss of sex hormone production and reproductive capacity (which can only be indicated a year after starting hormone therapy).

The specific combination of interventions within these categories is determined based on each transitioning person's unique health status, medical history, needs, contraindications, and personal preferences, as outlined in their individualised treatment plan. However, it is important to note that many gender-affirming surgical interventions are currently unavailable in Slovakia, which significantly limits treatment options and overall access to gender-affirming care. As of now, the Standard indicates that the only surgical interventions offered in the country are hysterectomy (with or without bilateral salpingo-oophorectomy) and breast surgery for FtM transition, as well as orchiectomy and breast surgery for MtF transition. It is worth emphasising that the Standard explicitly states that a "real-life test" is not required during either the diagnostic or intervention phase and, as such, is not considered an obligatory part of comprehensive healthcare management for trans individuals.

The intervention phase does not specify a universal maximum duration and varies depending on individual circumstances. However, it is required that individuals undergo this phase for a minimum of one year before they can obtain a "medical assessment for person's sex change" document. This document, which can only be issued by a psychiatrist with at least five years of experience or a psychiatrist-sexologist, serves as certification of the person's transition and is an essential part of the legal transition process. Without this document, the person's sex cannot be legally changed on any official documents. It is important to note that the term "sex" is used in this context due to Slovak legislation not recognizing the term "gender" for legal purposes related to transition.

3. Follow-up phase

The follow-up phase includes obligatory components, such as ongoing monitoring of hormone therapy, preventive gynaecological/urological check-ups as indicated for the general population and by the effects of undergone gender-affirming medical interventions, monitoring of surgical interventions and associated health status, and general medical care. Optional components vary depending on individual need and may include speech therapy, hair therapy, cosmetic and aesthetic care, further somatic interventions, including additional gender-affirming surgeries as well as psychosocial and psychotherapeutic care. Overall, the follow-up phase involves a range of medical and psychological services to support individuals' ongoing medical transition related needs.

LEGAL TRANSITION IN SLOVAKIA

The legislation of the Slovak Republic does not recognize the term “transition” or “gender reassignment” but only the pathologizing and incorrect term “sex change”. The procedure for changing a person's data (first name, surname, birth number, sex identification) as a result of a “sex change” is partly regulated by Act no. 300/1993 Coll. on name and surname and Act no. 301/1995 Coll. on birth number.

In order to change the gender marker on documents (from M to F and vice versa), trans people first need to change their birth number. The Birth Number Act states that the Ministry will, on request, change a person's birth number on the basis of a medical report of a change of sex. The first step is thus to obtain such a certificate (for further details see the medical transition in Slovakia part), the

second is to apply for a new birth number, on the basis of which a new birth certificate will be issued and the old one will be discarded. In practice, this means that a trans person needs to ask the relevant health care provider for a health certificate. They must obtain a certificate from the health care provider that recommends a change of birth number on the basis of the diagnosis and then submit the change of documents to the registry office to which they belong according to the place of birth. When they apply for a new identity card, they must bring proof of this change or a document confirming the new information - in this case a new birth certificate or a confirmation of its change - to the relevant County Police Department. With the birth certificate, as well as the already issued ID card, they can report changes to their public health insurance company and any other institutions they are registered with, such as schools, universities, unemployment offices, council tax registers, and the like. The whole process of changing the data and issuing the documents takes as long as any other document change if met with understanding from people in the Registrar Office. However, in practice, many transgender people face discrimination because staff working in the Registrar offices often have little to no competence and/or knowledge around these name changes associated with transitioning the

Legal gender recognition **is not available to non-binary and gender diverse persons in Slovakia who do not fit the binary gender roles**.

Currently there have been attempts in the Slovak Parliament to introduce a de facto ban on legal transition altogether with the argument of one of the proposing members of the bill being “to keep order in society”. At the time of writing, this bill passed to the second hearing as 87 MPsvoted in favour. Advocacy groups, activists and medical professionals are currently pushing back and fighting so the bill does not pass the second hearing.

Risk factors associated with LGBTQ+ people

Physical, social and legal transition processes can carry with them some risk factors because LGBTQ+ people belong to a minority group. Being part of a minority group means suffering discrimination, prejudice and stigma.

In 1992, Root theorized the psychological impact of discrimination against LGBTQ+ minority identities as *insidious trauma*. A form of this kind of trauma is the so-called "minority stress" (Meyer, 1995, 2003, 2007; Szel, Z., Török, Z., 2022): that means that LGBTQI+ people experience more stress than etero-cis people. According to the Minority Stress Model, implemented by Meyer (1995, 2003, 2007), minority stress, which includes discrimination, prejudice, and stigma, causes people to expect rejection, which in turn has a negative impact on their mental health. Minority stress is persistent, social in nature, and adds to the overall stress that everyone experiences. People who are the focus of prejudice often become watchful in order to foresee and avoid prejudice, negative regard, and violence (Meyer, 2003).

Minority stress is:

- *unique* because it's an additional factor to the general stress;
- *chronic* because it's an integral part of the culture;
- *socially based* because it derives from a series of social, institutional, and structural processes that are culture-dependent.

There are internal and external stressor that concur to the development of mental illness because they reduce the openness of the *window of tolerance* (Siegel, 1999). Genetics, biology, and endocrinology are examples of internal influences while external factors are environmental stresses such as verbal or physical or sexual abuse, transphobia, rejection from family or friends.

The consequence is an increased risk of mental disorders such as depression, suicide risk, eating disordes and anxiety, especially PTSD and a grown up of disadaptive behaviour just like prostitution, alcohol and substances use (Szel, Z. and, Török Z., 2022; Hughto et al., 2021).

Depression is a sad and deflected mood condition characterized by lack of energy, low self-confidence, sense of guilt and/or other syntomps related. A direct consequence of depression is the risk of suicide. Depression is often associated with anxiety: anxiety is a widespread feeling of worry, it can be focused on a situation or specific object, panical period, repetitive thoughts and/or behaviors and persistent anxiety reaction after traumatic events (Comer, R.J., 2014).

A consequence of minority stress are eating disorders: compared to their heterosexual and cisgender colleagues, LGBT adults and adolescents experience eating disorders more frequently (Parker and Harriger 2020). This higher incidence can be attributed to the higher levels of stress inherent in

organizations that serve sexual and gender minorities. Disordered eating habits are linked to reactions to stress, victimization, prejudice, and o-phobia. According to Parker and Harriger (2020), there is a connection between minority stress and uncontrolled eating disorders (binge eating) in lesbian and bisexual women as well as body dissatisfaction in gay men. Physical health is significantly at danger from eating disorders. Obsessive weight control and dietary limitations including fasting, using laxatives, and using diet pills might have negative effects on one's health. The risk of endocrine abnormalities, mental symptoms, renal, liver, musculoskeletal, and cardiovascular ailments rises with anabolic steroid use. The danger of suicide is the risk connected with eating disorders most strongly, and those who suffer from eating disorders have extremely high mortality rates.

In a study of Mcbee-Strayer and Rogers (2002), they study the epidemiology of suicidal behaviour in LGB people. They found that 91% of those people thought about suicide: in particular “41% of the respondents indicated a serious consideration of suicide including the identification of a specific suicide plan (23%) or a past suicide attempt (36%) with significant intent to die (13%)” (Mcbee-Strayer and Rogers, 2002, p.272). While from a meta-analysis by Liu et colleagues (2019) on the prevalence of nonsuicidal self-injury in LGBT people they found that the 29,68% of sexual minority and the 46,65% of gender minority have put such behavior into practice during life-time.

Another cause of suicide risk can be the post-traumatic stress disorder. It is an anxiety disorder in which fear and related symptoms persist long after the traumatic event (Comer, R.J., 2014). In fact, 17,8% of trans people suffer from PTSD (Keating, L. e Muller, R.T., 2019) because of discrimination. The authors claim that discrimination can be experienced as trauma by LGBTQ+ people. As a result, they exhibited higher levels of attachment anxiety and avoidance, difficulties accepting, being aware of, and coping with negative emotions, posttraumatic stress symptoms, and dissociative memory disturbances (*ibidem*).

Particularly, related to significant relationships (parents, partner, friends), there is a risk of being turned away from home or moving away from home due to the non-acceptance of coming-out by them. The consequence can be the absence of economical support and shelter that can lead to prostitution in exchange for these needs (Cochran et al., 2002). Cause and effect of prostitution is also joblessness, in fact there is a bidirectional correlation between the two variables due to the stigma that all trans people are prostitutes, especially MtF (Nemoto et al., 2004). In addition, to enhance their sexual performance, these people use drugs and alcohol: this phenomenon is called *chemsex* (Tomkins, George and Kliner, 2019). This tendency is used as a coping strategy, as self-medication in difficult life situations, and as a palliative for anxiety in sexual as well as social situations. These behaviors are also often fostered, especially in accidental societies, by exclusively LGBT friendly venues where alcohol and drug use is widespread putting such people at risk toward high consumption of potentially addictive drugs that make recovery from addiction difficult. These

risky behaviors can also have effects on physical health, for example cardiovascular and pulmonary diseases, sexually transmitted diseases and cancer (Szel, Z. and, Török Z., 2022).
Another risk factor for LGBTQ+ people is internalized homo-bi-transphobia that is the early development of negative social attitudes, beliefs and stereotypes about LGBTQ+ people themselves. These beliefs lead to self-stigmatization, which in turn puts at risk opportunities for social support by affecting intimate relationships. Additionally, there's a risk for mental and physical health which causes low self-confidence and raises the possibility of engaging in risky behaviors (Szel, Z. and, Török Z., 2022).

It is not uncommon for these people to be victims of partner violence, this violence can be physical, verbal and psychological such as every kind of relation, but the uniqueness of violence between LGBT couples is the menace of forced outing. Outing is the disclosure to others of another person's sexual orientation or gender identity. In addition, these people don't ask for help because of the fear of coming out (*ibidem*).
Hormonal therapy, that some of these people choose to use are responsible for some of the risk factors for physical health, in fact long-term hormone use poses risk like lowers fertility and raises the possibility of irreversible infertility (embryo cryopreservation). Additionally, hormone therapy may cause a decrease in libido in certain patients.

Collateral effects of this therapy are:

- Venous thromboembolism (deep vein thrombosis, pulmonary embolism)
- Increased risk of cholelithiasis and pancreatitis
- Weight gain
- Elevated liver function tests
- Erectile dysfunction
- Hypertension
- Type 2 diabetes
- Hyperprolactinemia, prolactinoma
- Polycythemia
- Weight gain
- Acne and male pattern baldness
- Sleep apnea
- Dyslipidemia
- Increased risk of hypomanic, manic or psychotic symptoms

In conclusion, mistrust of medical and mental health specialists as well as obstacles to obtaining services necessary all work against healing.

References

Root, M. P. (1992). Reconstructing the impact of trauma on personality. In L. S. Brown & M. Ballou (Eds.), Personality and psychopathology (pp. 229–265). New York, NY: Guilford
Meyer, I. H. (2003). Prejudice, social stress, and mental health in Lesbian, gay and bisexual populations: Conceptual issues and research evidence. Psychological Bulletin, 129, 674-697.ù

Meyer, I.H. (1995). Minority stress and mental health in gay men. Journal of Health and Social Behavior, 36 (1), 38-56.

Meyer, I.H. (2007). Prejudice and Discrimination as Social Stressors. In I.H. Meyer, & M.E. Northridge (A cura di), The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations (pp 242- 267). New York: Springer.

Szél, Z., & Török, Z. (2022). Open up the doors! An LGBTI handbook for healthcare professionals. Háttér Society.

Siegel, D. J. (1999). The developing mind: Toward a neurobiology of interpersonal experience. New York, NY: Guilford Press.

Hughto, Jaclyn M. W., Emily K. Quinn, Michael S. Dunbar, Adam J. Rose, Theresa I. Shireman, and Guneet K. Jasuja. (2021). "Prevalence and Co-Occurrence of Alcohol, Nicotine, and Other Substance Use Disorder Diagnoses Among US Transgender and Cisgender Adults." JAMA Network Open 4(2).

McBee-Strayer, Sandra M., and James R. Rogers. (2002). "Lesbian, Gay, and Bisexual Suicidal Behavior: Testing a Constructivist Model." Suicide and Life-Threatening Behavior 32(3). 272–83.

Liu, Richard T., Ana E. Sheehan, Rachel F. L. Walsh, Christina M. Sanzari, Shayna M. Cheek, and Evelyn M. Hernandez. (2019). "Prevalence and Correlates of Non-Suicidal Self-Injury among Lesbian, Gay, Bisexual, and Transgender Individuals: A Systematic Review and Meta-Analysis." Clinical Psychology Review 74. 101-783.

Keating, L., & Muller, R. T. (2018). LGBTQ+ people's experiences of barriers and welcoming factors when accessing and attending psychotherapy for psychological trauma. Manuscript submitted for publication.

Comer, R. J. (2014). Clinical Psychology. Worth Publisher, New York.

Cochran, Susan D., Vickie M. Mays, Deborah J. Bowen, Susan Gage, Deborah Bybee, Susan J. Roberts, Robert S. Goldstein, Ann Robison, Elizabeth J. Rankow, and Jocelyn White. (2001). "Cancer-Related Risk Indicators and Preventive Screening Behaviors among Lesbians and Bisexual Women." Ame- rican Journal of Public Health 91(4). 591–97.

Nemoto, T., Operario, D., Keatley, J., & Villegas, D. (2004). Social context of HIV risk behaviors among male-to-female transgenders of color. AIDS Care, 16, 724–735.

Tomkins, Andrew, Ryan George, and Merav Kliner. (2019). "Sexualised Drug Taking among Men Who Have Sex with Men: A Systematic Review." Perspectives in Public Health 139(1). 23–33.

ETHICAL ASPECTS

Ethics play a crucial role in the care for transgender people, as they guide healthcare professionals in providing respectful, inclusive, and affirming services. Ethical considerations ensure that transgender individuals receive care that respects their autonomy, dignity, and identity. It is essential for healthcare providers to uphold ethical principles such as non-discrimination, informed consent, confidentiality, and cultural sensitivity. Ethical care acknowledges the unique experiences and challenges faced by transgender individuals and aims to address health disparities, promote well-being, and advocate for the rights and healthcare needs of this population. By adhering to ethical standards, healthcare professionals can contribute to creating a healthcare system that is equitable, compassionate, and responsive to the diverse needs of transgender people.

Standards of Care 8

World Professional Association for Transgender Health (WPATH) had published a widely accepted set of guidelines, the Standards of Care, which can serve as a foundation for principles of ethics when providing care to transgender and gender diverse patients.

WPATH Standards of Care (version 8) emphasize the need for ethical, patient-centered, and affirming care for transgender and gender diverse individuals, while also promoting the rights, well-being, and dignity of this populationThe World Professional Association for Transgender Health (WPATH) has developed standards of care known as the WPATH Standards of Care (SOC), which provide guidelines for the ethical provision of healthcare to transgender and gender diverse individuals. The SOC document highlights several important ethical considerations.

Respect for Autonomy: Health providers should respect the autonomy of transgender and gender diverse patients, acknowledging their right to make informed decisions about their own bodies and gender-affirming care.

Non-Discrimination: Health providers should provide equal and non-discriminatory care to transgender and gender diverse patients, irrespective of their gender identity or expression.

Cultural Competence: Health providers should continuously educate themselves about transgender and gender diverse health issues, understand the unique challenges faced by these populations, and provide culturally competent care.

Informed Consent: Health providers should ensure that transgender and gender diverse patients receive comprehensive and accurate information about the benefits, risks, and alternatives to all available treatment options, enabling them to make fully informed decisions.

Privacy and Confidentiality: Health providers must prioritize the privacy and confidentiality of transgender and gender diverse patients, respecting their right to disclose their gender identity on their own terms.

Affirmative Care: Health providers should adopt an affirmative approach towards transgender and gender diverse patients, acknowledging and validating their gender identity and expression, and providing appropriate care that aligns with their needs.

Collaboration and Multidisciplinary Care: Health providers should work collaboratively with other healthcare professionals, such as mental health specialists, endocrinologists, and surgeons, to ensure comprehensive and coordinated care for transgender and gender diverse patients.

Continuous Education and Professional Development: Health providers should engage in ongoing education and training to stay updated with the latest research, guidelines, and best practices related to transgender and gender diverse healthcare.

Reflective Practice and Self-Awareness: Health providers should engage in reflective practice, continuously examining their own biases, beliefs, and assumptions about gender identity and expression, and working to provide compassionate and patient-centered care to transgender and gender diverse patients.

Diagnosis and Treatment: Explain the patient's diagnosis, including their gender dysphoria or transgender identity, and the available treatment options. Discuss the potential benefits, risks, and anticipated outcomes of each treatment option, such as hormone therapy, gender-affirming surgeries, or psychotherapy.

Risks and Side Effects: Provide a thorough overview of the potential risks, complications, and side effects associated with the proposed interventions or treatments. This includes both short-term and long-term effects, such as surgical complications, hormone-related health risks, or psychological effects.

Alternatives: Discuss alternative treatment options that may be available to the patient. For instance, if a patient is considering hormone therapy, inform them about the different types of hormone regimens, potential effects, and alternative approaches, such as non-hormonal interventions or watchful waiting.

Potential Outcomes: Explain the expected physical, psychological, and social changes that may occur as a result of the proposed interventions or treatments. Provide information about the potential benefits, such as improved gender dysphoria relief, enhanced well-being, or better alignment with their gender identity.

Timeline and Stages: Inform the patient about the timeline and stages involved in their proposed treatment plan. Explain the sequence of interventions, the expected duration of each stage, and any prerequisites or criteria that need to be met before proceeding to the next step.

Follow-up Care: Discuss the need for ongoing monitoring, follow-up appointments, and potential adjustments to the treatment plan. Emphasize the importance of regular check-ups, laboratory monitoring (if applicable), and psychological support throughout the treatment process.

Fertility Preservation: Address the potential impact of medical interventions on fertility and discuss options for fertility preservation, such as sperm or egg banking or other reproductive technologies. This is particularly relevant for transgender individuals who may want to have biological children in the future.

Costs and Insurance Coverage: Provide information about the financial aspects of the proposed interventions or treatments, including the estimated costs, potential insurance coverage, and available financial assistance programs or resources. Ensure that patients are aware of any out-of-pocket expenses they may incur.

Confidentiality and Privacy: Discuss the importance of patient confidentiality and privacy, as well as any limitations to confidentiality that may exist under legal or ethical requirements. Address any concerns related to the sharing of medical information with other healthcare providers or insurance companies.

Questions and Clarifications: Encourage patients to ask questions, seek clarification, and express any concerns or reservations they may have. Create an open and non-judgmental environment that fosters trust and facilitates an informed decision-making process.

It's important to note that the specific information provided during the informed consent process may vary based on individual patient circumstances, local regulations, and the specific healthcare interventions being considered.

Stigma

Transgender individuals often face various forms of stigmatization, which can have a significant impact on their mental and physical well-being. Stigmatization refers to the process of treating or viewing someone in a negative or discriminatory way based on certain characteristics or attributes. Addressing and combating stigmatization is crucial to promoting the well-being and equality of transgender patients. It involves education, advocacy, policy changes, and creating inclusive environments that respect and affirm gender diversity. Here are some common stigmatization issues experienced by transgender patients:

Social Stigma: Transgender individuals may face social stigma, which includes negative attitudes, beliefs, and prejudices from society. This can result in social isolation, rejection, and exclusion, leading to feelings of loneliness and depression.

Discrimination: Transgender individuals often encounter discrimination in different areas of life, such as employment, housing, healthcare, and education. They may face barriers to accessing basic services, unequal treatment, and limited opportunities due to their gender identity.

Verbal Abuse and Physical Violence: Transgender individuals are susceptible to verbal abuse, hate speech, and harassment. They may experience derogatory comments, slurs, or insults, which can significantly impact their self-esteem, mental health, and overall quality of life. Some transgender individuals may also face physical violence, including assault, hate crimes, and transgender-related homicides. This violence can cause severe physical injuries, emotional trauma, and even loss of life.

Internalized Stigma: Transgender individuals may internalize societal stigma and develop negative beliefs about themselves, leading to feelings of shame, guilt, and self-hatred. Internalized stigma can affect their self-worth, mental health, and ability to seek necessary healthcare.

Healthcare Disparities: Transgender individuals often encounter barriers to accessing appropriate healthcare services. They may face discrimination from healthcare providers, lack of knowledgeable providers, limited insurance coverage for gender-affirming care, and a lack of inclusive policies and practices in healthcare settings.

