

FROM INEQUALITY TO BETTER PRACTICE

Healthcare access in five European countries from the perspectives of trans people and healthcare practitioners.

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Preface

After five years as a student in Clinical Psychology at Ghent University, this thesis will be the last chapter of a challenging and satisfying time in my life. Studying psychology has made me aware of the complexity of the human mind. It has allowed me to better understand the many aspects of human communication and has taught me to always take an open-minded perspective and a critical look.

I was fortunate to find two (co-)promoters to pursue my own thesis topic, two experienced professors that guided me through this process of writing a thesis. The subject of the study is very close to me and that is why for two years I've put all my heart and mind into a quantitative study (which is broader than my thesis alone). I am, therefore, forever grateful for the confidence, strong advice and useful feedback from prof. dr. Joz Motmans and prof. dr. Alexis Dewaele.

I am also thankful to the more than thousand participants that generously took the time to complete the questionnaires. Also thank you to my mother for her nonstop motivational advice.

Finally, I want to thank all the professors and assistants at Ghent University for making our faculty and our curriculum the interesting, unique and inspirational experience that it is. I sincerely feel that we have been well prepared to step into the professional field.

Aisa Burgwal, May 22nd 2018

Abstract

This study is situated at the cutting edge of two major findings. Firstly, there's a growing body of research into experiences from transgender people in healthcare settings, which, among other things, points to various forms of discrimination and negative experiences. Several aspects can lead to prejudices, stereotyping, stigmatization and discrimination. One of the main aspects of importance here are attitudes. Secondly, we've witnessed a growing body of literature measuring the attitudes of healthcare providers towards certain minority groups. However, only a limited number of studies investigate attitudes from healthcare providers towards gender minorities.

The purpose of this study is to fill in the gap by comparing attitudes of trans people with those from healthcare providers regarding diagnosis and pathologisation of trans people, and regarding informed consent models. By means of two separate online and anonymous questionnaires, one for trans people and one for healthcare providers (ranging from surgeon to administrative staff), attitudes were measured in five different countries: Georgia, Poland, Serbia, Spain and Sweden. Results from 885 trans people and 829 healthcare providers showed that healthcare providers had more conservative attitudes for diagnosis and pathologisation, as well as for informed consent models, when compared to trans people. In regard to attitudes regarding informed consent models, a significant influence of age, education and country of residence was also found. This study gives valuable insight in the gap between the wishes and needs of trans people on the one hand, and the opinion/attitude of healthcare providers on these matters on the other.

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Literature Study

A number of studies have shown that transgender people face considerable problems when accessing healthcare (see for ex. Fundamental Rights Agency, 2014; Grant et al., 2010; Motmans, 2010; White Hughto, Rose, Pachankis, & Reisner, 2017; Zeluf et al., 2016). Also, comparative research on attitudes and opinions towards transgender people is lacking for now. In addition to a few studies and a number of targeted transgender surveys, the only figures on the attitude towards transgender discrimination are from the Special Eurobarometer 393 (European Commission, 2012). Up to now there has not been any research comparing attitudes/opinions of transgender people with other groups, for example healthcare providers. This study will compare the opinions and attitudes of transgender people regarding healthcare provisions for trans people with opinions and attitudes of healthcare providers in five different countries: Georgia, Poland, Serbia, Spain and Sweden. Such research is important, since negative attitudes are at the basis of stereotyping, stigmatization and transphobia, and can lead to negative behaviour towards others (R. Brown, 2010; D'haese, Dewaele, & Van Houtte, 2014; Goffman, 1963). The research question is as follows: "Are there differences in opinions/attitudes regarding healthcare between trans people and healthcare providers?". First, a clear definition of transgender will be given. Secondly, a literature review will be provided to indicate how important research on trans people is. The studies mentioned do not always refer to the five countries in this study because there is an overall lack of data regarding trans healthcare and therefore there are not always specific data for each country. A theoretical background on attitudes and opinions will also be given to substantiate the research question and the hypotheses formulated afterwards.