Mental Health Challenges: Stigmatization can contribute to higher rates of mental health issues among transgender individuals, such as depression, anxiety, and suicidality. The lack of acceptance and support from society can exacerbate these challenges.

Informed Consent

Consent is an essential ethical and legal requirement when providing healthcare to transgender patients. It ensures that patients have the necessary information to make autonomous decisions about their medical care and treatment options.

When working with transgender patients, healthcare providers should adhere to the following general **principles** of informed consent:

Disclosure: Healthcare providers should provide comprehensive and accurate information to transgender patients about the nature, purpose, risks, benefits, and potential outcomes of the proposed medical interventions or treatments. This includes explaining the available options, potential side effects, alternative approaches, and any anticipated long-term effects.

Voluntariness: Informed consent must be given voluntarily by the patient without coercion or pressure. Healthcare providers should avoid any attempts to influence or manipulate the patient's decision-making process. Patients should have the freedom to accept or decline specific medical interventions or treatments based on their individual needs, values, and goals.

Competence: Patients must possess the capacity to understand the information provided and make decisions regarding their healthcare. Healthcare providers should assess the patient's ability to comprehend the relevant information and ensure they are capable of providing informed consent. If a patient lacks decision-making capacity, substitute decision-makers, such as legal guardians or designated individuals, may be involved.

Comprehension: Healthcare providers should use clear and accessible language when discussing medical interventions or treatments with transgender patients. They should ensure that patients understand the information provided, including potential risks, benefits, and alternatives. If language barriers exist, interpreters or translated materials may be necessary.

Health and Therapy Care Providers working with Transgender and Non-binary Clients

Healthcare providers hold a critical role in supporting the well-being and development of transgender and intersex individuals, especially during the transition and legal gender recognition process. However, it is concerning to observe instances where healthcare providers, including those specializing in transgender care, are reported to behave in unsupportive or harmful ways towards transgender and non-binary clients. Research conducted in the Czech Republic by Transparent z.s. revealed that a significant number of transgender individuals experienced harassment, discrimination, and degrading treatment from care providers, with 25.1% of respondents reporting negative experiences. This highlights the urgent need for targeted recommendations and guidance directed towards healthcare providers in general, and those specializing in transgender healthcare specifically, to ensure the provision of respectful and inclusive care.

Scientific studies, such as the one conducted by Chapman et al. in 2012, indicate that we cannot assume that healthcare professionals will provide adequate and empathetic care. Families may hesitate to disclose their sexual orientation to healthcare providers due to a lack of trust that they will receive equal and unbiased care compared to heteronormative families. This underscores the significance of employing holistic care models that prioritize the individual's well-being and accommodate the unique characteristics of each family system. The adoption of such inclusive approaches is crucial in ensuring equitable and supportive healthcare experiences for all individuals, regardless of their sexual orientation or gender identity.

Jenner (2010) emphasizes the need for revising healthcare protocols and adapting them to the specific needs of transgender individuals. Providing care for transgender individuals requires knowledge of anatomical reassignments, the effects of hormone therapy, and cultural sensitivities related to gender identity communities. The quality of healthcare for transgender individuals is determined by the importance given to cultural sensitivity, institutional policy changes, and professional integrity.

In a study by Carlström and Gabrielsson (2020) on transgender clients' experiences with healthcare staff, it was found that transgender individuals are often deeply vulnerable and their dignity can be violated when receiving medical care. The authors highlight the importance of healthcare personnel recognizing this vulnerability and empowering transgender clients. By accepting their identities and focusing on their healthcare needs, healthcare professionals can contribute to restoring and upholding transgender individuals' trust in healthcare.

Sedlak, Veney, and Doheny (2016) note that although transgender issues are being discussed more openly in the general public, healthcare providers often express discomfort in interacting with transgender individuals due to a lack of education in transgender care and reliance on insensitive stereotypes.

These studies highlight the urgent need for healthcare providers to receive proper education and training in transgender healthcare, including understanding the specific needs, experiences, and cultural contexts of transgender individuals. By doing so, healthcare professionals can provide more empathetic, respectful, and effective care to transgender populations, fostering trust and improving overall healthcare experiences.

Self-determination

The statements you provided highlight important considerations for providing respectful and inclusive healthcare to transgender individuals. They emphasize the need to respect individuals' self-identified gender identities and to avoid imposing rigid categories or prerequisites for validation. Non-binary gender identities should be recognized and included, and the message of non-discrimination and access to resources should be clear.

The statements also stress the importance of comprehensive education and professional development for healthcare providers, ensuring they have the necessary knowledge and understanding of transgender issues. Respectful practices, such as using preferred names and pronouns, should be implemented, and individuals should have the freedom to choose their own names without unnecessary restrictions.

Regarding medical treatments, the option for hormone replacement therapy (HRT) and transition surgeries should be recognized as medically necessary for those who desire them, while not assuming automatic consent for all treatments. Funding for these treatments should not be contingent on treating transgender status as a disorder, but rather supporting individuals in making informed decisions about their health.

Separating access to specific treatments from legal gender recognition is important, acknowledging that they are separate issues. Healthcare professionals should also stay updated on international developments advocating for the depathologization of transgender identities in the medical field and self-identification as the basis for legal gender recognition, rather than requiring approval from regulatory bodies or specific medical procedures.

Overall, these statements call for a healthcare approach that prioritizes individual autonomy, respects diverse gender identities, and ensures equal access to healthcare resources for transgender individuals.

Knowledge and Awareness

The Ethical Principles of Psychologists and Code of Conduct by the American Psychological Association (APA, 2010) acknowledge the importance of psychologists obtaining training and competence in gender identity. Psychologists should engage in continuous education and training to develop an affirmative practice that respects and supports transgender and gender non-conforming individuals. This training should aim to counter societal ignorance, stigma, sensationalism, exploitation, and pathologization of transgender and gender non-conforming individuals.

Given that many psychologists have received little or no training on the LGBT population (APA, 2015), it is necessary for expert colleagues to take the lead in implementing and disseminating ongoing education and training practices to bridge these knowledge gaps.

Psychologists should adopt a non-judgmental professional attitude towards individuals with different gender identities and expressions from their own. They should increase their awareness of cisgender privilege, anti-trans prejudice, and discrimination. Strategies such as hosting panels with gender expansive individuals sharing their personal perspectives or including their narratives in course readings can contribute to fostering understanding and empathy (ACA, 2009).

By emphasizing the need for education, training, and a non-judgmental attitude, these guidelines aim to promote competent and affirming psychological practices for transgender and gender non-conforming individuals.

According to the ACA, ALGBTIC Competencies for Counseling Transgender Clients, as can be seen from the context of helping relationships, psychologists should have more knowledge regarding the fol- lowing points:

- Physical aspects (e.g., access to health care, HIV, and other health is- sues).
- Social aspects (e.g., family/ partner relationships)
- Emotional aspects (e.g., anxiety, depression, substance abuse).
- Cultural aspects (e.g., lack of support from others in their racial/ethnic group).
- Spiritual aspects (e.g., possible conflicts between their spiritual values and their family's).
- Stressors, e.g., financial problems as a result of employment discrimination (ACA, 2009).

Communication and Self-Reflection

Creating training spaces for healthcare professionals to develop their intrapersonal and interpersonal skills is crucial for providing quality care to transgender and intersex individuals. These training spaces should focus on the following objectives:

1. Self-reflection: Healthcare professionals should be encouraged to identify and examine their own cultural background, values, and principles. This self-awareness helps them recognize and address any biases, prejudices, or stereotypes they may hold, enabling them to provide care in a non-discriminatory and respectful manner.
2. Effective communication: Healthcare professionals need to learn and apply communication models that foster empathy and establish trust with transgender and intersex individuals. These models promote active listening, understanding, and validation of their experiences, which can help prevent instances of violence or mistreatment within healthcare practices and protocols.

By providing training opportunities that address these aspects, healthcare professionals can enhance their ability to deliver culturally sensitive and affirming care to transgender and intersex individuals. This, in turn, contributes to the creation of a healthcare environment that is safe, inclusive, and supportive for all patients.

General Recommendations

- **Believe** – all identities are valid;
- **Respect** – not only tolerate, but respect gender variance and expression;
- **Support, empower** – create safe spaces, communicate, befriend;
- **Protect** – protect trans clients and encourage respect for them, even in their absence.

- Never assume someone's gender based on the ways they dress or express themselves. Unless you know for certain, it is better to use gen- der-neutral language, or ask discreetly.
- Respect the client's preferred name, even if it is different from the name in their legal documents.
- Use the client's preferred pronouns or gendered language and remind others to use them too, even in their absence.
- Don't ask transition-related and intimate questions that are not related to the consulted problem out of curiosity.
- Don't insist on biological categories that maket he klient either a man or a woman.
- Believe and respect the ways in which the person refers to themselves.
- If the client wishes to keep their gender identity a secret, do not discuss it with other people.
- Secure easy access to restrooms and gendered facilities – ask trans clients which ones they prefer to use and ensure that they will be safe using them.

Coming Out

Disclosing one's transgender identity is a deeply personal and sensitive matter that requires trust and bravery. When engaging in conversations about gender identity or transition, it is crucial to prioritize the following approach: 1) Ask the trans individual if they are comfortable with answering any questions, respecting their boundaries and autonomy; and 2) Recognize that even if your questions stem from innocent curiosity, the trans person has the right to end the discussion at any point if they feel uncomfortable. By creating an environment where privacy and integrity are respected, it becomes easier for the trans individual to navigate these conversations while feeling supported and secure.

Use of Name and Pronouns

Respecting the chosen name and pronouns of transgender individuals is vital for creating an inclusive and affirming environment. Some transgender clients may experience anxiety when their birth name is used, while others see it as a part of their past that they wish to move beyond. It is crucial to honor the name that a transgender person is currently using and refrain from sharing their birth name without permission, as this would be an invasion of their privacy.

When unsure about someone's pronouns, it is best to listen to how others address them and follow suit. If it becomes necessary to ask, a helpful approach is to begin by sharing your own pronouns,

such as "I'm Dan, I use he and him pronouns. And you?" Using the given pronouns to address the person and encouraging others to do the same creates an inclusive environment. In the event of unintentionally using the wrong pronoun, acknowledging the mistake, apologizing, and then moving forward is important. By practicing these respectful behaviors, we contribute to fostering a more supportive and understanding society (GLAAD, 2018).

Asking Questions

It is important to respect the privacy and boundaries of all clients, regardless of their gender identity. Asking about a person's genitals or inquiring about their surgical status is inappropriate and intrusive, regardless of whether the individual is cisgender or transgender. It is not our place to seek or share such personal information unless the individual willingly chooses to disclose it. Respecting confidentiality is paramount, and disclosing personal details about transgender individuals and their identities should only occur if absolutely necessary. By maintaining these ethical principles, we foster a safe and trusting environment for all clients.

Know Your Own Limits

When providing care for a transgender client, it is advisable to seek relevant information if you are unsure or unaware of a particular aspect. Making assumptions or sharing potentially incorrect information can be harmful and hurtful. It is better to approach the client with respect and ask questions when appropriate, demonstrating a willingness to learn and understand their unique needs and experiences. Online resources can be valuable tools for educating oneself and gaining a deeper understanding of transgender identities and issues. By actively seeking knowledge and being open to learning, healthcare providers can deliver more informed and sensitive care to transgender clients (GLAAD, 2018).

Debunking Misconceptions

In the public and professional space, there are unfortunately numerous misconceptions and misunderstandings about transgender people. These misconceptions often stem from a lack of accurate information, societal biases, and limited exposure to diverse transgender experiences. Such misconceptions can contribute to stigma, discrimination, and the marginalization of transgender individuals.

Most common misconceptions:

Misconception: Being transgender is a phase or a result of confusion.
Reality: Gender identity is a deeply ingrained aspect of a person's identity and is not a phase or confusion.

Misconception: Transgender people are mentally ill.
Reality: Being transgender is not classified as a mental illness by major medical and psychiatric organizations.

Misconception: Transgender people are just seeking attention.
Reality: Transgender individuals often face significant discrimination and stigma, and their transition is an authentic expression of their gender identity, not a ploy for attention.

Misconception: Transgender people are a threat to others, especially in restrooms or changing facilities.
Reality: There is no evidence to support the claim that transgender people pose a threat to others. In fact, transgender individuals are more likely to face harassment or violence in public spaces.

Misconception: Transgender children are too young to know their gender identity.
Reality: Many transgender individuals report experiencing gender dysphoria from a young age, and gender identity can be deeply ingrained in a child's sense of self.

Misconception: Transgender individuals are confused about their sexual orientation.
Reality: Gender identity and sexual orientation are distinct aspects of a person's identity. Transgender individuals can have any sexual orientation, just like cisgender individuals.

Misconception: Transitioning is always accompanied by medical interventions or surgeries.
Reality: Transitioning is a highly individual process, and not all transgender individuals pursue medical interventions or surgeries. Transitioning can involve social, legal, and psychological aspects as well.

Misconception: Transgender individuals regret transitioning.
Reality: While some individuals may experience challenges during their transition, regret among transgender individuals who undergo gender-affirming care is relatively low.

Misconception: Accepting transgender individuals is a recent social trend.
Reality: Transgender people have existed throughout history and across cultures. Recognition and understanding of transgender identities have evolved over time, but their existence is not a recent phenomenon.

Misconception: Detransitioning is common among transgender individuals.
Reality: Detransitioning is relatively rare, and it is important not to overgeneralize individual experiences to the broader transgender community.

Misleading Theory of Rapid onset gender dysphoria (ROGD)

"Rapid onset gender dysphoria" (ROGD) is a term/concept (not clinical term) that was introduced in a controversial study published in 2018. The study proposed the concept of ROGD to describe a phenomenon where adolescents, particularly assigned female at birth, supposedly experience a sudden and intense onset of gender dysphoria after exposure to online media or social influences.

It's important to note that the concept of ROGD has been widely criticized within the scientific and transgender healthcare communities. Many experts have raised concerns about the study's methodology, sample size, lack of scientific rigor, and potential for bias, used secondary dates. The World Professional Association for Transgender Health (WPATH) and the American Academy of Pediatrics (AAP) have both issued statements expressing skepticism about the validity and utility of the concept of ROGD.

The concept of ROGD has been criticized for potentially pathologizing and stigmatizing transgender individuals, particularly youth, by suggesting that their gender identities are the result of social contagion or external influences. Such claims can contribute to harmful narratives that undermine transgender people's identities and experiences.

It's important to approach discussions around gender dysphoria and transgender identities with care, relying on evidence-based research and the expertise of healthcare professionals who specialize in transgender healthcare. Validating and supporting transgender individuals in their gender identities and providing access to affirming healthcare is crucial for their well-being.

References

American Psychological Association. (2015). Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. American Psychologist, 70(9), 832-864.doi.org/10.1037/a0039906) https://www.apa.org/practice/guidelines/transgender.pdf

Aragón A. M. et al., Theoretical Background Report, SWITCH, 2020

Carlström, R., Ek, S., & Gabrielsson, S. (2020). 'Treat me with respect': transgender persons' experiences of encounters with healthcare staff. Scandinavian Journal of Caring Sciences.

Chapman, R., Zappia, T., & Shields, L. (2012). An essay about health professionals' attitudes toward lesbian, gay, bisexual and transgender parents seeking healthcare for their children. Scandi- navian Journal of Caring Sciences, 26(2), 333-339.

Ervin, A. (n.d.). The Ethics of Working with Ground Rules Transgender and Gender. Retrieved November 10, 2020, from https://cdn.ymaws.com/www.papsy.org/resource/collection/C954A5EF-F25C-4505-A0EA-25C6047A068D/W16_Ethics_of_Transgender.pdf

GLAAD (2018). Transgender FAQ. Retrieved November 10, 2020, from https://www.glaad.org/transgender/transfaq

Jenner, C. O. (2010). Transsexual primary care. Journal of the American Academy of Nurse Practitioners, 22(8), 403-408.

Pavlica, K. et al. (2018). The Fears and Hopes of Trans People. Pra- gue: Transparent, z. s.

Sedlak, C. A., Veney, A. J., & Doheny, M. O. B. (2016). Caring for the transgender individual. Orthopaedic Nursing, 35(5), 301-306.

Seeking Safety (2020) http©2020 Treatment Innovations www.treat- ment-innovations.org and www.seeking- safety.orgs://www.ncbi.nlm.nih.gov/pmc/articles/PMC1868418/

World Professional Association for Transgender Health (WPATH). (2011). Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People. Retrieved November 10, 2020, from https://www.wpath.org/publications/soc

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TRANSIT

Training to Raise Acknowledge NeedS and Inclusion of Transgender

MEDICAL MODULE

Medical aspects of transition

Medical and surgical aspects of transition in gender variant adolescent and adults are a very specialized issue. The general basis must be known by any medical practitioner, to guarantee the safety of any other therapeutic need and the continuity care of hormones therapies.

In Italy, since this year, we are multiplying finally the specialized and multiprofessional centers allowed at least to provide hormones therapies also to minors. Generally, those centers also for adults were very few, especially in the southern regions, but only the Careggi in Florence was allowed to take care of gender variant minors.

Because transgender persons are evaluated to be at about 1% of population and a larger number of minors could at least for a few years be accountable as gender variant (1.5% approx.), we need to have at least one center in any province.

Another important concept to explain is that not every gender variant person, especially minors, are going to ask for medical treatment.

In fact, we can illustrate gender variance as a diverse and complex minority population, with a significant portion of individuals who only respond to the question of incongruence with the social expectations tied to the sex assigned at birth. These individuals may also be referred to by regional labels such as "femminiello" and "masculone" in the Neapolitan area, or by terms like "Gender Non-Conforming" in the US or "Queer" in the UK. This group also includes individuals whose voice, appearance, and movements naturally deviate from the societal norms associated with binary male and female identities. For instance, effeminate men and androgynous or masculine women are not only born with these characteristics, but these traits are also epigenetically connected to brain development during the final trimester of pregnancy. It is crucial to highlight this epigenetic aspect because, unfortunately, many people still perceive effeminacy, in particular, as a neurotic or stereotypical attribute.

Said so, if a larger group can be considered gender variant or gender non-conforming without requiring medical or surgical transition, we have a second group that also responds to another phenomenological instance: the body with which they identify and the need for alignment.

These individuals, classified as Gender Incongruent according to the ICD-11 classification, are divided into three main age groups: children, adolescents, and adults.

Children do not require any medical or surgical interventions. Their larger population, compared to the adolescent or adult group, still poses a neurological and psychological mystery. Recent studies

using Inclusive Data Collection have shown that an affirmative approach to gender incongruence in childhood does not necessarily lead to a definitive transgender identity in adolescence or adulthood. Conversely, when families restrict the gender expression of variant children, it can result in Adverse Childhood Events (ACE), contributing to mental health issues, poorer adolescent lifestyles, and reduced quality and lifespan. While suicide is a potential adverse outcome, the risks predominantly involve physical, psychological, and sexual violence against these children. It is crucial to offer Affirmative Psychotherapy or at least Affirmative Psycho-education to parents, caregivers, and educational environments to prevent ACEs. Many of these gender variant children naturally undergo changes in their gender identity during adolescence, aided by both affirmative psychological support and the maturation of their developing brains and bodies. Most of the spontaneously "desistant" individuals identify as LGB or display effeminate, androgynous, or masculine traits, sometimes confusing these attributes with transgenderism. Additionally, there are instances of "straight" individuals who experience a gender variant phase during childhood for various reasons.

Adolescents on the opposite are most “persistent” in their desire to became transgender also physically and can be approached also with hormones and in some legislation with breast surgeries to avoid the spontaneous transformation of the undesired body or to permit first desired transformation complete or uncomplete in the opposite sex.

We must remember that non-binary individuals constitute at least one-third of the adult transgender population. Consequently, in childhood and adolescence, individuals may express a desire to be or identify not only as part of the opposite sex but also as a mix, a different gender, or as having no gender at all.

It is important to acknowledge the existence of "desistant" and "de-transitional" adolescents. Similar to children, albeit to a lesser extent, some gender variant adolescents may identify as LGB or gender non-conforming, initially confusing these identities with transgenderism. In contrast, very few "straight" adolescents question their assigned gender roles, though they may explore gender variance without seeking medical interventions. Recent studies have shed light on the de-transitional phenomenon, primarily attributing it to two main factors:

- homo-transphobic environment that forces one to re-concealment;
- non-binary identity recognized in a second moment.

In most cases is the use of the blocker of GnRh (as Triptorelin, the only one permitted in Italy for instance), that permit the adolescents better to understand themselves. As already said for children any conversion therapy or violence against them is only causing a mental health burden, dangerous life-styles and health consequences. In this case, suicide must be considered a potential risk in case of homo-transphobic environment especially when parents are opposing the natural behavior of gender variant children. Also, in this case we need to assess Affirmative Psychotherapy or

Affirmative Psycho-education for their parents and support them in the schools, university or at the beginning of their working life.

During this stage of life, another significant risk for transgender adolescents is the possibility of being expelled from their homes or experiencing even more severe forms of violence. It is crucial to assess and establish specific social assistance programs to ensure these adolescents can continue their education and successfully transition into the workforce like their peers. Conversely, the risk of homelessness, engaging in sex work, substance abuse, or criminal behaviors becomes more prevalent when adolescents face challenges in accessing medical and surgical options and need to resort to extreme measures to secure the necessary funds.

These risks persist because many medical and surgical interventions for transgender individuals are still costly and only a limited number of them are available free of charge in Italy. It is essential to recognize this and advocate, as professionals, for comprehensive financial support to be provided. Moreover, consideration should be given to extending free access to certain surgeries, particularly for "straight" individuals, particularly girls, who may also face risks such as engaging in sex work, experiencing mental health burdens, or resorting to criminal behaviors due to their unmet needs.
In Italy, adolescents are permitted to use Triptorelin, subject to multiprofessional and parental approval, while adhering strictly to medical controls and receiving appropriate psychological support.

The transition centers in the last decade saw a rise of request especially of female assigned at birth people for hormone therapy in adolescence. As already said, studies on general population don't confirm this fact. Researchers suppose two main factors are causing this discrepancy:

- parents of male assigned at birth are less liberal to approve any gender variance to their sons
- the side effect on skeletal growth is a useful tool for female assigned at birth to become a taller transgender boy, but is absolutely not reasonable for assigned male at birth, already taller than female population

The specific effects of all the Agonist and Antagonist of GnRh are explained in the figures below. In Italy only Triptorelin is allowed. As shown, Triptorelin is blocking natural GnRh after a phase of Flare Up of the hormonal system, because Triptorelin is a GnRh agonist. As professionals, we should also request the use of different hormones to better personalize those therapies.

Fig. 1 GnRH agonist mechanism

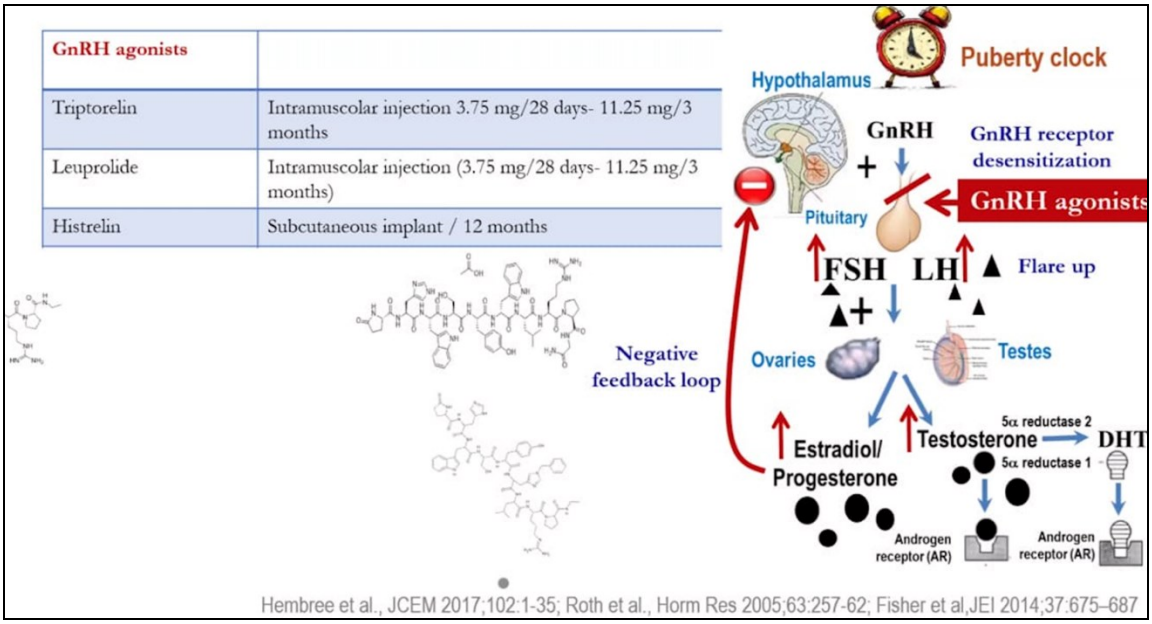


Fig. 2 GnRH antagonist mechanism

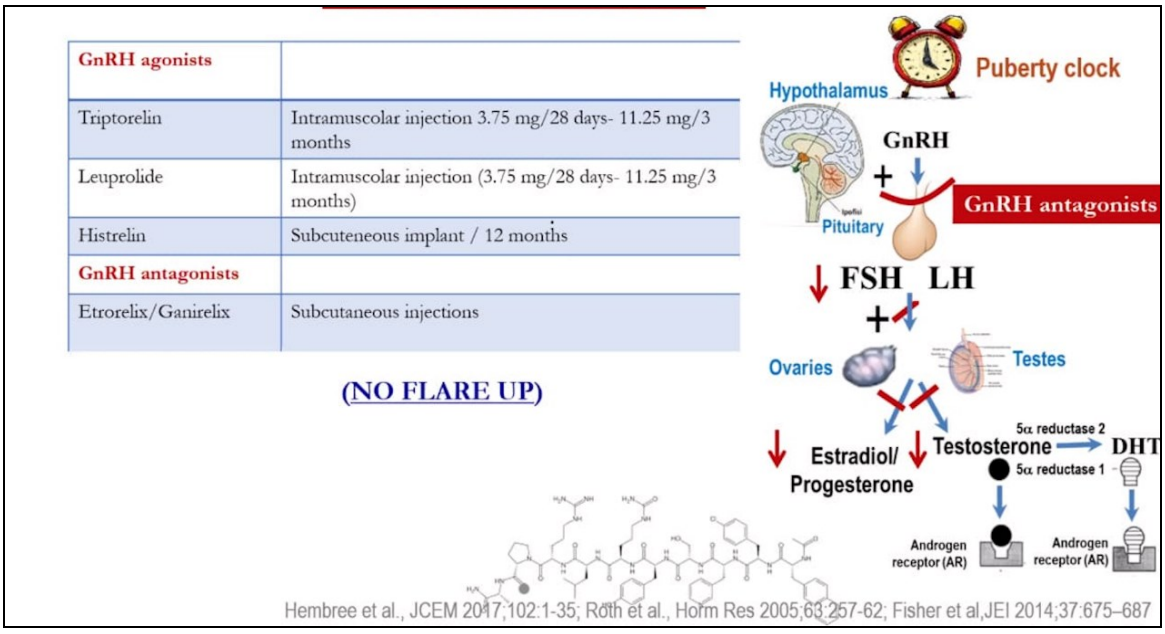
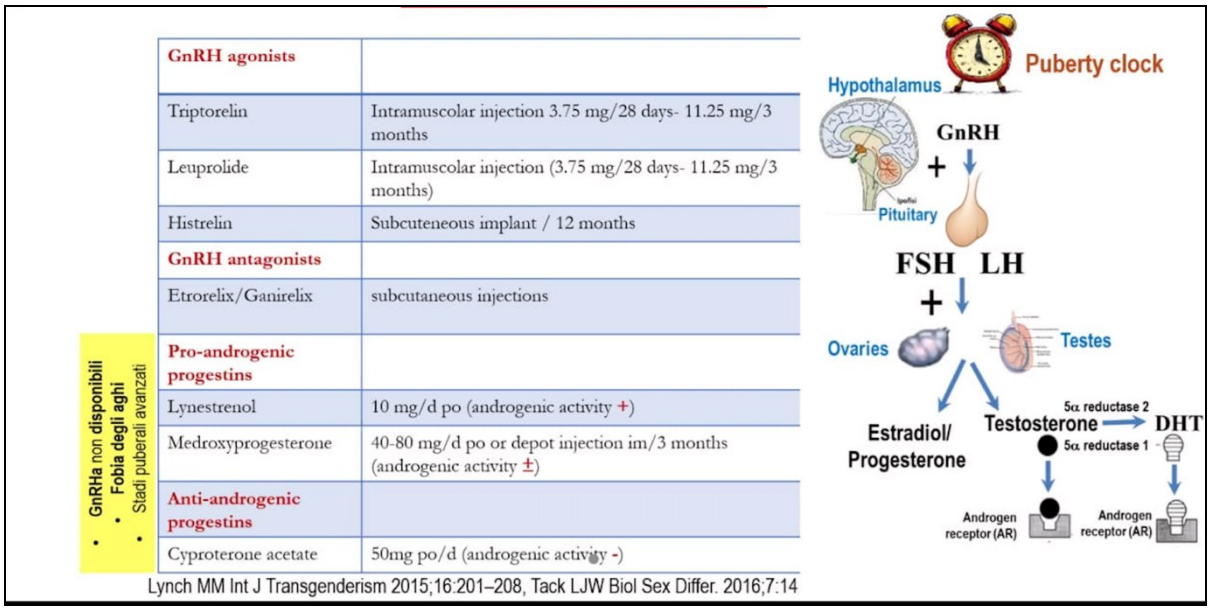


Fig. 3 GnRH Other hormones mechanism



GnRH agonists	
Triptorelin	Intramuscolar injection 3.75 mg/28 days- 11.25 mg/3 months
Leuprolide	Intramuscolar injection (3.75 mg/28 days- 11.25 mg/3 months)
Histrelin	Subcuteneous implant / 12 months
GnRH antagonists	
Etrorelix/Ganirelix	subcutaneous injections
Pro-androgenic progestins	
Lynestrenol	10 mg/d po (androgenic activity +)
Medroxyprogesterone	40-80 mg/d po or depot injection im/3 months (androgenic activity ±)
Anti-androgenic progestins	
Cyproterone acetate	50mg po/d (androgenic activity -)

Lynch MM Int J Transgenderism 2015;16:201–208, Tack LJW Biol Sex Differ. 2016;7:14

The advantages of the use of Triptorelin are:

- the extension of self-assessment phase without the pain of body changes
- easy and less invasive surgeries in adults, especially for the breast masculinization in AFAB, and larynx, face shape and hair removal in AMAB
- apart from the skeletal growth any other effect is completely reversible
- it prevents self-use of cross sex hormones at this age without medical control, which is very life threatening
- reduction of any specific mental health burden, that includes dysphoria (DSM-V), or suicidal risk, anxiety, depression, cPTSD, borderline symptoms, eating disorders and substance abuse.

At this age it is very important to guarantee fertility preservation before the use of Triptorelin. In Italy the law number 40/2004 today doesn't permit the use of sperm or ovaries for transgender persons or for LGBTI people, but laws can change. If an adolescent is going to be a desistant, the fertility preservation is going to become useless, because, as already explained, there's any side effect on fertility. On the opposite, fertility preservation could be useful (if changing the law), and is going to be necessary when adolescents are going to continue and transform their bodies when adults more extensively.

The use of Triptorelin in Italy depends on the rules indicated by the AIFA note of 2019, and its gratuity depending on the AIFA note of 2020, the multiprofessional institution that is allowed to prescribe it must also receive both parental approbations.

Adults are not exempt from the possibility of de-transitioning or coming out later in life, including in their elderly years. The study of de-transitioning primarily revolves around the influence of a homo-transphobic environment, particularly within the workplace, but it can also be influenced by factors such as the underconsideration of non-binary identities or ongoing dysphoria. Dysphoria itself is influenced by the presence of a homo-transphobic environment, and it correlates with Adverse Childhood Events (ACEs) and a history of discrimination in family and school environments during early age.
In a broader perspective, providing psychological support to former gender variant children, adolescents, and especially their parents, to cultivate affirmation and self-affirmation can help reduce the likelihood of dysphoric outcomes in adulthood. The process of coming out later in life often relates to an individual's experiences of homo-transphobic education, and it may occur in psychologically vulnerable individuals who, more frequently than the general population, struggle with preexisting mental health issues mentioned earlier.

The medical and surgical aspects to consider in adults depend on whether it should be a feminizing, masculizing or non-binary option.

Non-binary individuals are estimated to comprise approximately one-third of transgender adults. However, it is important to note that this categorization is subjective and relies on self-perception. This means that a significant portion of individuals who identify within the male or female binary may not necessarily seek all available medical and surgical pathways. The key concept is personalization, tailoring medical interventions to meet the specific needs and self-identified goals of each transgender adult.

In adulthood, cross-hormone therapy is accessible to transgender individuals at no cost, following AIFA note 2020. The process involves multiprofessional oversight, including the involvement of a psychiatrist or psychologist who can certify the presence of "gender dysphoria" as mandated by law, as well as an Endocrinologist who initiates the transition process. It is worth noting that, as supported by scientific evidence and outlined in SOC-8, there is a shift from a model centered solely on "gender dysphoria" to an "informed consensus" model. As professionals, we are expected to adhere to this updated approach, ensuring that decisions regarding medical interventions are based on comprehensive discussions and mutual agreement between the healthcare provider and the individual seeking care.

It is crucial to emphasize that the provision of free cross-hormones helps prevent the illegal use of these substances and the marginalization of transgender individuals, who may resort to sex work or criminal activities to afford them privately. To address this issue, we should advocate for an increased number of multiprofessional centers, with a minimum of one center per ASL (Local Health Authority), to ensure accessible and comprehensive care for transgender individuals.

The risks of illegal use are:

- Higher doses,
- Side Effects not assessed,
- Contaminants in the preparations,
- Lower doses from those stated,
- Inactive doses.

At the same time, only a “gender dysphoria” certification is giving permission to endocrinological changes.
As shown in *Table 1* we have a lot of hormonal possibilities to use and others could arise from a pharmacological research, to reduce side effects.

Table 1
Gender affirming hormone therapy

Hormone	Route	Doses	Considerations
Transgender women			
Estradiol valerate Estradiol Estradiol valerate or cypionate	Oral Transdermal patch. New patch placed every 3 – 5 d Parenteral	2 – 6mg/d 0.025 – 0.2mg/d 5 – 30mg IM every 2wk 2 – 10mg IM every wk	<45 years >45 years
Anti-androgens Spironolactone Cyproterone acetate	 Oral Oral	 100 – 300mg/d 25 mg/d	 Preferred in USA Preferred in Europe
Triptorelin (GnRH agonist)	SC	3.75mg/monthly 11.25mg/3 monthly	Preferred in UK instead of antiandrogens
Transgender men			
Testosterone Testosterone enanthate or cypionate Testosterone undecanoate Testosterone gel	 Parenteral Parenteral Transdermal Transdermal	 100 – 200mg every 2-4 wk or 50% per 1-2 wk 1000mg every 12 wk 50 – 100mg/d 2.5 – 7.5mg/d	

Hormone	Route	Doses	Considerations
1.6% Testosterone patch			

SC - subcutaneous; WK - week.

In male transgender adults, the target therapy is testosterone, with a recommended range of 320 to 1000 ng/dl to achieve a blood concentration of 11.1-34.7 nmol/lm, similar to assigned males at birth (AMAB).Comprehensive masculinizing therapy follows the principles of hormone replacement therapy for male hypogonadism. If an individual has undergone ovariectomy, continued cross-hormone therapy is necessary to prevent potential consequences of hypogonadism. It is advisable to maintain hormone therapy throughout their lifetime.

The interruption of it is causing a partial reversal of body and mental effects, risking physical dissatisfaction and the recurrence of gender dysphoria. Hormonal continuity must be guaranteed lifelong especially in situations of imprisonment or hospitalization where bureaucracy might be a barrier.

Masculinization appears thanks testosterone in the form of these changes:

- Disappearance of the menstrual cycle (amenorrhea)
- Enlarged clitoris
- Reduction of fat mass
- Increase in strength and muscle mass
- Lowering of voice timbre
- Increased sebum production (Acne appearance)
- Hair distribution with male pattern

Sexually the changes obtained are the reduction in sexual distress, more frequent attainment of orgasms, an increase in libido, sexual fantasies, arousal and masturbation.

In the transgender feminine persons two hormonal targets are available: demasculinization and feminization. Demasculinization can be achieved through the use of progestin-like hormones or Triptorelin, while feminization involves the use of Estradiol.

The effects of feminizing and demasculinizing therapy in transgender individuals include:

- reduction of sebum production,
- body and facial hair distribution (in variable degree)
- increase of fat mass in the gynoid regions

- reduction of lean mass

Hormone therapy does not produce changes in the timbre of the voice in transgender people adult AMABs, which means that if they don't already have a feminine voice or if they strongly dislike their voice, they could attain also to Larynx surgical or logopedic changes.

It takes 6 months for any possible change by hormone therapy in transgender women, with its peak after two years.

It is producing:

- decrease in physical dissatisfaction
- only 20% of AMAB attain a complete Feminine Tanner scale grade 4 or 5
- as a consequence, 60% of AMAB trans people ask for breast augmentation

Sexual consequences are:

- the reduction of spontaneous erections
- 60% reduction in two years of testicular volume if not surgically eliminated
- in the first 3-6 months temporary decrease of the libido
- then a rise in Sexual QoL
- a reduction in sexual distress
- a rise in body satisfaction indexes

The use of only demasculinizing hormones, like Cyproterone, Spironolactone and Triptorelin is one of the possible choices for non-binary transgender AMAB adults as well as a reduced dose of femininizing hormones like Estradiol.

On the other hand, lowering the doses of testosterone or giving progesterone analogues or triptorelin (abroad are possible also the other blockers of GnRH) are possible pathways for non-binary transgender AMAB adults.

This is especially of interest for transgender safety to know that a lower dose means also fewer side effects (see *Box 1* and *Box 2*).

Minoxidil for hair growth, Eflornithine for hair removal or Furosemide are other medications we can prescribe to transgender binary or non-binary people.

Box 1. Side-effects of hormonal preparations for trans men and women.

Trans women	Trans men
• Breast development takes 2 years	• Beard and body hair growth
• Decreased hair loss	• Male pattern baldness
• Reduced muscle bulk	• Enlarged clitoris
• Erection/orgasm harder to achieve	• Heightened libido
• Weight gain	• Acne
	• Sleep apnoea
	• Weight gain
• Reproductive implications, such as infertility	• Reproductive implications, such as infertility

Box 2. Risks of hormonal preparations for trans men and women.

Medications for trans women	**Medications for trans men**	**Self-medication**
Thrombosis	Polycythaemia	Non-genuine or inactive product
Gallstones	Hyperlipidaemia	Contaminated/harmful preparation
Elevated liver enzymes	Cardiovascular disease	May have contraindications
Hypertriglyceridemia	Hypertension	Inadequate monitoring, such as liver fuction tests
Hyperprolactinaemia	Type 2 diabetes	Over- or underdosing
Type 2 diabetes		

Long-term follow-up requires ongoing monitoring of hormone medications. Measuring blood pressure, BMI and blood tests at least every 6 months for the first 3 years is recommended by a number of specialist sources. You need also test for:

- Full blood count;
- Electrolytes;
- Liver function;
- HbA1C
- Lipids;
- Testosterone;
- Estrogen;
- Prolactin;
- Thyroid function.

Surgical aspects of transition are either more complex. Gender-affirming surgical options: Transgender individuals may pursue none, one, or combinations of the described procedures that could be summurized this way:

Transmasculine surgery:

- Thyroplasty
- Subcutaneous mastectomy
- Hysterectomy
- Unilateral or bilateral oophorectomy
- Vaginectomy
- Metoidioplasty, phalloplasty, scrotoplasty
- Implantation of testicular prostheses or erectile devices
- Lipofilling
- Liposuction
- Facial masculinization
- Chest masculinization
- Pectoral implants

There are various types of phalloplasty:

- Metoidoplasty
- Abdominal flap phalloplasty
- Anterior thigh flap phalloplasty
- Radial flap phalloplasty

- Latissimus dorsi myocutaneous flap phalloplasty

Transfeminine surgery:

- Facial feminization
- Lipofilling
- Liposuction
- Hair reconstruction
- Hair removal
- Thyroid chondroplasty
- Glottoplasty (voice surgery)
- Breast augmentation
- Penectomy, orchiectomy
- Vaginoplasty, labiaplasty, clitoroplasty

There are also various types of vaginoplasty but the most common is the penis-scrotal flap vaginoplasty.

For breast augmentation, in Italy, is not required any authorization by any competent Court, since it is not a demolition intervention and it is not irreversible. It is advisable to have been on hormone therapy for at least 6 months when is given the maximum expression of obtainable breast volume with the hormone's therapies only.