Transgender: Concepts and Definitions, Prevalence, and Empirical Evidence

The study of transgender people is relatively recent and emerged from medical studies around 100 years ago (Hines, 2007). The term transgender (or shortly trans) is increasingly used since the 1990's as an umbrella term, which includes those people whose gender expression and/or identity differs from conventional expectations based on the physical sex assigned at birth (Massachusetts Institute of Technology, 2006). It was introduced by trans people themselves to get rid of the pathologising effect of the term transsexualism (Stryker, 2006). The gender identity of transgender people differs to varying degrees to the sex assigned at birth (Bockting, 1999). Gender identity is a person's intrinsic feeling of being male (a boy or a man), female (a girl or a woman) or an alternative gender (Bockting, 1999). A gender identity different from the sex assigned

at birth can lead to gender dysphoria. This is distress caused by a discrepancy between a person's gender identity and a person's sex assigned at birth (and the associated gender roles and/or primary or secondary sex characteristics) (Fisk, 1973; Massachusetts Institute of Technology, 2006). With regard to the development of gender identity and the causes of gender dysphoria, no single cause has been found so far. In the literature, genetic, hormonal, neurodevelopmental and psychosocial factors play a role (De Vries & Cohen-Kettenis, 2012; Meyer-Bahlburg, 2010; Vrouenraets, Fredriks, Hannema, Cohen-Kettenis, & de Vries, 2015). However, not all transgender people suffer from gender incongruence between the sex assigned at birth and their gender identity. Transgender people therefore do not necessarily experience gender dysphoria and others experience this for only a period of their lives. Counselling and/or medical treatment can relieve gender dysphoria by finding a gender role and expression that is more comfortable for the person. This treatment is highly individualized: some trans people are helped with only therapeutic conversations and do not need further treatment, while other trans people may need hormone therapy and sometimes (certain) surgical procedures to feel more comfortable in their body and gender role (Coleman et al., 2012). However, not all transgender people seek psychological or medical help. A report, published in 2017, showed that one in four trans people (27.1%) did not seek psychological or medical help for being trans (Smiley et al., 2017).

Prevalence.

Exact data on the prevalence of trans-identified individuals do not exist (Eyssel, Koehler, Dekker, Sehner, & Nieder, 2017). The prevalence varies in different studies. This variation is due to a wide variety in methodologies. Existing studies have applied criteria that differ in exclusivity (for example genital surgery as the strictest criterion) (Arcelus et al., 2015; De Cuypere et al., 2007; Kuyper & Wijzen, 2014; Meyer zu Hoberge, 2009; Van Caenegem et al., 2015; Wilson, Sharp, & Carr, 1999). Collin, Reisner, Tangpricha, and Goodman (2016) concluded in their systematic review a prevalence of 0.0092% for trans people who used surgical or hormonal transition-related treatment, 0.0068% for trans people with a trans-related diagnosis. The prevalence of individuals who identified as trans was much higher (0.335% after eliminating one outlier study).

Empirical evidence.

To demonstrate the importance of research on transgender people in healthcare, a social background is outlined. There is a variety of research that shows that trans people often have to deal with discrimination when accessing or trying to access healthcare (see for

ex. Fundamental Rights Agency, 2016; Grant et al., 2010). They also often report negative experiences such as inappropriate curiosity, physical and/or even sexual assault from healthcare personnel (see for ex. Fundamental Rights Agency, 2014; Grant et al., 2011). Both trans people and healthcare providers also indicate that the latter have a lack of knowledge and have received too little information about trans-specific healthcare during and after their training (see for ex. Bauer, Zong, Scheim, Hammond, & Thind, 2015; Fundamental Rights Agency, 2016; Whittle, Turner, Combs, & Rhodes, 2008). Finally, we also highlight limitations when trying to access trans-specific treatments. In particular the costs that are linked to trans-specific treatments, because in many countries trans-specific treatments are not covered by health insurance (Fundamental Rights Agency, 2014, 2016; Grant et al., 2010). Also the link between surgeries and other medical procedures on the one hand and legal gender recognition on the other hand, which further limits trans people in their pursuit of treatment (see for ex. Fundamental Rights Agency, 2016; Transgender Europe, 2016b).

Discrimination when accessing healthcare.

The European Union Agency for Fundamental Rights (FRA) published a report in 2014 that claimed that one in five European trans people felt discriminated by healthcare personnel (22%) and social service personnel (19%) due to their gender identity (Fundamental Rights Agency, 2014). This was twice as high among trans respondents as among other respondents in the FRA EU LGBT survey (LGBT is an acronym that stands for lesbian, gay, bisexual and transgender), which was conducted at the same time. Experiences of discrimination differed from country to country (ranging from 8% for Slovakia to 30% for France, with also Sweden as one of the countries with the highest rates (26%)) (Fundamental Rights Agency, 2014). Other studies report similar results (see for ex. Grant et al., 2010). A study in Serbia reported that 29% of the respondents stated that their gender identity had affected how they were treated within the public health system (Balzer & Hutta, 2015). Furthermore, the results from the FRA study showed that openness about one's gender identity was linked to more negative experiences and more discrimination (30% when fully or partly open vs. 16% when not open to medical personnel) and one in five respondents reported inappropriate curiosity (21%), while 17% felt their specific needs were ignored (Fundamental Rights Agency, 2014; Grant et al., 2010). These obstacles in healthcare can prevent someone to live full-time according to their gender identity (Motmans, 2010; Whittle, Turner, & Al-Alami, 2007). In some studies trans people even report physical assault (26%) and sexual assault (10%) by healthcare professionals (Grant et al., 2011). The experience of