There are various other issues for the protection of transgender people in healthcare systems:

- non-discrimination policy of gender identity and gender expression
- inclusive chart of patients' rights
- free access to hormone therapy and their continuity lifelong
- protocols for interaction with transgender patients:
- Inclusive forms (in paper or electronic)
- Affirmative approach
- Room assignment
- Access to bathrooms
- Access to personal items that assist persons during gender transition

Inclusive forms (in paper or electronic)

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Further, especially in surgical cases, fertility preservation must be taken into consideration.

The available options are:

- Cryopreservation of semen for AMAB people
- Oocyte cryopreservation for AFAB people
- Cryopreservation of ovarian or testicular tissue during operations of hysteron-annexectomy and orchiectomy/vaginoplasty, respectively
-

Another sensitive sex-related issue to confront with gender-affirming hormone therapy is a reversible but not complete reduction of reproductive capacity. Transgender people having sex with opposite sex persons (considering sex at birth) have to use contraceptive method or plan their parenthood.

AMAB transgender people can use condoms in the case of vaginal penetrative intercourse of AFAB people with functioning reproductive system. Condoms and PREP must be considered also in the case of anal penetrative intercourse with AMAB.

AFAB transgender people are recommended to use a contraceptive method in case of their vaginal penetrative intercourse with AMAB people with functioning reproductive system.

Other Specific Effects (tab. a), Side Effects (tab. b), Blood test to do (tab. c), General and Specific Surgeries and other interventions (tab. d and tab. e) are summarized below:

a)

Trans women	Trans men
Breast development (takes approx. 2 years)	Beard and body hair growth
Hair loss slowed down	Male pattern baldness
Muscle bulk reduced	Enlarged clitoris
Erection/orgasm harder to achieve	Heightened libido
Weight gain for both	Acne
Reproductive implications for both	Sleep apnoea

b)

Trans women	Trans men
Thrombosis	Polycythaemia
Elevated liver enzymes	Elevated liver enzymes
Gallstones	Hypertension
Hypertriglyceridaemia	Hyperlipidaemia
Hyperprolactinaemia	Cardiovascular disease

Type 2 diabetes	Type 2 diabetes

c)

	Trans women	Trans men
Baseline monitoring	BMI, BP, FBC, urea and electrolytes, LFTs, HbA1c, lipid profile, testosterone, estradiol, prolactin, T4 and TSH	
Ongoing monitoring	BMI, BP, FBC, urea and electrolytes, LFTs, HbA21, lipid profile, testosterone, estradiol, prolactin	
Time frame	6 monthly for first 3 years, then annually	
Example drugs (Gn-RH analogues)	Goserelin intramuscular injection, 3.6 mg monthly or 10.8 mg every three months	
Example drugs (cross-sex hormones)	Estradiol patches 50-150 mg every three days Oestrogel 2-3 measured per day Oral estradiol 1-6 mg daily Important information: • Dose is titrated to blood estradiol level • Patches and gels have lower thrombosis risk • Stop 3-4 weeks prior to surgery for thrombosis risk	Transdermal testosterone Testim or Testogel 5mg daily Intramuscular testosterone: Nebido 1 g every three months Sustanon 250 mg every 2-3 weeks

d)

Trans men	Trans women
Chest reconstruction	Facial feminizing, thyroid chondroplasty and breast augmentation
Hysterectomy, salpingo-oophorechtomy, vaginectomy	Penectomy, orchiectomy
Phalloplasty, metatoidioplasty, urethroplasty, scrotoplasty, testicular prosthesis and erectile protheses	Vaginoplasty, cliteroplasty and labioplasty
Hair transplantation	Phono-surgery

e)

Trans men	Trans women
Psychotherapy	Psychotherapy
Hormone therapy	Hormone therapy
Speech therapy	Speech therapy
Vaginectomy	Penectomy
Hysterectomy	Bilateral orchiectomy
Salpinoophorectomy	Vaginoplasty
Metoidioplasty/Phalloplasty	Clitoroplasty and labiaplasty
Urethroplasty	
Scrotoplasty	
Penile prosthesis	

Useful summaries on AFAB check list for monitoring healthcare after cross-hormones and surgeries:

1) Monitoring laboratory parameters:
   a) Lack of reference range data
   b) Interpreting laboratory tests that vary by sex
   c) Effects of long–term testosterone therapy

2) Screening for cervical cancer–Pap smear testing
   a) Sample rejection by automated system due to identity discrepancy
b) Higher percentage of inadequate smears
   c) Challenges in interpretation–long–term testosterone therapy, lack of experience

3) Screening for breast cancer
   a) Sample rejection by automated system due to identity discrepancy
   b) Difficult interpretation–unfamiliarity with effects of long–term testosterone, limited literature experience

4) No standard guidelines for uterine and ovarian cancer screening

Monitoring:

- Estradiol levels every 3 months during first 6 months of testosterone therapy or until there has been no uterine bleeding for 6 months
- Free/total testosterone levels every 3 months until testosterone levels are in the normal physiological male range

Parameters:

- Polycythemia (1)–hematocrit
- Weight gain (obesity)/ Increase in fat to muscle mass ratio (1)
- Elevated liver enzymes (1)–liver function tests
- Hyperlipidemia(2)–lipid profile
- Cardiovascular risk factors (2*)
- Hypertension (2*)
- Type–2 Diabetes (2*)–fasting and post–prandial blood glucose/ HbA1c
- Osteoporosis–Measuring BMD after age of 60 years or earlier if additional risk factors present (previous fractures, family history, steroid use etc)
- Breast cancer (3)–Breast cancer screening as for natal females if breast tissue present, if s/p bilateral mastectomy with male chest reconstruction need only preform chest exam yearly.
- Cervical cancer(3)–PAP test as for natal females
- Uterine, ovarian cancer (3)–No standard screening guidelines

Useful summaries on AMAB check list for monitoring healthcare after cross-hormones and surgeries:

1) Monitoring laboratory parameters
   a) Limited published reference range data
   b) Interpreting laboratory tests that vary by sex
   c) Effects of long–term anti–androgenic therapy

2) Screening for prostate cancer:
   a) Sample rejection by automated system due to identity discrepancy
   b) Interpreting PSA levels on long term anti–androgenic therapy (falsely low values)
   c) Challenges in biopsy interpretation–less familiarity, long–term effects of hormones

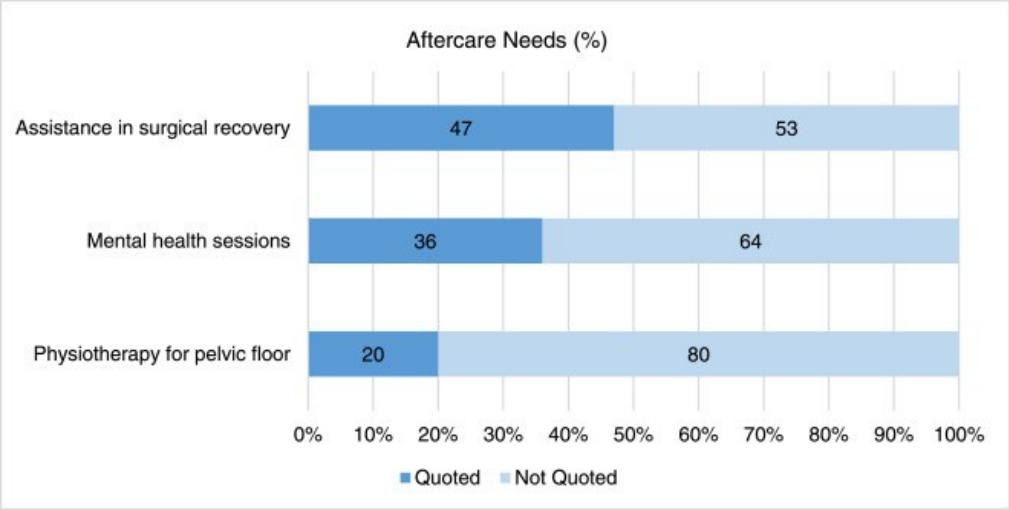
Monitoring:

- Estradiol and free/total testosterone hormone levels every 3 months
- Follow up every 3 months/ first year and then 1–2 times/year

Parameters:

- Thromboembolic disease (1)
- Weight gain (obesity)/ Increase in fat to muscle mass ratio (1)
- Gallstones (1)
- Elevated liver enzymes (1)–liver function tests
- Increased triglycerides (1)–lipid profile
- Coronary artery disease (1*)
- Hypertension (2)
- Hyperprolactinemia (2)–prolactin levels
- Type–II Diabetes (2*)–fasting and post–prandial blood glucose/ HbA1c
- Cerebrovascular disease
- Severe migraine headaches
- Monitoring serum electrolytes if patient is on spironolactone–2–3 times/ first year
- Osteoporosis–Measuring bone density afterage of 60 years or earlier if additional risk factors present (previous fractures, family history, steroid use, etc.)
- Breast cancer (3)–Screening as for natal females if no additional risk factors
- Prostate cancer (3)–Screening as for natal males
- Neovagina–No Pap testing recommended

An interesting point of view is illustrated in this figure:



The need for post-operative healthcare in transgender individuals is often overlooked. In the study mentioned, the most significant issue identified is the lack of support during the recovery period following surgeries. This challenge is influenced by factors such as homelessness, social isolation, family rejection, and economic hardship, particularly in cases involving illegal employment. It is crucial to consider these factors prior to surgeries and collaborate with patients to find timely solutions.

The second aspect pertains to the importance of mental health sessions. While undergoing a significant bodily transformation is generally perceived as a triumph by transgender individuals, they may still require psychological support during the initial phase of adaptation.

Additionally, physiotherapy for the pelvic floor is essential following sex reassignment surgery.

References

SOC-8: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9553112/

Previous 2016 guide on therapies, still valid for all pharmacological and surgical aspects: https://transcare.ucsf.edu/guidelines

Cross-Hormones Health Protocols: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8999511/

Cardiovascular Risk Associated with Gender Affirming Hormone Therapy in Transgender Population https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8515285/

Practical advice for a 10-minute Transgender consultation https://bjgpopen.org/content/1/3/bjgpopen17X101001

Gender identity and the management of the transgender patient: a guide for non-specialists https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5407520/

Pediatrics aspects of Transition in UK: https://www.dovepress.com/gender-dysphoria-optimizing-healthcare-for-transgender-and-gender-dive-peer-reviewed-fulltext-article-NDT

Post-operative psychological and physiotherapeutic problems: https://www.sciencedirect.com/science/article/pii/S1743609521006317?via%3Dihub

QoL improves after interventions or hormones, but remains below the general population: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5925023/

The width of the neck and the presence of the Adam's apple identify the Gender
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7288875/

Changing the shape of the larynx may be a risk factor, but it has not been studied and there are no guidelines for properly intubating transgender people.
https://journals.sagepub.com/doi/full/10.1177/0145561320910680?rfr_dat=cr_pub++0pubmed&url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org

The tone of voice is changed by Testosterone significantly
https://pubmed.ncbi.nlm.nih.gov/33568701/

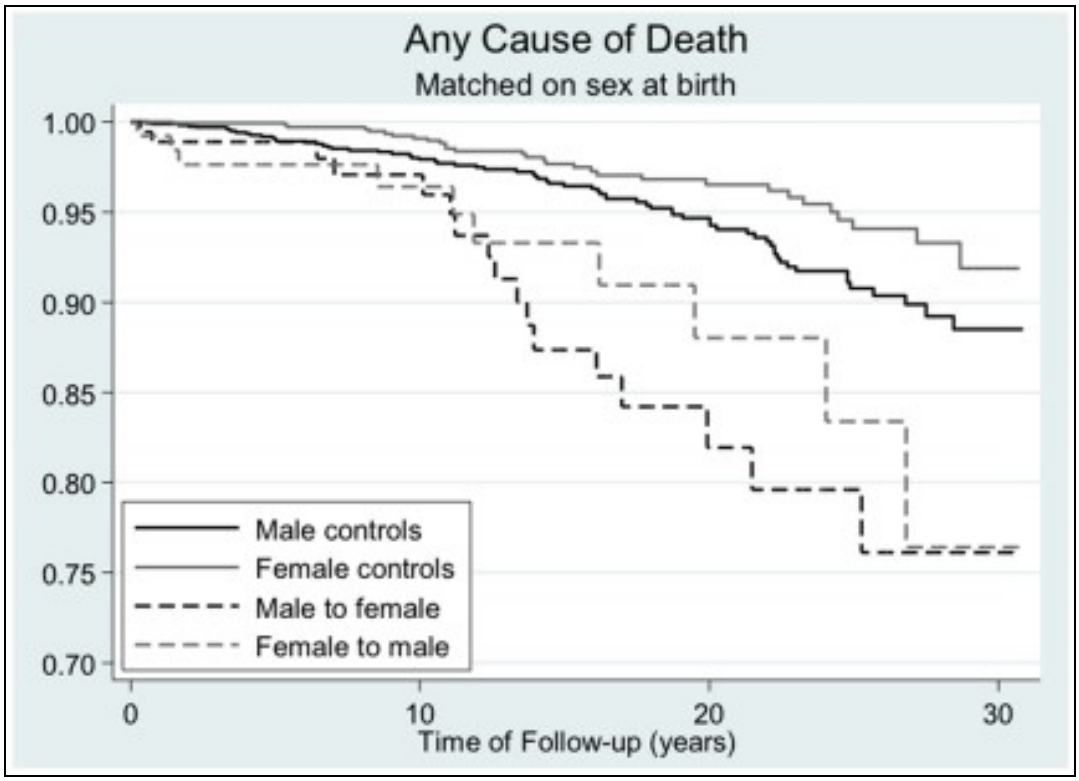
Estrogen and Mental Health https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8048738/

But also https://pubmed.ncbi.nlm.nih.gov/33494281/

Mental Health and Hormones https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7191719/

Clinical-therapeutic aspects of caring for LGBTQ+ persons

Transgender and gender non-conforming people have elevated overall mortality compared with cisgender people. In a UK study, specifically, deaths from external causes (suicides, homicides, and accidental poisoning), endocrine disorders, and other ill-defined and unspecified causes were considered as the first causes of the early mortality of transgender people. The same study showed than transfeminine individuals had a decreased cancer mortality risk compared with cisgender women but the same risk as cisgender men, whereas transmasculine individuals had the same cancer mortality risk as cisgender people. Cardiological risks are also higher in transgender people especially if they take hormones without BMI and medical control. Mental health burden is as well a problem in transgender persons, not only because of suicidal risk, but in terms of Anxiety, Depression, Eating Disorders, Nicotine-Alcohol-Drugs abuse, Borderline personality disturbs and PTSD.



A syndemic point of view is necessary to understand how social, economic, familiar, psychologic and biologic factors not only sum but multiply mental and physical risks and they entail together the higher and earlier mortality of transgender persons.
The more common model in use is the Minority Stress model, depending from elevated generic and specific distress and discrimination, during infancy and actually, involving mental burden and specific homo-transphobic introverted problems, that all together arise dangerous lifestyles, that are becoming the final causes of the arisen mortality in transgender people.
We must also consider biological factors in the meanwhile:

1) A major BMI is to be considered in AFAB transgender people (male or non-binary) in association or not with Polycystic Ovaries and Hypothyroidism
2) The Triptorelin use is only causing a major height and a bone distress during its use, perfectly reverted by cross-hormones or spontaneous puberty induction
3) The Cross-hormones have also a biological impact, for the arising BMI in both AFAB and AMAB transgender people and causing other Neuro-Cardio Vascular risks, especially if not in a medical follow-up. Estrogens are causing in fact hyperlipidemia, diabetes and obesity, while androgens are causing hypertension and obesity. Deep venous thrombosis is a potential risk assessed between 3% and 8% for transgender women using still Ethinylestradiol.

Risks of hormonal preparations for trans men and women.[2]

Medications for trans women	**Medications for trans men**	**Self-medication**
Thrombosis	Polycythaemia	Non-genuine or inactive product
Gallstones	Hyperlipidaemia	Contaminated/harmful preparation
Elevated liver enzymes	Cardiovascular disease	May have contraindications
Hypertriglyceridemia	Hypertension	Inadequate monitoring, such as liver fuction tests
Hyperprolactinaemia	Type 2 diabetes	Over- or underdosing
Type 2 diabetes		

Minority Stress or cPTSD?

Psychiatrists and cognitive psychologists adopted also a different model than minority stress, the Post Traumatic Stress Disorder (PTSD), witch especially in the form of cPTSD (complex PTSD) is a diagnosis in itself and a model to explain the reason of the dangerous life śtyle in which transgender people are involved since an early adolescence.

We must also say that a protective and affirmative environment, especially the familiar one, is preventing for the most part Minority Stress or cPTSD and all their mental, behavioral and physical health consequences.

In the opposite case, a homo-transphobic environment since early childhood is the cause of minority stress or cPTSD. The early childhood discrimination or mistreatmentare resumed in the ACE model (Adverse Childhood Experience). Different parameters must be considered as higher in transgender ACE risks, especially violence and neglect areas. Secondary ACEs are also very important in the Gender Variant children as the specific homo-transphobic bullying or the poverty and lower scholarity caused by the early expulsion from home. A medical specific secondary ACE is the homo-transphobic healthcare approach, especially in the case of conversion therapy abuse.

All healthcare workers must be trained to avoid conversion abuse, to learn an affirmative approach to LGBTI people, to have specific knowledge on the specific health differences of LGBTI people, and to build specific path or protocols to permit especially intersex and transgender persons to approach a better lifestyle, health precautions, health prevention and cares in follow-up.

Internalized homo-transphobia or heterosexism can act as barriers, preventing LGBTI individuals from accessing healthcare programs altogether. In such cases, it is crucial to provide specific affirmative psychotherapy for transgender individuals. Given that heterosexism or homo-transphobia can be pervasive issues affecting not only transgender parents but also healthcare workers, offering them an affirmative psychoeducational program can also be beneficial.

The specific protocols needed in any country to preserve transgender health are based on:

1) ICD-11
2) SOC-8
3) LGBTI Health Data Collection

Transgender individuals can also work as healthcare professionals. Just like all LGBTI healthcare workers, they should be actively included in training projects and protected by specific protocols that uphold their professional dignity:

1) Alias career
2) Support to Coming Out
3) Gender budget analysis with at least a cumulative LGBTI category
4) Training in LGBTI gender medicine

To reduce or avoid ACE and other discriminations since childhood, preserve gender variant persons from Minority Stress and cPTSD and their consequences, it could be useful to start with a pre-natal course for any future parent. The reasons are:

1) We are born LGBTI or rather anyone is born already with a specific sexual and gender identity
2) At birth we already have evidently intersex children, actually concealed and erased under M or F mandatory choices
3) During early childhood, there is still a possibility for individuals to come out as gender variant, although this is not necessarily predetermined or inevitable.
4) During childhood and especially adolescence it is possible to come out as LGB
5) During adolescence the persisting or coming out as a gender variant person is usually an identity fact
6) Any effort to change with conversion therapy abuse or mistreatments, neglect or violence, the sexual orientation or the gender identity of any gender variant children is only causing a bigger mental health burden and worse lifestyle and their consequences are a lesser quality of life and an early mortality. It has been showen that any kind of conversion therapy is also an abuse to those who could not live openly as transgender in their adulthood or those people asking to change because they were influenced by a familiar or social homo-transphobic environment.

As the suicidal risk is a major problem, we must begin to learn a few concepts:

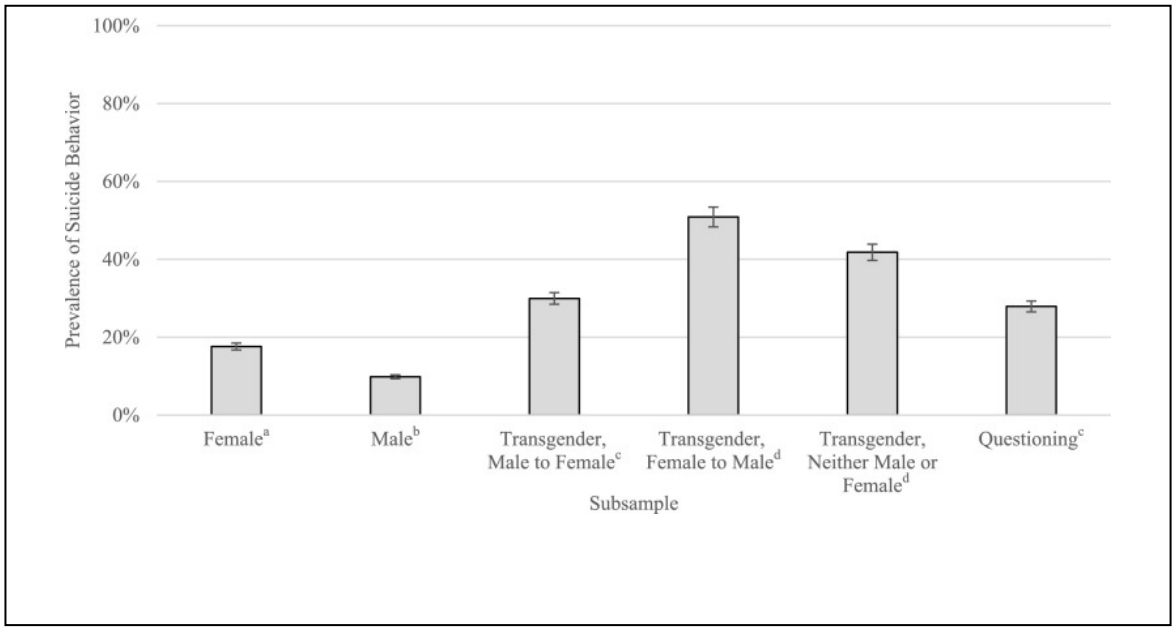
1) AFAB are usually risking attempted suicide and non-suicidal self-harm

2) AMAB are usually risking to die of intentional suicide

This is also true for transgender persons. Between 30% and 51% of transgender adolescents reported engaging in lifetime suicide behavior. Also, questioning and non-binary people have a higher risk than general population.

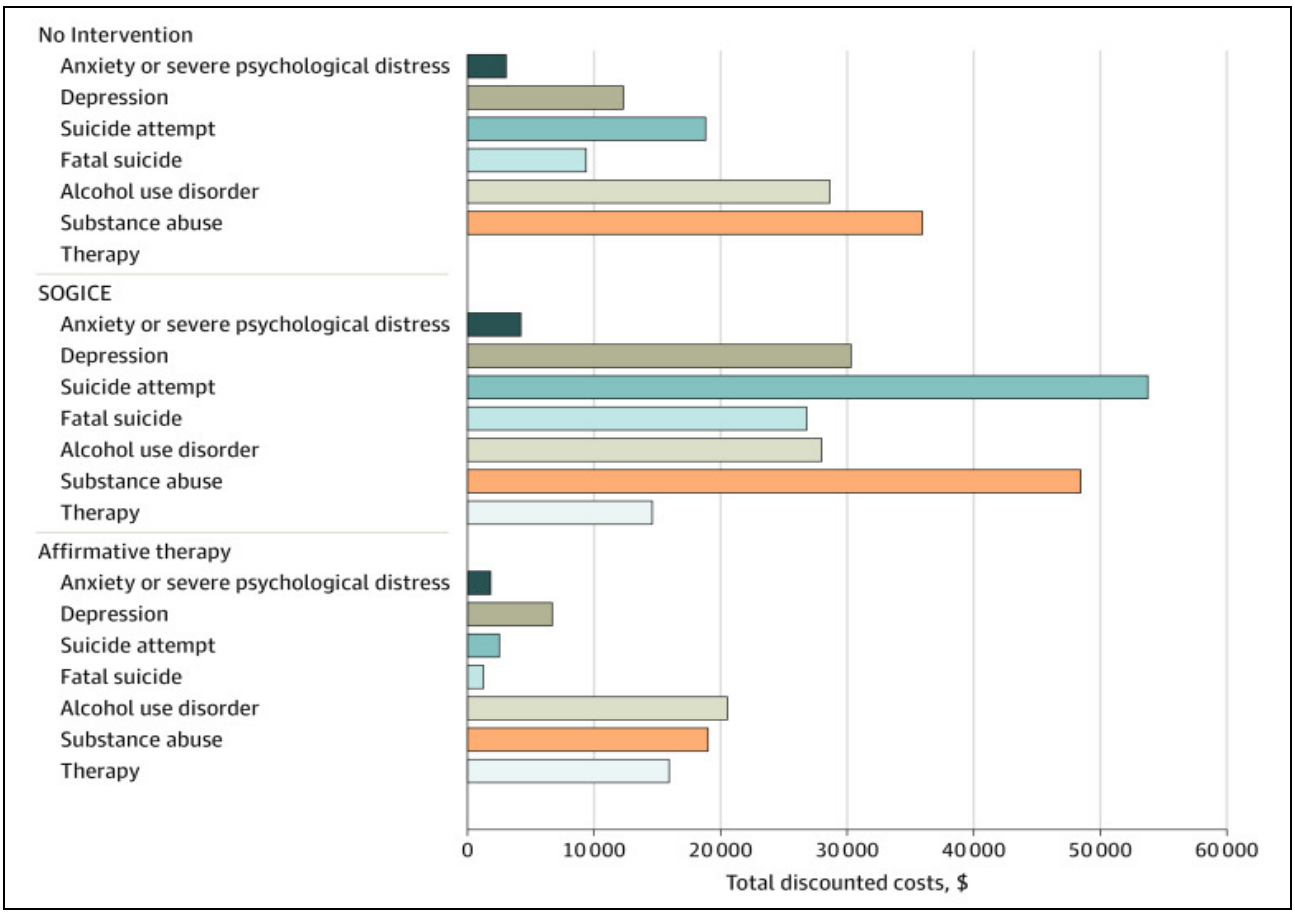
It is not yet fully understood whether the neurological pathways associated with gender identity differ from those that contribute to various risk factors. Epigenetic factors may also play a role in influencing these pathways. Additionally, social factors may contribute to increased risk behaviors among transgender women. However, it is important to note that the main distinction between attempted and intentional suicide remains tied to the sex assigned at birth rather than gender identity.

influencing these pathways. Additionally, social factors may contribute to increased risk behaviors among transgender women. However, it is important to note that the main distinction between attempted and intentional suicide remains tied to the sex assigned at birth rather than gender identity.



Eating disorders are also more often evident in LGBTI people. Usually, they occur as well as anxiety or depression, when the environment is homo-transphobic since childhood or if LGBTI people are still closeted. We only have epidemiological data from USA, but we can say that an affirmative approach or an affirmative psychotherapy, to the parents or to the transgender patient could be helping the most.

Affirmative psychotherapy is actually a specific approach to LGBTI needs and includes their parents because they also have a coming out problem and a minority stress as being transgender parents into a homo-transphobic environment.



This model works also in the case of Nicotine-Alcohol-Drugs abusers.

In cases like eating disorders and doping abuse for bodybuilding, it is essential to consider the additional social impact of minority stress on LGBTI communities. Some individuals may feel compelled to conform to specific roles, lifestyles, or body characteristics imposed by societal expectations, even if it goes against their own desires or compromises their safety. This pressure to conform can be detrimental to their well-being and contribute to harmful behaviors.

The facilitating the use of Triptorelin, cross-hormones or cross-surgeries are actually being demonstrated to be extremely important to reduce any kind of mental health burden, including borderline personality disorders.

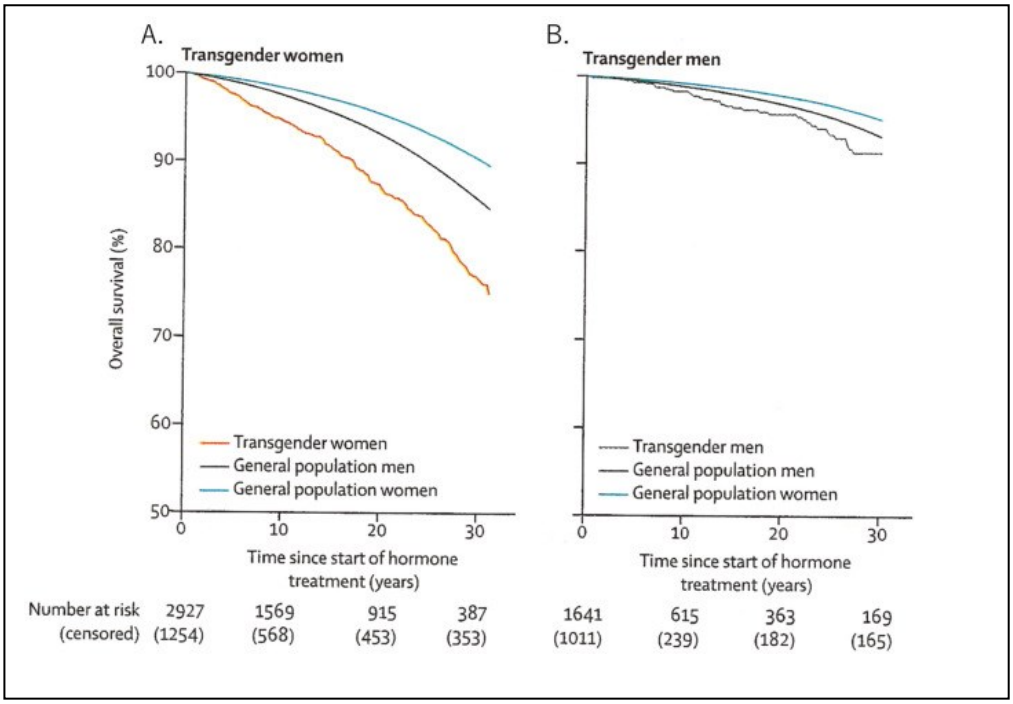
The highest rates of certain borderline diagnoses in transgender individuals can be attributed to various factors, including inadequate psychological tests, biases among mental health workers, and potential specific brain pathways. It is possible that all three factors contribute to this phenomenon.

Moreover, the abuse of nicotine, alcohol, and drugs among transgender individuals poses significant risks, including a higher incidence of cancer and neuro-cardiovascular complications. Unhealthy

lifestyle habits, initiated at an earlier age, are more prevalent in transgender individuals and can lead to long-term neuro-cardiovascular and oncological effects. The elevated rates of smoking in this population have been consistently linked to victimization and minority stress. The same can be observed for alcohol and drug abuse.

While a change in legal gender marker has been associated with lower odds of tobacco use among transgender women, there were no significant differences in tobacco use based on hormone treatment status. Therefore, specific programs aimed at reducing tobacco use in transgender individuals are necessary, especially considering the potential risks associated with cross-hormone therapy.

It is crucial to recognize that tobacco abuse remains the primary cause of cardiological risk in transgender individuals. Additionally, other specific neuro-cardiovascular risk factors related to hormonal use, such as lipid profiles, coagulation risk, insulin resistance, atrial fibrillation, hypertension, and BMI, must be closely monitored to reduce mortality risks.



Obesity as previously indicated is also an oncological risk factor for breast cancer.

Biological causes are not the sole factor contributing to obesity in transgender individuals, but they do play a significant role. However, it is important to recognize that discrimination in sport and healthcare systems can also have a substantial impact on the ability of transgender individuals to maintain or achieve a safe BMI (Body Mass Index).

A major risk today in oncology continues to be the absence of inclusive protocol permitting transgender people to have screening for free. The appearance as opposite gender and the recognizing of their gender identity are both a limitation for their access to screening for bureaucratic reasons. The homo-transphobic prejudices of healthcare workers or of the healthcare forms, especially electronic ones, are another big issue. The healthcare forms are usually dividing people only as Male or Female which is strictly mandatory as for oncological screenings. Other causes to consider are the lesser scholarity, the poverty and the fear of homo-transphobic reactions.

The oncological risks related to reproductive organs are known to be reduced by the cross-hormone therapy but not enough to avoid screenings of:

1) Prostate in Transgender women or AMAB non-binary people,

2) PAP test for Transgender men and AFAB non-binary persons,

3) Other reasons PAP test is also a good idea for transgender women with neo-vagina,

4) Mammography should be mandatory for both of them especially when obese,

The HPV could also cause anal cancer, and so:

5) Any transgender person having penetrative anal sex must be checked with anal smear test.

Pituitary hyperplasia caused in transgender women by hormonal changes could be associated with a benign Prolactinoma.

Sexually transmitted infections (STIs) are a major problem for transgender people involved in sex work or abusing drugs/alcohol or if they are not using for any other reason any PREP and Condoms to prevent them. Their partners should be also specifically involved in epidemiological follow-up, especially if sex workers clients are drug/alcohol abusers or are not on PREP or not using condoms. Specific affirmative approach must be considered for those persons. We need to introduce also studying and working programs for transgender people to help them to avoid as unavoidable the sex work and help them access better condom and PREP protection. Specific harm reduction program must be considered for transgender persons and their partners around the questions of alcohol-drugs abuse and condom-PREP use to reduce any risk of STIs permitting them to continue, if necessary, a sex work life style.

It is always important to prevent STIs using free vaccinations from adolescence up to 40 years old:

1) HPV
2) HBV

3) HAV
4) Meningitis

HPV and HBV are also a main cause of mortal cancers in transgender people and must be especially considered. After venereology we also can say something about dermatology.

Transgender men have a higher risk of acne, sebum or alopecia. Isotreonine must be avoided or at least fertility must be taken under control also in case of amenorrhea. The chest binding to conceal breasts is also dangerous for breathing, especially in smokers, and for dermatological risks.

In transgender women the dermatological risks are usually melasma and effects of illegal filling and depilation.

Still not well studied are the cross-hormones interactions with other medicaments.

We must say that PREP is absolutely safe for transgender people as well as any kind of vaccination.

We already know something about anti-epileptic drugs and sedative side effects interactions. Anesthetists must be very careful to avoid physical harm during intubation: transgender male for biological and transgender women for surgical reasons having little larynx. Especially important to them is to know that testosterone is changing the awakening phase, and doses must be lower than in women in transgender males to avoid side effects.

Another important healthcare issue to address is fertility preservation prior to initiating cross-hormone therapy or surgeries in transgender individuals. Providing options for fertility preservation, such as sperm or egg freezing, allows individuals to retain the possibility of biological parenthood in the future. Additionally, it is crucial to train midwives and gynecologists on how to approach and support natural pregnancies in transgender males or AFAB (Assigned Female at Birth) non-binary individuals. This ensures that comprehensive and inclusive reproductive healthcare is available to all individuals, regardless of their gender identity.

References

General Transgender Health Risks: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3043071/ con grafico

General Transgender Health Risks: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6169934/ con tabelle

Suicide risk in transgender people: https://pubmed.ncbi.nlm.nih.gov/33232071/

Mental Health and Discrimination for being gay, lesbian, transgender, or bisexual: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6317573/ con tabella

Nicotine alcohol and drug abuse: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7862992/

Alcohol Abuse and Transgender Discrimination: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7502497/

LGBTI Mental Health: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7587912/

Obesity in Transgender People: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7358708/

Cardiovascular Risk in LGBTI people: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10072899/

This is also about cardiovascular risk in LGBTI people: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8515285/

Specific Cardiovascular Risk in Trans People: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8638087/

Cardiovascular Arrhythmias and Trans People: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7411199/

Oncologia in transgender men: https://www.fertstert.org/article/S0015-0282(21)01810-0/fulltext

U.S. Oncology Guidelines in Transgender People: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7807311/

Benefits of the Gender-affirming Approach and the Gatekeeping Issue

Affirmative mental health care for transgender and gender non-conforming people is a new approach invented in the US that developed progressively into a more trans-affirmative practice. Basically, it moved or elsewhere “transitioned” from a disease-based to an affirmative identity-based model of transgender people health.

The first definition of gender-affirming approach comes from Heck 2017: “Affirmative/assertive psychotherapy is culturally relevant, addresses the influence of social inequities, enhances resilience and fosters coping, and reduces systematic barriers”.

What is about actually a TGNC affirmative mental healthcare?

We have the following points to discuss and learn to use:

1. Core belief is that “individuals know themselves”
2. There is no “gatekeeping” approach
3. The most important point is the establishing of a working alliance
4. The work on therapeutic alliance is about acceptance, warmth, non-judgmental approach
5. The whole affirmative approach is non-pathologizing.
6. Its goals and aspirations are all client driven
7. There are no need TGNC people to educate their providers
8. There is no need to fit TGNC people into narrow and biased definitions
9. It works on Minority Stress and Internalized Homo-Transphobia
10. It works on Straight-Male Normativity and Toxic Narrative
11. Establishing collaboration with other professionals makes the affirmative approach stronger and safer for TGNC people
12. It especially works with parents and people of TGNC environment and their homo-transphobic or internalized instances

The gender affirming approach holds significant importance in preventing or addressing internalized transphobia within patients and psychotherapists. Internalized transphobia can be understood through four interconnected dimensions:

1) Pride in transgender identity (reverse scored)
2) Investment in passing as a cisgender person
3) Alienation from other transgender people
4) Shame

These parameters are closely linked to minority stress and its consequential impact on the mental and general health of transgender individuals.

Disease-based model is actually used in most Countries.

It means that “normative gender identity” development has been compromised causing distress (Gender Dysphoria model) that can be alleviated by establishing congruence between sex, gender identity and gender role. It permits in these cases, considered in itself as pathological and non-reversible, the use of hormonal and surgical sex reassignment.

Affirmative Identity-based model on the other hand means that “gender variance” is an example of human diversity. It is not solely based on a specific dysphoric model, as research indicates that gender dysphoria can often arise from familial, social, educational, religious, and homo-transphobic influences. Additionally, internalized homo-transphobia can contribute to the experience of gender dysphoria. Recognizing that distress in transgender and gender non-conforming (TGNC) individuals can stem from social stigma and the ongoing fight for equality, it is more beneficial to focus on promoting acceptance, support, and equality within families and schools rather than pathologizing and categorizing all TGNC individuals as inherently dysphoric or ill.

The gender affirmative model has led to a paradigm shift, reflected in the ICD-11, which no longer includes a psychiatric definition of transgenderism. Instead, a new chapter on gender incongruence was created within the framework of sexual specific problems. If in some countries gender dysphoria and gender Incongruence are used as synonymous, this is completely wrong. GD definition is still the most used to initiate any treatment, following the law prescription.

Its criteria are:

1) Incongruence between experienced and expressed gender with the assigned sex at birth (at least during 6 months);
2) A strong desire to get rid of current secondary sex characteristics for sex characteristics of another sex;
3) A strong suffering because of this incongruence if not treated with hormones or surgery.

The recognition of the opposite sex on identity cards is a distinct yet current issue mandated by the law, primarily serving to reinforce social binary norms.

The gender dysphoria diagnostic model undervalues or ignores the role of social stigma and discrimination of non-normative gender presentations.

Transgender persons who do not report a distress related to their identities or experiences may be determined as inappropriate to receive medical services for not meeting the gender dysphoria

diagnostic criteria. The embrace of the "distress narrative" tends to overlook the significant prevalence of other mental health burdens, including anxiety, depression, eating disorders, tobacco-alcohol-substance abuse, suicidal risk, and complex post-traumatic stress disorder (cPTSD).

Gender incongruence, on the other hand, is defined only as a marked and persistent incongruence between the gender felt or experienced and the sex assigned to birth. This definition in the ICD-11 is no longer part of the chapter on mental disorders but is part of a new chapter called “conditions related to sexual health”. The ICD-11 replaces the state of distress associated with that incongruence by the terms dislike or discomfort with less psychopathological connotations.

Only two diagnostic criteria must be met without necessarily the individual wanting to get rid of their primary or secondary sexual characteristics of the felt gender:

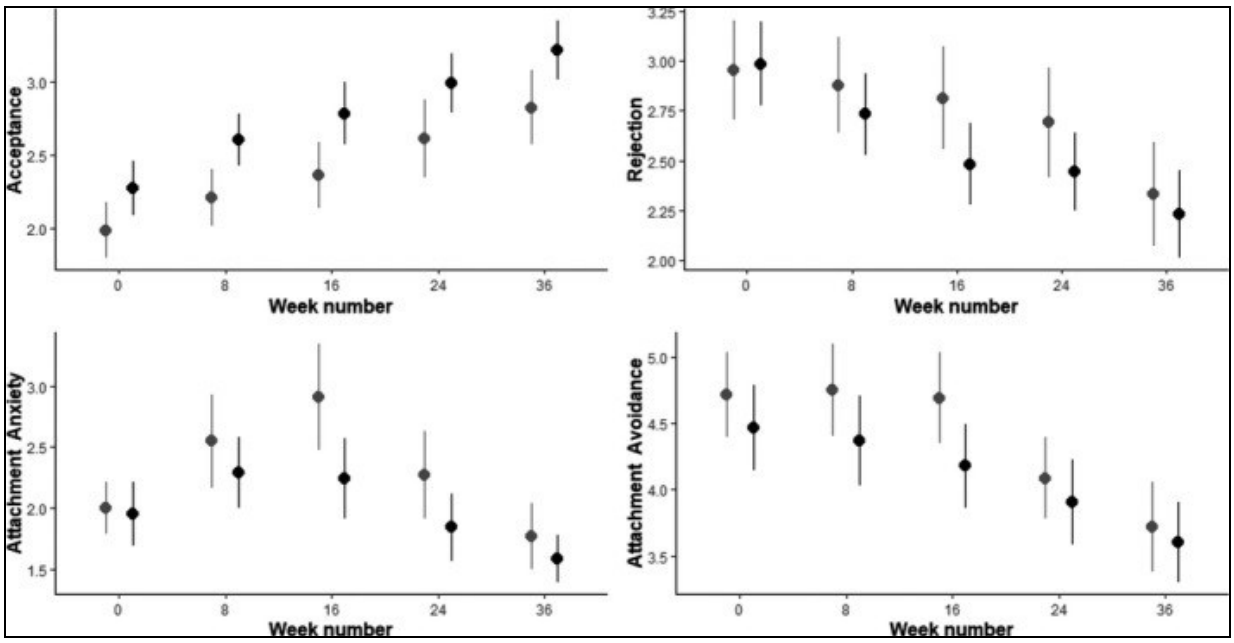
1) Persistent feeling of dislike with the primary or secondary sexual characteristics;
2) Along with the desire to be treated and accepted as a person of the felt gender.