discrimination varies across trans people, with an increased likelihood for members of ethnic minorities (Grant et al., 2011), individuals transitioning later in life, individuals with low social economic status (Lombardi, 2009) and individuals where the healthcare professionals were aware of their transgender status (Grant et al., 2010).

Negative healthcare experiences are also linked to negative outcomes. For example, as a result of the high rates of negative attitudes from healthcare providers, trans people often wait longer before consulting a doctor or other medical worker or their readiness to use healthcare services might be further reduced (Fundamental Rights Agency, 2016; Grant et al., 2010; Motmans, 2010; Socias et al., 2014). A Swedish study showed that negative healthcare experiences are key predictors of bad self-reported health, self-reported disability and a lower quality of life (Zeluf et al., 2016). The collective impact of these discriminatory events expose trans people to increased risks, such as HIV infection, smoking and drug/alcohol use. Mental and physical health can be impaired as well, such as a higher risk for suicide attempts and overall poorer health (Grant et al., 2010). Studies showed that even over 2/3 of transgender individuals report suicidal ideation, and around 30-40% have attempted suicide at least once (Grant et al., 2010; Smiley et al., 2017). All these negative outcomes can be influenced by different risk factors, such as a low educational level, unemployment, low income, sexual and physical assault, being engaged in sex work, openness about one's gender identity, etc. (Grant et al., 2010; White Hughto et al., 2017).

Lack of knowledge & education among healthcare practitioners.

Insufficient access to healthcare for trans people is not only the result of discrimination; the lack of knowledge of healthcare providers regarding trans-specific care also contributes in many circumstances to an inability to provide adequate care to trans people. The EU-wide Transgender Eurostudy in 2008 reported that 30% of the respondents experienced that healthcare providers lacked knowledge when attempting to provide care to them as trans people (Whittle et al., 2008). Other studies report similar results (Bauer et al., 2015; Grant et al., 2010; White Hughto et al., 2017). In contrast, when asked to healthcare providers in Serbia whether they believed that their knowledge about LGBT issues was sufficient, 31% believed that they had enough knowledge on needs and issues of trans people, 54% were not certain and only 15% believed that their knowledge was not sufficient (Đurić & Todorčić, 2006). Also, when asked if there should be additional training on health, needs and issues of LGBT populations, 41% of healthcare providers disagree with the statement, in contrast to 25% who agree and 34%

who are uncertain (Đurić & Todorić, 2006). However, a qualitative study in Ontario, Canada, has shown that physicians commonly identified barriers to care provision in the context of not knowing the available resources or care strategies appropriate for the trans patient population (Snelgrove, Jasudavicius, Rowe, Head, & Bauer, 2012). Healthcare professionals are indeed often uninformed or have false convictions about trans identities, trans-specific healthcare and difficulties faced by trans people concerning healthcare (Bauer et al., 2009; Rondahl, 2009).

LGBTI (those who add intersex people to LGBT groups use this extended acronym) is also still seen as a pathological problem in many EU Member States (Fundamental Rights Agency, 2016). A 2015 study from the Women's Initiatives Supporting Group (WISG) indicated that healthcare workers in Georgia had a vague knowledge about gender identity, trans people and trans-specific healthcare. One group of healthcare workers in this study defined transgender as a problem in self-perception and one's own sex, another group was unaware of the difference between sexual orientation and gender identity (Aghdgomelashvili, Gvianishvil, Todua, & Ratiani, 2015). In another study in Serbia, almost one of four providers viewed transsexualism as a mental disorder (23.4%), while others considered it a bodily disorder (13.8%) (Vidic, 2015).