This would solely be sufficient for granting the diagnosis of gender incongruence. We still speak about diagnosis because within healthcare systems, the prescription of hormones or surgeries for transgender individuals is typically recognized and categorized within a specific chapter of the ICD. This would imply an Informed consent model to undergo medical-surgical interventions to achieve a gender confirmation. Thanks to the gender affirmative approach other mental health needs will be considered and at the same time treated with Affirmative Psycho-therapy for TGNC people.

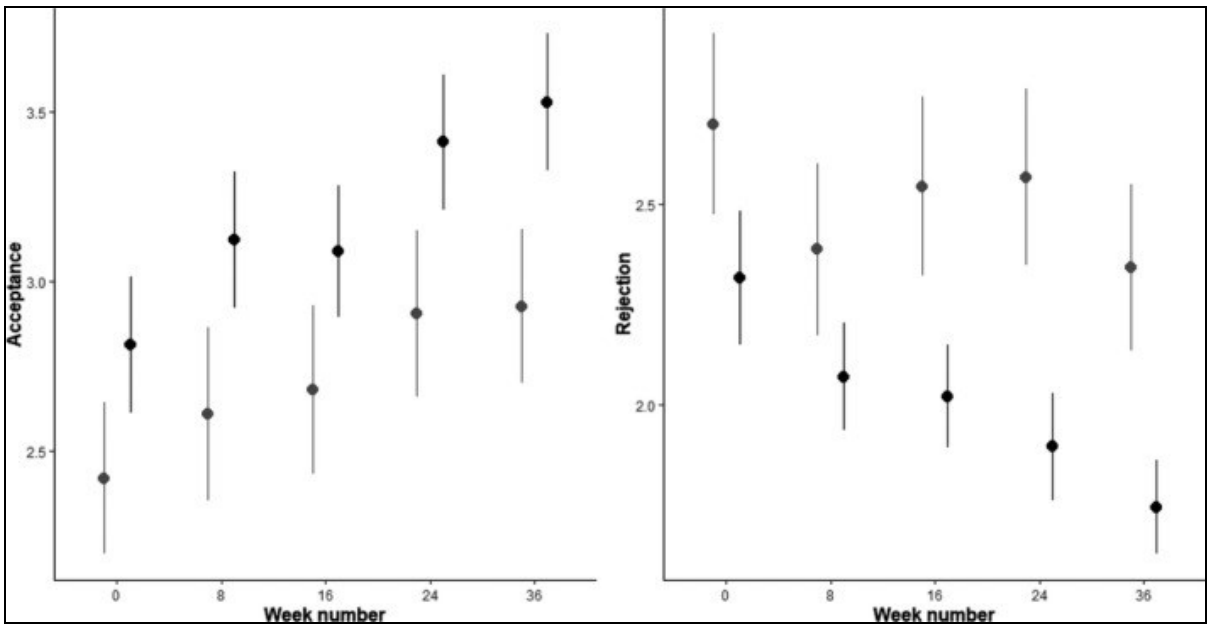
Affirmative therapy work on homo-transphobic internalized ideas.

As already said, transgender people suffer especially of anxiety, depression, eating disorders, tobacco-alcohol-substance dependence, cPTSD and have a much higher suicidal risk. Many studies showed that a specific affirmative approach can reduce or quite eliminate those problems.

It happens to be important to study familiar relations to know if TGNC people suffered of adverse childhood experience and try to remediate to them. TGNC parents could need affirmative therapy too, in order to complete their own path of acceptance and coming out as parents of TGNC persons. If TGNC are still children or adolescent the affirmative therapy to their parents could stop the adverse childhood experiences especially of harming or neglecting.



In this figure the studied population of young adults' reports regarding their fathers' (gray bars) and mothers' (black bars) acceptance and rejection, and regarding their own attachment anxiety and attachment avoidance.



In this other figure Fathers' (gray bars) and mothers' (black bars) of the same study self-reports regarding their acceptance and rejection of their young adults.

This kind of studies represents the need of an affirmative approach with parents too, and the similar-mourning process psychotherapists have to confront with families initially non accepting LGBTI children coming out in affirmative settings.

Other intersectional minority status must be considered in any affirmative approach. As minority religion, ethnicity, socio-economic status or disabilities are also in itself causes of Minority Stress and could arise in TGNC people they can together increase their mental health burdens. Remember that gender variance is a non-pathological human condition, but Minority Status and Minority Stress are the causes of mental health problems.

A TGNC person should not have to prove distress about identity or substantiate diagnostic criteria in order to gain access to desired health services. However, they must "possess the cognitive ability to make an informed decision about healthcare," including voicing an understanding of the risks, benefits, and information needed to make an informed decision about moving forward with medical services related to transition.

Respect for a person's right of self-determination: In healthcare settings, respecting the right of self-determination for transgender individuals is crucial. It means recognizing their autonomy in making decisions about their healthcare, including the choice to pursue gender-affirming treatments or procedures. Healthcare providers should create a supportive and inclusive environment where transgender individuals feel comfortable discussing their healthcare needs and goals. This includes using their preferred name and pronouns, actively listening to their experiences, and involving them in shared decision-making processes. Respecting self-determination in healthcare settings helps to ensure that transgender individuals receive patient-centered care that aligns with their unique needs and identities.

GATEKEEPING

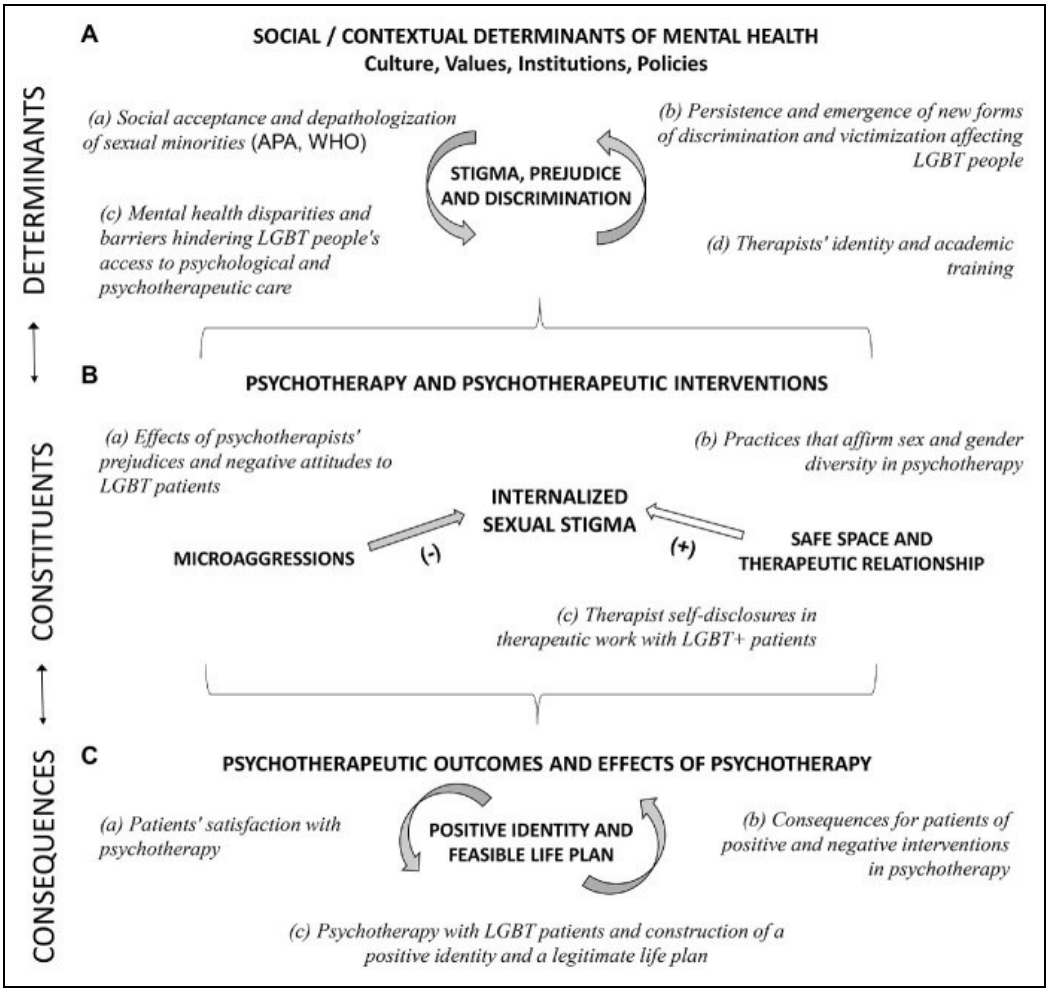
In the medical context, the concept of "gatekeeping" is based on the doctors controlling or regulate access to certain medical services, treatments, or referrals. The term "gatekeeping" suggests that these professionals serve as gatekeepers, determining whether or not a patient should receive specific healthcare services. In terms of trans-specific care, there is a widespread belief on the part of health professionals that trans people are unable to determine their own identity, so they freely choose to subject them to various often humiliating examinations, treatments or months or years of real-life-tests before providing access to trans-specific treatment and in some countries (Czech Republic) salso legal gender recognition. This makes trans people feel powerless over decisions about their lives, and this has a negative impact on their mental health.

Although this gatekeeping approach was initially designed to ensure that individuals seeking transgender-related healthcare received appropriate care and to minimize the potential for regret or dissatisfaction, it pathologizes being transgender, places unnecessary burdens on individuals seeking gender-affirming care, and may perpetuate discrimination and stigmatization. The gatekeeping model has been associated with high levels of psychological distress and barriers to accessing necessary healthcare for transgender individuals.

In recent years, there has been a shift towards individualized approach and an informed consent model of care for transgender people. Informed consent emphasizes that individuals are capable of making their own decisions regarding their healthcare and do not need external approval or gatekeeping processes to access gender-affirming treatments. This approach respects individuals' autonomy and acknowledges their expertise about their own gender identity and healthcare needs.

In therapeutic settings we must consider also the gatekeeper's role:

- It can affect the therapeutic alliance;
- The client can experience the gatekeeping as a situational obstacle rather than a chance to increase self-awareness;
- It's considered institutional discrimination
- The problem of therapeutic alliance must be revised in an Affirmative Approach:
- Therapeutic support is not requested straight away;
- Often the request is experienced as urgent in order to get a prompt solution to the problem;
- Typically, clients diagnosed with gender dysphoria have experienced discrimination within the healthcare sector therefore they started the therapeutic sessions;
- It is crucial to show a sympathetic approach towards transgender's issues related especially with regard to the private life and pronouns to be used.



Because any model and its use for legal transition depends from laws and health protocols we need to know where to ask to change them to impact in reducing gatekeeping phenomenon and guarantee any medical aspect of transition through a more inclusive gender affirmative approach:

- We need to ban Conversion Therapy as dangerous and antiscientific;
- We need to apply ICD-11 and change the laws on Gender Transition in order to guarantee the Informed Consent mode (SOC-8)I;
- We need to introduce LGBTI inclusive data collection as a duty in any scientific or health record, in order to receive epidemiological studies;
- We need to prepare trainers in affirmative therapy;

- We need to introduce in Mental Health Professionals the duty to develop competence on Affirmative Therapy;
- We need to understand any Health Workers must be prepared on LGBTI medical, psychological or nurses' studies.

We can begin all of this also with a peer-to-peer training beginning with a bottom to top model, starting from those points:

1) Avoiding trans-gender normative narratives.
2) Keeping an open mind
3) Engaging in self-examination
4) Do not assume a destination.
5) Prioritize client self-determination over medical practitioner frustration, confusion, opinion.
6) Be aware that social presentation or transition may be nuanced and complex.
7) Understand barriers and be willing to advocate for clients.
8) Make sure to hit all the most relevant points while conducting initial assessments and throughout the whole treatment process.
9) Psy health workers who work with trans clients may need to spend some time in the assessment process clarifying their position with regard to psychopathology and its relationship to transition.
10) Psy health workers can be helpful by increasing awareness of the available opportunities for their clients' engagement with the trans community and supporting their clients' accessing resilience factors through such involvement.

References

"Standard of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People" (SoC-8) – WPATH, 2022

"APA Guidelines for Psychological Practice with Sexual Minority Persons" - APA, 2021.

"APA Ethics Code" – APA, 2017.

"APA Guidelines for Psychological Practice with Transgender and Gender Nonconforming People" – APA, 2012.

Internalized Transphobia: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6983734/

Eating Disorders in LGBTI People: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8380626/

Attachment-based family therapy for sexual and gender minority young adults and their nonaccepting parents: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9325072/

Community Role to cope better results after Affirmative Psychotherapy: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8183324/

AFFIRM methodology of "affirmative" psychotherapy: https://pubmed.ncbi.nlm.nih.gov/33562876/

Affirmative approach in Primary Care: https://www.sciencedirect.com/science/article/pii/S0095454321000075?via%3Dihub

Affirmative approach in Psychotherapy settings: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7755929/

Evidence Based efficacy of Affirmative Psychotherapy with LGBTI people: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6291842/

Evidence Based efficacy of Affirmative Psychotherapy specific working with Transgender clients: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7752815/

Systematic Review on Affirmative Psychotherapy on Transgender and non-Binary people: https://www.sciencedirect.com/science/article/pii/S0272735822001143?via%3Dihub

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TRANSIT

Training to Raise Acknowledge NeedS and Inclusion of Transgender

LEGAL MODULE

Violation of transgender people's rights

Universal Declaration of Human Rights

"... the recognition of the specific dignity and of the equal and inalienable rights of all the members of Human Society is the basis of Freedom, justice and peace in the World."
(Preamble to the Universal Declaration of Human Rights, 1948)
… but is it really so for everyone?

Article 1 – All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.
NO!: Transgender people suffer discrimination from their **"siblings"** which can be both visible and invisible in all life contexts and there are no anti-discrimination laws, in most countries, that protect people for their gender identity. There is a tendency to stigmatize behaviors and customs that do not conform to "typically accepted social norms" in a given human community because of so-called ***cisnormativity***, neologism **that identifies being cisgender as the only normally existing gender identity**.

Article 2 – Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.
NO!: Transgender people suffer discrimination because of their gender identity.

Article 3 – Everyone has the right to life, liberty and security.
NO!: Transgender people, in some countries, are victims of hate crimes, which are crimes perpetrated because of their existence within a certain minority social group.

Article 5 – No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
NO!: In several countries, trans persons must undergo sterilization and other medical procedures in order to transition: this creates mental tension for those hoping to become parents **and it violates the right to family and health**.

Article 7 – All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.
NO!: Actually, there are laws that freely discriminate against these people. For example, in some countries there is an impossibility to marry and/or adopt children; in some others to have a consensual homosexual relationship as it is often punished with the death penalty.

Article 12 – No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honor and reputation. Everyone has the right to the protection of the law against such interference or attacks.
NO!: Not all states have laws that protect transgender people from being bullied, struggling to keep one's work or find a new one, being forced to undergo conversion therapy, receive psychiatric diagnoses that force restorative therapies designed to change their gender expression or identity or must undergo psychiatric evaluation processes based on binary and **cis**normative assumptions in order to access hormonal treatments or gender-related surgeries, experiencing any kind of assault, ending up homeless, and being abandoned by one's family.

Article 16 – *1.* Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution. *2.* Marriage shall be entered into only with the free and full consent of the intending spouses. *3.* The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.
NO!: This article does not require Member States to legalize marriages, but, at most, civil unions which, however, do not involve the same rights and duties. In some countries, trans people have to renounce everything they have, including ties such as marriage.

Article 22 – Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international cooperation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.
NO!: Transgender people are not supported by national law

Article 23 – *1.* Everyone has the right to work, to free choice of employment, to just and favorable conditions of work and to protection against unemployment. *2.* Everyone, without any discrimination, has the right to equal pay for equal work. *3.* Everyone who works has the right to just and favorable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection. *4.* Everyone has the right to form and to join trade unions for the protection of his **or her** interests.
NO!: Trans people cannot choose their jobs or sometimes they have to leave the one they have because of bullying (vertical: by superiors; horizontal: by colleagues), non-recognition of their

personal identity, prejudices, association to prostitution and their appearance. They often have only one choice: **sex work**.

Article 25 - *1.* Everyone has the right to a standard of living adequate for the health and well-being of **themselves** and of **their** family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. *2.* Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.
NO!: Not at all. In such countries adoption is not permitted to LGBTQ+ people so, if one of partners has a child the other one has no rights to that child. Something similar happens with Civil Unions, in fact, the partners have no rights over each other. Also healthcare contests are not the best for them because of prejudice and lack of knowledge on this theme. A widespread phenomenon is "gatekeeping": it is based on the belief on the part of health professionals that trans people are unable to determine their own identity, so they freely choose to subject them to months or years of therapy before transitioning. This makes trans people feel powerless over decisions about their lives, and this has a negative impact on their mental health.

Article 30 – Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.
NO!: It is violated because of the violation **by** the others!

The Yogyakarta Principles

The Yogyakarta Principles refer to a set of principles on the application of international human rights law in relation to sexual orientation and gender identity. They were developed in November 2006 by a group of human rights experts from various countries, and were named after the city of Yogyakarta, Indonesia, where the principles were adopted.

The Yogyakarta Principles consist of a comprehensive set of 29 principles that provide guidance on how existing human rights standards can be applied to address the specific challenges faced by lesbian, gay, bisexual, transgender, and intersex (LGBTI) individuals. These principles cover a wide range of issues, including non-discrimination, the right to life, freedom from torture and other cruel, inhuman, or degrading treatment or punishment, privacy, freedom of expression, and the right to asylum.

The Yogyakarta Principles are not legally binding in themselves, but they serve as a valuable tool for advocates, policymakers, and governments to promote and protect the human rights of LGBTI individuals. They have been widely endorsed by various international and regional organizations,

such as the United Nations, and have played a significant role in advancing the understanding and recognition of LGBTI rights globally. These principles emphasize the importance of recognizing and respecting the rights of transgender individuals, including their right to self-determination, non-discrimination, access to healthcare, and protection from violence and mistreatment.

Principle 3: The Right to Recognition before the Law: Transgender individuals have the right to be recognized in their self-identified gender and should not be forced to undergo medical procedures, including surgery, sterilization, or hormonal therapy, as a requirement for legal recognition.

Principle 18: Protection from Medical Abuse: Transgender individuals have the right to access appropriate and affordable healthcare, including gender-affirming treatments and procedures, without discrimination or coercion.

Principle 19: Protection from Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: Transgender individuals should be protected from all forms of violence, torture, or cruel treatment, including forced medical interventions or conversion therapy.

Principle 20: Protection from Arbitrary Deprivation of Liberty: Transgender individuals should not be detained or imprisoned based solely on their gender identity and expression.

Principle 21: The Right to Freedom of Expression: Transgender individuals have the right to express their gender identity and to communicate information and ideas related to gender identity and expression, without discrimination or censorship.

Other international standards:

International Covenant on Civil and Political Rights (ICCPR): The ICCPR, a legally binding treaty adopted by the United Nations, protects civil and political rights, including the right to life, freedom of expression, privacy, and equality before the law. These provisions are applicable to transgender people and their rights.

Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT): The CAT is an international treaty that prohibits torture and other forms of cruel, inhuman, or degrading treatment or punishment. It applies to all individuals, including transgender people, and aims to prevent mistreatment and abuse.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW): While primarily focused on gender equality and women's rights, CEDAW also addresses discrimination and rights violations faced by transgender women who may be subjected to intersecting forms of discrimination based on both gender and gender identity.

Convention on the Rights of the Child (CRC): The CRC outlines the rights of children, including transgender children, and emphasizes the need for their protection, non-discrimination, and access to appropriate healthcare, education, and social support.

References

Universal Declaration of Human Rights:
https://www.un.org/en/about-us/universal-declaration-of-human-rights

The Yogyakarta Principles:
https://yogyakartaprinciples.org/

https://it.wikipedia.org/wiki/Diritti_LGBT_nel_mondo

https://it.wikipedia.org/wiki/Diritti_umani

https://it.wikipedia.org/wiki/Violenza_contro_le_persone_LGBT

Switch Manual

Office of the High Commissioner for Human Rights. (2015). A step forward for intersex visibility and human rights. Retrieved November 10, 2020, from https://www.ohchr.org/EN/NewsEvents/Pages/Astepforwardfor- intersexvisibility.aspx

Legal gender recognition and homotransphobia legislation

ITALY

Legal gender recognition

In Italy, the Ministry of Justice published on its online page this message entitled "*Rules of Gender Recognition*" (https://www.giustizia.it/giustizia/it/mg_3_1_22.page?tab=d#).
The laws of reference are Law No. 164 of April 14, 1982 (Rules on sex attribution rectification) in relation to prerequisites and Art. Article 31 of Legislative Decree No. 150 of September 1, 2011 (Supplementary provisions to the Code of Civil Procedure on the reduction and simplification of civil proceedings of cognition, pursuant to Article 54 of Law No. 69 of June 18, 2009) in relation to the procedure to be followed.
The requirement is the identification of gender dysphoria, which is defined as a condition experienced by an individual who does not identify with the gender assigned to them at birth.
With regard to surgery, individuals seeking to undergo gender reassignment do not need to have surgery: these are the conclusions reached by recent case law, which is consistent with major rulings handed down by the European Court of Human Rights and changes in civil society.The legal authority must conduct a thorough investigation to confirm that the applicant has completed their own journey, is serious and unequivocal about their decision, and has arrived at their destination. To that end, the medical and psychotherapeutic treatments received by the person seeking gender reassignment authorization must be documented, as must the person's awareness, voluntary nature, and irreversibility of the choice (for example, through official specialist medico-legal counseling). A ruling based on preserving the right to health can also authorize gender reassignment surgery when the objective is to assist an individual to attain mental and physical equilibrium, although this is not a requirement.
With regard to procedure, the petitioner must make an application with the court of the jurisdiction in which the applicant (the individual seeking gender reassignment authorization) resides. Legal representation is required. The petitioner is required to notify the applicant's spouse and children about the submission, and the public prosecutor is also involved in the process. A court panel rules on the case and makes a decision.
With regard to effects of the judgment, the court orders the civil registrar of the municipality where the birth certificate was issued to make the rectification in the appropriate record in the judgment

approving the application. The civil registrar must then correct every other civil status record and other register office documents. Although not required, the judgment may order rectification of the applicant's first name (Christian name), considering the importance of the name in identifying and categorizing the person as belonging to one sex rather than the other. The verdict is not retroactive, but only takes effect when it becomes “res judicata” (i.e. when it becomes final, because it is no longer subject to appeal at this point).

With regard to consequences of gender reassignment on marriage, when the judgment is final, the marriage will be dissolved or the civil effects of a marriage observed in accordance with religious rites will cease (i.e., it will be grounds for divorce automatically) along with the dissolution of a civil partnership between people of the same sex. However, the applicant and their spouse may jointly make a statement in person at the hearing to express their willingness to form a civil partnership between people of the same sex and to make any statements regarding their choice of surname and property rights arising out of their matrimonial relationship until the case has been resolved by the court. To enter the civil partnership in the register of civil partnerships and to record any statements made by the parties regarding their choice of surname and any property rights arising out of their matrimonial relationship, the court will issue a ruling in this case instructing the civil registrar of the municipality where the marriage was celebrated, or where the transcript is filed if the marriage took place abroad.

Homotransphobia legislation

There are no laws in Italy that classify homo-transphobia as a hate crime. The lone attempt was supported by Congressman Alessandro Zan. The Zan law against homophobia and transphobia was enacted in the Chamber on November 4, 2020, but it was rejected by the Senate on October 27, 2021, by a vote of 154 to 131.

By the way, ten articles made up the law's text; they introduce new offenses, create a system of sanctions for them, establish a national day against discrimination, and plan to set up facilities to help discrimination victims.

Art. 2 of the new law was supposed to modify Art. 604 bis C.P., which punishes discrimination based on race, ethnicity, nationality, and religion. It additionally provides for the repression of discriminatory acts based "on sex, gender, sexual orientation, and gender identity". In fact, the revised version of Article 604 would also increase the punishment to 50% for crimes committed with the intention of inciting hatred or discrimination on the basis of sex, gender, sexual orientation, or gender identity, or to support organizations, movement associations, or groups that have the aforementioned objectives as one of their goals.

According to Article 7 of the law text, the national day against homophobia, lesbophobia, biphobia, and transphobia is supposed to be on May 17 with the goal of promoting a culture of respect and inclusion and opposing prejudice, discrimination, and violence motivated by sexual orientation and gender identity. Public agencies and educational institutions should have led the celebrations without making it a festival.

Art. 8 charged UNAR (Office for the Fight Against Discrimination established at the Council Presidency-Department for Equal Opportunities) with developing a national strategy to combat discrimination based on sexual orientation and gender identity every three years, including measures affecting the worlds of education, work, and media communication. It was expected that centers against discrimination based on sexual orientation and gender identity would be established throughout the national territory, providing legal, health, psychological, and social mediation assistance, as well as, if necessary, accommodation and food to victims of the offenses specified in article 604-bis.

References

https://www.thegoodintown.it/ddl-zan-bocciato-al-senato-cosa-voleva-e-perche-non-e-passato/

https://www.giustizia.it/giustizia/it/mg_3_1_22.page?tab=d#

CZECH REPUBLIC

Legal Gender Recognition

Czech Republic allows for the legal change of gender, but it required a diagnosis of "gender incongruence" (so far still only transsexualism legally applies as a mental disorder) and the completion of medical procedures, including surgery and hormone therapy. These requirements were viewed by many transgender rights activists as too invasive and restrictive, not respecting the individual's self-determined gender identity.

The main problematic aspects related to the legal gender recognition process in Czechia can be summarized as follows:

1. **Invasive Medical Requirements**: As of 2023 the Czech Republic still requires individuals seeking to change their gender marker to undergo hormone therapy and full surgical transition including castration before recognition of their gender identity. This process is invasive and fails to respect the autonomy of transgender individuals, many of whom may not want or be able to physically undergo these procedures.
2. **Pathologizing Identity**: Legal gender recognition is based on a diagnosis of of "gender incongruence" (however so far still only transsexualism legally applies as mental disorder). The implication of this requirement is that being transgender is viewed as a purely medical issue or disorder, which is a perspective that is stigmatizing and disrespectful.
3. **Mandatory Divorce/End to civil partnership**: If an individual was married, they are required to get divorced in order to change their legal gender. This places an undue burden on individuals and their families.
4. **No Recognition of Non-Binary Identities:** The laws do not allow for recognition of non-binary or other gender identities beyond male or female.
5. **Long Process**: The process to change one's legal gender is long and could be emotionally draining. It requires a number of medical tests and examiniations, a year on hormones, approval of committee and invasive surgery (castration). It is not available to persons under 18.

These issues lead to a variety of negative impacts, including discrimination, lack of access to appropriate services, and general distress for transgender individuals. Organizations have argued for a simpler, more respectful system that recognizes self-identified gender without the need for medical intervention or other restrictive requirements.

Pursuant to Section 29(1) of the Civil Code (Act no. 89/2012) the change of a registered gender of a person is made after a surgical operation with concurrent sterilisation and modification of reproductive organs. This provision is further specified in the Act on Specific Health Services (Act no. 373/2011), which states in Section 21(1) that for the purposes of the law, the gender reassignment includes performing medical operation, whose aim is to surgically modify the sex of the patient together with sterilizing the person. In order to obtain legal recognition of their gender identity, the Czech transgender persons incl. transgender women and girls therefore must undergo an irreversible surgical treatment accompanied by mandatory sterilisation.

Court decisions and judgments

Transgender Europe and ILGA Europe vs Czech Republic (Collective Complaint no. 117/2015, decision taken on May 15, 2018)

Surgical treatment, as regulated in the Czech Republic, does not pursue health protection. Imposing an obligation on an individual to undergo such a serious surgical procedure, which may in fact be harmful to health, cannot be regarded as consistent with the State's duty not to interfere with the right to health, and States must in such a case remove such interference (para. 80). Referring to international human rights standards, including the jurisprudence of the ECtHR, the Committee concludes that there has been a violation of Article 11(1) of the European Social Charter.

Relevant international standards

Various international organisations have repeatedly expressed their concerns that the de facto involuntary surgical intervention and sterilisation gravely violates rights of transgender women and constitute a harmful practice. The WHO, together with HCHR, UN Women, UNAIDS, UNDP, UNFPA and UNICEF strongly expressed their concern about the practice in 2014 in their common statement “Eliminating forced, coercive and otherwise involuntary sterilisation: An interagency statement”.

In Europe, the practice of conditioning gender reassignment by surgical operation and sterilisation as forced medical treatment has been criticised by the Committee of Ministers and the Parliamentary Assembly of the Council of Europe, which later adopted a resolution, directly suggesting to member states to adopt laws, which will not oblige transgender persons to undergo surgery for the purpose of legal recognition of their gender.

The practice was already condemned by the European Court of Human Rights as a violation of the right to privacy in the judgment A.P., Garçon and Nicot v. France (6 April 2017, nos. 9885/12, 52471/13, 52596/13). The practice however still persists in some European states, including Czechia.

According to the Yogyakarta principles, a professional soft-law document regarding the rights of LGBTI persons, ensuring the respect for bodily and mental integrity of a person presumes the prohibition of involuntary invasive medical treatment, such as sterilisation and surgery.

Currently, there is a case pending at the European Court of Human Rights pertaining to a complaint by T.H. v. Czech Republic after the Czech Constitutional Court failed to declare the sterilization requirement as unconstitutional.

Homo/transphobia legislation

The Czech Republic has insufficient legislation against homophobia/transphobia. The lack of these protections was the main reason why in ILGA-Europe Annual Review 2023 achieved only 26% in legal indicators.

The only legislation addressing this issue is the Anti-Discrimination Act (Act No. 198/2009 Coll.), which prohibits discrimination in various areas of public life, including employment, education, social protection, healthcare, and access to goods and services.

Under the Anti-Discrimination Act, it is unlawful to discriminate against individuals based on their gender identity, among other protected characteristics. This means that transgender individuals are protected from discrimination and harassment in areas such as employment, housing, education, and public services.

Equality and non-discrimination

There is no crime of hate speech in the Criminal Code of the Czech Republic. In contrast to crimes committed on the grounds of race, ethnic group, nationality, political opinion, religion, the Criminal Code does not impose especially severe punishment for crimes committed with homophobic motives, which are also not considered an ‘aggravating circumstance’.

In 2022 following a murder of two Slovak LGBTI+ people in Bratislava, an alliance of Czech organizations (Together Against Hatred) was formed to call for adoptions of better legal protections of LGBTI+ persons. One of the requirements was to recognize homophobic and transphobic motivation as a factor in hatecrime legislation:

According to statistics from organization In IUSTITIA, LGBT+ people were the second most at-risk group of people in the Czech Republic for bias-motivated attacks in 2021, with consequences for quality of life and safety concerns. However, perpetrators of homophobic and transphobic attacks are

not investigated, prosecuted and punished by law enforcement agencies in the same way as perpetrators of racial, ethnic, national or religious bias attacks, resulting in a lack of protection for LGBT+ victims. There is a need for LGBT+ people to be explicitly mentioned as a group in the facts of bias crimes. The Criminal Code should therefore recognise homophobic and transphobic motivation as a specific aggravating factor for the application of higher penal rates and take into account relationship orientation or gender identity in the qualified 'prejudicial' elements of certain general offences (bodily harm, extortion, etc.).

References

Transgender-Europe and ILGA-Europe v. Czech Republic:
https://www.coe.int/en/web/european-social-charter/processed-complaints/-/asset_publisher/5GEFkJmH2bYG/content/no-117-2015-transgender-europe-and-ilga-europe-v-czech-republic

The Interagency Statement:
http://www.who.int/reproductivehealth/publications/gender_rights/eliminating-forcedsterilization/en/

Ilga-Europe Annual Review 2023:
https://www.ilga-europe.org/report/annual-review-2023/

Together Against Hatred initiative:
https://spolecneprotinenavisti.cz/
https://docs.google.com/forms/d/e/1FAIpQLScOiLhP9LRL45mrgvowQCO4nMPpbUblQiEpSeSs6NB5L51j1w/viewform

SLOVAK REPUBLIC

In 1992, the European Court of Human Rights set out that human rights standards for transgender people are to be respected internationally. In the case of B. v. France, the ECHR concluded for the first time that not allowing a transgender person to change their official records violates the Convention for the Protection of Fundamental Human Rights and Fundamental Freedoms *(violation of Article 8 concerning the right to respect for private and family life)*. The ECHR also confirmed this conclusion in the decisions in Christine Goodwin v. the UK in 2002, Grant v. the UK in 2006, and Y.T. v. Bulgaria in 2020.

Despite this, the transition process is not comprehensively regulated in the Slovak Republic at this time. The legislation of the Slovak Republic does not currently recognize the term “transition” or “gender reassignment” but only the pathologizing and incorrect term “sex change”. The procedure for changing a person's data (first name, surname, birth number, sex identification) as a result of a “sex change” is partly regulated by Act no. 300/1993 Coll. on name and surname and Act no. 301/1995 Coll. on birth number.

The now invalid 1981 Announcement of the Ministry of Health of the Socialist Republic of Slovakia entitled *"Medical interventions for intersex, transsexual, sexual deviants and the procedure for issuing an opinion for registration in the registry office for transsexual persons" was* repealed by the adoption of Act No. 277/1994 Coll. on health care in 1994, which created a legal vacuum where no legislation governing transitioning was in place. The aforementioned legal vacuum was sought to be replaced by a new guideline of the Ministry of Health of the Slovak Republic approved by the Minister of Health on 22 March 2022, entitled *"Expert Guideline of the Ministry of Health of the Slovak Republic on the unification of procedures for the provision of health care for gender reassignment prior to the issuance of a medical opinion on the change of sex of a person administratively registered in the registry office"*, the effectiveness of which has been suspended as of 18.5.2022 up until the new document on *“Standard Procedure for the Diagnosis and Comprehensive Management of Healthcare for an Adult with Transsexualism”* was approved on 3.3.2023 after immense advocacy work of LGBTI+ organizations and medical experts in Slovakia (for further details, see medical transition in Slovakia section). The approval of this *Standard* meant that castration and sterilization cannot be a requirement of psychiatric evaluation anywhere in Slovakia for issuing a trans person with the so called *“medical assessment for person’s sex change”* document, which is by Registrar offices for completing legal transition (birth certificate and sex identification/ gender marker change). However, despite the significant advancements, these newly adopted legal frameworks are currently still being challenged by the anti-trans movement and opposers of gender-affirminghealth care which contributes to a pervasive feeling of uncertainty and fear experienced by transgender people in Slovakia.

Given the above, it is easy to see why several national experts suggest that trans people have long been completely overlooked by the law, especially considering that the Slovak legislators were unable to address the legal status and certain essential legal aspects of trans people's lives, such as the transition, for several decades, effectively deeming Slovak trans people unworthy of legal attention.

THE LEGAL PROTECTION OF TRANS PEOPLE IN SLOVAKIA

The rights of trans people are already protected by the existing international obligations of the Slovak Republic, thus ensuring a broad scope of their application. The application of these rights is therefore not a question of creating new human rights or bringing forward additional "super-standard" rights, but of applying the already existing universal human rights unquestionably to trans people and their specific life situations. Therefore, no human rights should be denied to trans people. However, transgender people have for centuries been and continue to be subjected to transphobia and other forms of intolerance and discrimination, not infrequently within their own families, including criminalisation, marginalisation, social exclusion and violence on the basis of gender identity, which means that certain measures are therefore needed to ensure the full enjoyment of human rights by these persons.

The European Union (of which the Slovak Republic is a part) is committed to the principle of the universality of human rights and reaffirms that no discrimination or justification of hatred, including discrimination against transgender persons on the basis of gender identity, can be justified by reference to cultural, traditional or religious values or other norms of the 'majority society'. In accordance with the case law of the European Court of Human Rights, any difference in treatment must be objectively and reasonably justified in order not to discriminate, meaning the pursuit of a legitimate aim and the use of adequate means to achieve it. However, the purpose of reasoning about human rights, fundamental freedoms and related international legal obligations of the State is not to 'smuggle' into national social and legal orders norms that are contrary to a given cultural or value tradition. On the contrary, the argumentation on human rights and fundamental freedoms for trans people points to the pillars of existing values that states, including Slovakia, have voluntarily accepted and identified with by acceding to international human rights conventions or joining European Union or the Council of Europe.

Gender identity is considered a protected characteristic and a legally prohibited ground for discrimination. The rights, to which every person is entitled regardless of their gender identity, are not exhaustive, they are indivisible and international human rights treaties are living documents whose scope is shaped in everyday life and evolves over time to respond to current demands for the protection and promotion of human rights. Law is an important tool for the protection and promotion

of the rights of trans people. This is not only because it can create the conditions to improve their lives by enabling and guaranteeing treatment and opportunities on an equal basis with others. As part of social norms, legal norms have additional social and educational functions, and thus the potential to positively influence societal perceptions of the need to protect and promote the rights of trans people, and to combat prejudice, rejection and hatred.

For example, the Constitution of the Slovak Republic says that *"fundamental rights and freedoms are guaranteed to all within the territory of the Slovak Republic..."* Sexual orientation and gender identity are not directly mentioned in it, but they can be included under the term *"other status"*, which was first explicitly stated by the Constitutional Court of the Slovak Republic in its ruling in 2005. The principle of non-discrimination on grounds of sexual orientation and gender identity is contained in the Equal Treatment Act and applies to the areas of employment and similar legal relations, social security and social benefits, health care, provision of goods and services, including housing, and education. It also applies to other national legislation to which the anti-discrimination law applies. However, despite the anti-discrimination legislation, still, the enforcement of the law is difficult to manage.

DISCRIMINATORY LAWS

Slovak legislation does not allow for the alignment of trans people's educational documents with new, legally and legitimately issued ID documents with new birth certificate and new name, which not only exposes trans people to forced coming out, but also violates international legal obligations arising from the Convention for the Protection of Human Rights and Fundamental Freedoms, to which the Slovak Republic is legally bound. Under Article 8 of this Convention, *"Everyone has the right to respect for his private and family life..."*, Slovakia is violating this Convention with two laws. Act No. 245/2008 Coll. Section 18, paragraph 5, which states: *"The data on the documents on the acquired education must match the data on the child, pupil or listener contained in the relevant pedagogical documentation. The head teacher shall be responsible for the conformity of the data and the correctness of the forms."* Paragraph 7 of this law adds: *"It shall be prohibited to correct data in the educational documents."* The second law by which Slovakia violates the obligations to which it has committed itself is the Act on Archives and Registers and on the Amendment of Certain Acts No. 395/2002 Coll., Section 12, Paragraph 2, which states: *"The archives shall provide access to archival documents by making copies, extracts, certificates, copies, study and public display of archival documents."* In practice, this means that whenever a transgender person is required totheir obtained education and qualifications, they are subjected to an unwanted invasion of their privacy because they must prove their qualifications with a document that does not match their chosen name and other identifying information identical to the information on their ID card.

As Slovakia currently does not have any legal recognition of same-sex partnerships, if a married or remarried person starts the process of transition, they must divorce, even if the partners wish to remain married.

A serious consequence of the lack of legislation is prejudice and hateful attacks on transgender people on social networks, in school environments, and other areas of public life. Many teachers and professionals in mainstream practice, whether in counseling settings or clinical practice, do not have sufficient and up-to-date information on this issue and are therefore unable to adequately guide and support trans* gender people through the whole process. There is also a lack of public education and support for family members of trans* people, including their children.

The European Commission against Racism and Intolerance (ECRI) has repeatedly noted the inadequate human rights legislative framework for transgender people in Slovakia. It recommends that the Slovak authorities, in close cooperation with civil society, develop and implement an action plan for LGBTI+ people, with objectives such as raising public awareness of the conditions in which LGBTI+ people live, promoting a better understanding of their situation, protecting them from hate crimes, hate speech and discrimination, and ensuring the effective implementation of their right to equal treatment.

PART II

2022-2-IT01-KA210-VET-000094028

TRANSIT

Training to Raise Acknowledge NeedS and Inclusion of Transgender

TRANSGENDER CLIENTS IN HEALTHCARE SETTINGS

Methodological Guidelines For Healthcare Professionals

Introduction

The purpose of these methodological guidelines is to provide healthcare professionals with a clear and comprehensive framework for approaching transgender clients in a sensitive and respectful manner. These guidelines are intended for use by healthcare professionals across various disciplines, including primary care, mental health, and specialized care providers. The aim is to ensure that transgender clients receive high-quality, equitable, and compassionate care that meets their unique needs.

Cultural competence is an essential component of healthcare delivery, as it enables healthcare professionals to effectively address the diverse needs of their clients. Developing cultural competence with regard to transgender clients is crucial for several reasons:

Health disparities: Transgender individuals face significant health disparities compared to their cisgender counterparts, including higher rates of mental health issues, substance use, and experiences of violence and discrimination.

Barriers to care: Transgender clients often encounter multiple barriers to accessing healthcare, such as provider bias, inadequate provider knowledge, and difficulties with insurance coverage.

Legal and ethical obligation: Healthcare professionals have a duty to provide competent care to all clients, regardless of their gender identity or expression.

Definitions and Terminology

Understanding key terms and definitions related to transgender health is critical for effective communication and care provision. These terms include primarily:

Transgender: An umbrella term for individuals whose gender identity is different from the sex assigned to them at birth.

Cisgender: A term for individuals whose gender identity aligns with the sex assigned to them at birth.

Non-binary: Non-binary refers to a gender identity that does not exclusively align with either the category of male or female.

Gender Identity: A person's internal sense of being male, female, or something else, which may or may not correspond to their assigned sex at birth.

Gender Expression: The way a person presents their gender to the world through their behavior, clothing, hairstyle, and other external characteristics.

Gender Dysphoria: A clinically significant distress or impairment related to the incongruence between a person's gender identity and their assigned sex at birth.

Transphobia: Transphobia is the prejudice, discrimination, or hostility towards individuals who identify as transgender or gender non-conforming.

Section II: Core Principles

Respect for Autonomy

Recognizing and respecting the autonomy of transgender clients is crucial for fostering trust and ensuring that they receive care that aligns with their values, preferences, and goals. This includes honoring their self-identified gender, supporting their decisions regarding transition-related care, and involving them in all aspects of the decision-making process.

Non-discrimination

Healthcare professionals have a responsibility to provide care that is free from discrimination based on gender identity, gender expression, or any other characteristic. This commitment should be reflected in both individual actions and institutional policies. Providers must actively work to identify and address biases, both implicit and explicit, in order to create a safe and welcoming environment for transgender clients.

Confidentiality and Privacy

Protecting the confidentiality and privacy of transgender clients is essential for maintaining trust and ensuring that they feel comfortable seeking and receiving care. Healthcare professionals should be aware of and adhere to relevant laws and regulations concerning the privacy of medical information, as well as take additional measures to safeguard sensitive information related to a client's gender identity and transition history.

Informed Consent

Informed consent is a critical component of ethical healthcare practice. Providers must ensure that transgender clients have the necessary information to make informed decisions about their care, including the risks, benefits, and alternatives of any proposed interventions. Healthcare professionals should communicate this information in a clear, accessible, and culturally sensitive manner, and must obtain explicit consent from the client before proceeding with any treatment or intervention.

Collaboration and Shared Decision-Making

Effective care for transgender clients requires a collaborative approach that involves the client, healthcare professionals, and, when appropriate, family members or other support persons. Shared decision-making empowers clients to take an active role in their care and ensures that their values and preferences are incorporated into the treatment plan. Providers should strive to

create an open and supportive environment in which clients feel comfortable discussing their concerns, asking questions, and providing input on their care.

Section III: Developing Cultural Competence

A. Personal Reflection and Bias Awareness Healthcare professionals should engage in ongoing self-reflection to identify and address any personal biases or assumptions related to gender identity and expression. This process may involve:

Reflecting on personal beliefs, attitudes, and experiences related to transgender individuals and communities.

Acknowledging and addressing any discomfort or uncertainty related to providing care for transgender clients.

Seeking feedback from colleagues, supervisors, and clients to identify areas for growth and improvement.

B. Training and Education Continuous education and training are essential for developing cultural competence and staying up-to-date on best practices in transgender healthcare. Healthcare professionals should:

Attend workshops, conferences, and other educational events that focus on transgender health and cultural competence.

Review current research, clinical guidelines, and expert recommendations to inform their practice.

Seek out opportunities for mentorship, consultation, or supervision from experienced providers who specialize in transgender care.

C. Access to Resources and Support Healthcare professionals should familiarize themselves with resources and support services that can assist them in providing culturally competent care to transgender clients. This may include:

Professional organizations and advocacy groups, such as the World Professional Association for Transgender Health (WPATH) or the National Center for Transgender Equality (NCTE), which offer guidelines, research, and educational materials.

Local and regional transgender support groups, community organizations, and networks that can provide insight into the unique needs and experiences of transgender individuals in their area.

Online forums, social media groups, and other platforms where healthcare professionals can connect with their peers and share experiences, resources, and strategies for providing culturally competent care.

Section IV: Communication

Use of Appropriate Language and Pronouns

Using appropriate language and pronouns is essential for creating a welcoming and respectful environment for transgender clients. Therefore, healthcare professionals shouldf amiliarize themselves with terminology related to gender identity, expression, and the process of transition. They should also ask clients about their preferred name and pronouns, and consistently use them in all interactions. Last but not least, i tis important to avoid using language that is overly medicalized, stigmatizing, pathologizing or offensive.

Active Listening

Active listening involves fully engaging with the client, paying attention to their verbal and nonverbal cues, and responding in a way that demonstrates understanding and empathy. To practice active listening, healthcare professionals should:

Give the client their undivided attention and avoid interrupting or multitasking during the conversation.

Encourage the client to express their thoughts, feelings, and concerns by asking open-ended questions and using supportive body language.

Summarize and reflect back the client's statements to ensure accurate understanding and demonstrate empathy.

Empathy and Compassion

Empathy and compassion are vital for building rapport and trust with transgender clients. Providers should:

Validate the client's feelings and experiences, acknowledging the challenges they may face related to their gender identity.

Express genuine care and concern for the client's well-being, both emotionally and physically.

Avoid making judgments or expressing personal opinions that may undermine the client's sense of self-worth or autonomy.

Avoiding Assumptions and Stereotyping

Healthcare professionals should be aware of common stereotypes and assumptions related to transgender individuals and actively work to challenge these beliefs in their practice. This includes:

Avoiding assumptions about the client's sexual orientation, relationship status, or family structure based on their gender identity.

Refraining from making assumptions about the client's transition goals or the extent of medical interventions they may desire.

Recognizing that transgender clients may have diverse gender identities and expressions that do not necessarily conform to binary categories of male or female.

Principles of Client-Centered Care

● Working step-by-step.

● Client knows their own needs best.

● Safe and confidential communication.

● Respectfully exploring options.

● Search for access points to client resources, verbalization,

imagination, creativity, movement-oriented approaches and

activities, expressive therapy (art therapy, drama therapy,

dance therapy, music therapy, etc.).

● Accepting and working with the client’s apprehension.

Section V: Clinical Assessment and Care

Comprehensive History

Gathering a thorough history is crucial for understanding the unique needs and experiences of transgender clients. Healthcare professionals should explore the following areas:

1. Gender Identity and Expression a. Discuss the client's gender identity and how it has evolved over time. b. Ask about the client's experiences related to their gender expression, including any challenges or discrimination they have faced. c. Inquire about the client's support system, including family, friends, and community resources.

2. Medical and Surgical History a. Obtain information about any previous or ongoing gender-affirming medical treatments, such as hormone therapy or surgeries. b. Review the client's general medical history, including any chronic conditions, medications, allergies, and immunization status. c. Discuss the client's reproductive health history, including contraception, pregnancy, and sexually transmitted infections, as appropriate.
3. Mental Health and Well-being a. Screen for mental health concerns, such as depression, anxiety, or substance use, recognizing that transgender clients may be at higher risk for these issues. b. Assess for gender dysphoria and its impact on the client's daily functioning and quality of life. c. Explore the client's coping strategies and sources of resilience, as well as any barriers to accessing mental health care.

Physical Examination

Conducting a respectful and sensitive physical examination is essential for building trust and ensuring the comfort of transgender clients. Key considerations include:

1. Sensitivity and Privacy

   a. Clearly explain the purpose and steps of the examination, obtaining informed consent before proceeding. b. Provide the client with privacy and autonomy during the examination, such as allowing them to undress and dress in private. c. Be aware of any potential triggers related to the client's body or previous trauma and approach these areas with caution.

2. Genital and Breast Examinations

   a. Discuss the necessity of genital and breast examinations with the client, taking into account their gender identity, transition status, and preferences. b. Use gender-neutral language when discussing genitalia and avoid making assumptions about the client's anatomy. c. Conduct examinations in a respectful and gentle manner, prioritizing the client's comfort and dignity.

Screening and Preventive Care

Providing appropriate screening and preventive care for transgender clients requires understanding their unique healthcare needs and risks. Considerations include:

1. Hormone Therapy a. Assess the client's eligibility for hormone therapy based on their goals, medical history, and potential contraindications. b. Monitor hormone levels and adjust treatment as needed to achieve desired outcomes while minimizing potential risks. c. Provide ongoing education and support to help the client manage potential side effects and adhere to their treatment plan.
2. Surgical Interventions a. Discuss the client's goals and expectations related to gender-affirming surgeries, providing information about available procedures and potential outcomes. b. Assess the client's readiness for surgery based on their medical, psychological, and social factors, as well as any relevant criteria outlined in professional

guidelines. c. Collaborate with surgical providers and coordinate care to ensure optimal outcomes and support throughout the surgical process.

3. Mental Health Support a. Provide referrals to mental health professionals with expertise in transgender care, as needed, to address issues such as gender dysphoria, anxiety, depression, or trauma. b. Collaborate with mental health providers to develop a comprehensive treatment plan that addresses the client's unique needs and goals. c. Encourage the client to access community resources and support groups for additional social and emotional support.

Section VI: Documentation and Medical Records

Name and Pronoun Usage

Ensuring that documentation and medical records accurately reflect the client's preferred name and pronouns is important for maintaining privacy, respect, and continuity of care. Healthcare professionals should:

1. Use the client's preferred name and pronouns in all documentation, including progress notes, referral letters, and electronic medical records.
2. If required to use the client's legal name due to billing or insurance purposes, clearly indicate their preferred name in a prominent location within the medical record to minimize confusion or misgendering.
3. Update the client's demographic information in the medical record as they undergo legal name or gender marker changes, ensuring that historical records are maintained for reference.

Making Clinical Sites More Transgender Accessible

1. Include all genders on patient health data forms.
2. Introduce gender-variant affirming signage, artwork and medi-cal information displays in reception areas and examination rooms.
3. Educate all staff about how to affirm a patient’s gender identity and welcome all clients.
4. Provide clients with unisex restrooms.
5. Ask the transgender individual which pronoun they prefer (Selix et al, 2016.)

Confidentiality and Disclosure

Safeguarding the privacy of transgender clients' medical information, particularly regarding their gender identity and transition history, is essential for ensuring their comfort and trust. Providers should:

1. Be familiar with and adhere to relevant laws and regulations governing the privacy and disclosure of medical information, including the Health Insurance Portability and Accountability Act (HIPAA) in the United States.

2. Obtain explicit consent from the client before disclosing information related to their gender identity or transition history to other providers or third parties, unless required by law or necessary for the provision of appropriate care.
3. Train administrative and support staff on the importance of maintaining the confidentiality of transgender clients' medical information and develop policies to prevent inadvertent disclosures or breaches of privacy.

Section VIII: Advocacy and Systemic Change

Role of Healthcare Professionals in Advocacy Healthcare professionals have a unique opportunity and responsibility to advocate for transgender clients at the individual, institutional, and societal levels. By engaging in advocacy efforts, providers can help to:

1. Promote access to high-quality, culturally competent healthcare services for transgender individuals.
2. Address systemic barriers and disparities that disproportionately affect transgender communities, such as discrimination, stigma, and lack of insurance coverage.
3. Foster a more inclusive and equitable healthcare system that respects and supports the diverse needs and experiences of all clients, regardless of their gender identity.

B. Individual Advocacy Providers can engage in individual advocacy by supporting their transgender clients in navigating the healthcare system and accessing the resources and care they need. This may involve:

1. Assisting clients with insurance pre-authorizations, appeals, or other administrative processes related to their care.
2. Providing referrals to legal, financial, or community resources that can help clients address barriers to care or other challenges related to their gender identity.
3. Encouraging clients to advocate for themselves and their needs, by providing information, tools, and support to help them effectively communicate with providers and navigate the healthcare system.

C. Institutional Advocacy Healthcare professionals can work within their organizations to promote policies and practices that support transgender clients and create a more inclusive healthcare environment. This may include:

1. Advocating for the adoption of non-discrimination policies that protect transgender clients and staff from bias and harassment.
2. Developing or revising clinical guidelines and protocols to ensure that they are informed by current research and best practices in transgender healthcare.
3. Implementing staff training programs on transgender cultural competence and sensitivity, as well as strategies for addressing bias and discrimination within the workplace.

D. Societal Advocacy Providers can also engage in broader societal advocacy efforts to address systemic barriers and promote greater equity and inclusion for transgender communities. This may involve:

1. Participating in public awareness campaigns, educational initiatives, or community events that raise awareness about transgender health issues and promote greater understanding and acceptance.
2. Collaborating with professional organizations, advocacy groups, or policymakers to develop and implement policies and legislation that protect transgender individuals' rights and access to care.
3. Conducting or supporting research on transgender health disparities, best practices, and interventions, in order to advance knowledge and inform policy and practice in the field.

References

:

American Psychological Association. (2015). Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. American Psychologist, 70(9), 832-864.doi.org/10.1037/a0039906) https://www.apa.org/practice/guidelines/transgender.pdf

Carlström, R., Ek, S., & Gabrielsson, S. (2020). 'Treat me with respect': transgender persons' experiences of encounters with healthcare staff. Scandinavian Journal of Caring Sciences.

Center of Excellence for Transgender Health. (n.d.). University of California, San Francisco. Retrieved from https://transcare.ucsf.edul

Chapman, R., Zappia, T., & Shields, L. (2012). An essay about health professionals' attitudes toward lesbian, gay, bisexual and transgender parents seeking healthcare for their children. Scandinavian Journal of Caring Sciences, 26(2), 333-339.

Erickson-Schroth, L. (Ed.). (2014). Trans Bodies, Trans Selves: A Resource for the Transgender Community. Oxford University Press.

Ervin, A. (n.d.). The Ethics of Working with Ground Rules Transgender and Gender. Retrieved November 10, 2020, from https://cdn.ymaws.com/www.papsy.org/resource/collec- tion/C954A5EF-F25C-4505-A0EA-25C6047A068D/W16_Ethics_of_Transgender.pdf

Jenner, C. O. (2010). Transsexual primary care. Journal of the American Academy of Nurse Practitioners, 22(8), 403-408.

Makadon, H. J., Mayer, K. H., Potter, J., & Goldhammer, H. (Eds.). (2016). The Fenway Guide to LGBT Health. American College of Physicians.

Sedlak, C. A., Veney, A. J., & Doheny, M. O. B. (2016). Caring for the transgender individual. Orthopaedic Nursing, 35(5), 301-306.

Vincent, B. (2019). Transgender Health: A Practitioner's Guide to Binary and Non-Binary Trans Patient Care. Jessica Kingsley Publishers.

World Professional Association for Transgender Health (WPATH). (2022). Standards of Care 8.

PART III

Evaluation Questionnaire - TRANSIT

1. I am aware of institutional barriers that may inhibit transgender people from using health care services.

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

2. LGBTQ people mostly only experience sexual health-related disparities (eg. HIV/AIDS)

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

3. Transgender men may need pap smears

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

4. LGBT individuals are more likely to report mental health problems (such as anxiety and depression).

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

5. Smoking is more prevalent among sexual minority women, putting them at greater risk for certain respiratory diseases.

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

6. All men who have sex with men are gay. *

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

7. Suicidal ideation and attempted suicide are just as common among heterosexual, cisgender individuals as among LGBT individuals.

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

8. Lesbians do not need routine pap smears, since they do not have sexual relations with men

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

9. I am aware of research indicating that LGBT+ individuals experience disproportionate levels of health and mental health problems compared to heterosexual Individuals.

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

10. LGBT+ individuals must be discreet about their sexual orientation around children.

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

11. I have received adequate clinical training and supervision to work with transgender clients/patients.

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

12. I feel adequately prepared to discuss LGBTQ+ - related topics in healthcare today

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

13. The formal curriculum at my school adequately covers sexual and gender minority-specific health topics.

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

14. I feel competent to asses a person who is LGBT+ in a therapeutic setting.

Sign just one circle from 1 Strongly Disagree to 7 Strongly Agree

	1	2	3	4	5	6	7	
Strongly Disagree	◯	◯	◯	◯	◯	◯	◯	Strongly agree

15. Describe in few words what you gained from this TRANSIT training or you think you're going to gain with it.

_____
_____
_____
_____

Effectiveness Feedback Questionnaire for the "Training to Raise Acknowledge NeedS and Inclusion of Transgender" (TRANSIT) Course

Section 1: *Participant Information*

Name: _____

Organization: _____

Role/Position: _____

Email: _____

Section 2: *General Training Feedback*

Please provide your feedback on the effectiveness of the "Training to Raise Acknowledge NeedS and Inclusion of Transgender" course. You can share your thoughts, experiences, and suggestions.

1. How would you describe your overall experience with the training course?

_____

_____

2. Did the training course meet your expectations? Why or why not? Please elaborate.
   a. Yes
   b. No

_____

_____

3. In what specific ways did the training course increase your knowledge and understanding of transgender-specific issues?

_____

_____

4. How did the training course enhance your skills in supporting and serving transgender individuals? Please provide examples, if possible.

_____

_____

5. Do you feel that the knowledge, skills and competencies you obtained during the training could help contribute to positive changes in institutional policies regarding LGBTQ+ and transgender inclusion? If yes, please provide examples or explain how.
   a. Yes

b. No
c. Not applicable

6. How did the training course improve your professional integrity when working with LGBTQ+ individuals?

7. Did you notice a reduction in prejudices, stereotypes, and discrimination against LGBTQ+ people after attending the training course? Please elaborate.

   a. Yes
   b. No
   c. Not sure

8. In what ways did the training course raise your awareness of the specific needs and challenges faced by transgender individuals?

9. Were there any specific topics or areas that you found particularly beneficial or impactful during the training course? Why?

10. Did the training course adequately address the objectives outlined at the beginning of the training activities? If not, what aspects could be improved?

    a. Yes, all objectives were addressed
    b. Some objectives were addressed
    c. No, objectives were not addressed

11. Based on your experience, what suggestions or recommendations do you have for enhancing the effectiveness of future training courses on LGBTQ+ issues?

Section 3: *Training Objectives*

Please rate the extent to which you feel the training course has achieved the following objectives, on a scale of 1 to 5 (1 being strongly disagree and 5 being strongly agree):

1. The training course increased my knowledge and understanding of LGBTQ+ and trans-specific issues.
2. The training course enhanced my skills in effectively supporting and serving transgender individuals.
3. The training course helped me develop cultural sensitivity towards transgender individuals.
4. The training course improved my professional integrity when working with LGBTQ+ individuals.
5. The training course reduced prejudices, stereotypes, and discrimination against LGBTQ+ people.
6. The training course raised my awareness of the specific needs and challenges faced by transgender individuals.

Section 4: *Skills Development*

Please indicate the extent to which the training course helped you improve the following skills, on a scale of 1 to 5 (1 being no improvement and 5 being significant improvement):

1. Understanding of transgender terminology and concepts.
2. Ability to provide appropriate support and guidance to transgender individuals.
3. Communication skills when interacting with transgender individuals.
4. Advocacy skills for promoting the rights and needs of transgender individuals.
5. Cultural competence in working with diverse LGBTQ+ communities.
6. Knowledge of legal and ethical considerations related to transgender issues.

Section 5: *Additional Comments*

Please feel free to provide any additional comments, feedback, or suggestions regarding the "Training to Raise Acknowledge NeedS and Inclusion of Transgender" course.

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire. Your feedback is valuable in assessing and improving the effectiveness of the training course.

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