That transsexualism is still seen by many as a mental disorder is not that strange, because transsexualism is still codified within the International Classification of Diseases (ICD-10) (World Health Organization, 2010). However, this is being criticized by organizations, such as the World Professional Association for Transgender Health (WPATH), because speaking in terms of a disorder involves the pathologisation of a phenomenon that only involves a difference (between sex assigned at birth and gender identity) (Motmans, 2010). Organizations such as Transgender Europe (TGEU) state that, despite scientific controversy, different forms of transgender remain listed as psychological disorders in diagnostic manuals such as the ICD-10. They explicitly reject this pathologisation. TGEU is convinced that this form of stigmatization, which is in fact based on the erroneous assumption that gender variance is a disorder, is discriminatory (Motmans, 2010). Therefore, they refer to the 'Yogyakarta principles' (principles concerning the application of the international human rights law regarding sexual orientation and gender identity) (International Commission of Jurists (ICJ), 2006). Nevertheless, there is also a realistic fear in countries such as France and Poland that removing transsexualism from diagnostic manuals will abstain trans people from accessing healthcare services, more specifically that treatment will no longer be provided

or will no longer be covered by health insurance when removing the diagnosis (Fundamental Rights Agency, 2016). Thus, a potential benefit of including transsexualism in the ICD-10 is that its codification makes it a medically recognized condition requiring attention from providers. Trans-specific healthcare has already limited financial refunds, so keeping a diagnosis in internationally accepted manuals will help trans people with limited financial resources. However, experts in transgender health have reached consensus that transgender identity per se should not be psychopathologised, but rather should be retained as a medical diagnosis, without a psychiatric mark. Therefore, the ICD-11, which is now being developed and will normally be finalized in 2018, no longer wants to use the diagnosis of transsexualism, but will probably change it into the diagnosis of gender incongruence in adolescence and adulthood (GIAA), which will most likely be placed in a new chapter, unrelated to mental health (Winter, De Cuypere, Green, Kane, & Knudson, 2016). In one study from the Netherlands, Flanders and the UK, transgender respondents (and their relatives/partner) indicated that if the new diagnostic term is indeed retained, it is important that the term should not be stigmatizing to individuals any longer (Beek et al., 2016). Unfortunately, because of high comorbidity of disorders, healthcare providers often think that also transsexualism is accompanied with other psychiatric conditions. They also think that it puts a patient at higher risk of other mental illnesses but most of them do not have any other diagnoses (Snelgrove et al., 2012). Although, there are studies, for example the study of Wallien, Swaab, and Cohen-Kettenis (2007), where the risk of co-occurring psychiatric problems in children and adolescents with gender dysphoria is high. The percentage of children who fulfilled DSM criteria of at least one other diagnoses was 52%. The precise mechanisms that link gender dysphoria with coexisting psychopathology are still unknown.

All in all, there are different possible reasons why there is such a lack of knowledge. Firstly, training is lacking in the academic setting. In some countries, there is no course on gender identity or trans issues during or after medical school. In other countries we see that on average 45 to 55% of the professionals have had transgender education, with trainings of three to five hours (Dy, Osburn, Morrison, Grant, & Merguerian, 2016; Lelutiu-Weinberger et al., 2016; Morrison et al., 2017; Obedin-Maliver et al., 2011). In Poland some providers reported that there were trans-specific healthcare courses, but in Spain training on trans issues was seen as non-existent (Fundamental Rights Agency, 2016). In Serbia, topics on gender identity were not present during their medical training, as reported by healthcare providers (Vidic, 2015). Where training is available, healthcare

providers usually describe it as voluntary and rare (Fundamental Rights Agency, 2016). In addition, topics on homosexuality and sexual orientation are more present during medical training compared to topics relating to gender identity and trans people (Seaborne, Prince, & Kushner, 2015; Vidic, 2015). These first topics are more present after basic medical training as well, which possibly reflects more interest in these topics (Vidic, 2015). A few professionals also discussed that the lack of available research on trans people and the small number of trans people in healthcare forms a barrier to acquire knowledge (Fundamental Rights Agency, 2016). This reflects a perception that certain healthcare providers will be interested in trans healthcare and include this in their practice when there is information available, and other providers will not. Another study did show that 88% of medical students wanted to learn more about trans people during their medical training (Chan, Skocylas, & Safer, 2016). Only a minority of non-specialist professionals were aware of the issues facing trans people (Fundamental Rights Agency, 2016). Of the trans-specific healthcare professionals, there were high levels of awareness, but with some conflicting attitudes. Some trans-specific professionals (for example in Finland and Latvia) were opposed to funding trans-specific healthcare with state resources (Fundamental Rights Agency, 2016). One American study showed that when training was available, it led to an increase in self-perceived skills and a decrease in negative attitudes towards transgender patients (Lelutiu-Weinberger et al., 2016). Different studies also showed that professionals found training very important, informative and helpful (Dy et al., 2016; Lelutiu-Weinberger et al., 2016). Then, besides the lack of knowledge, physicians commonly identify not knowing the available resources appropriate for the trans patient population. A major barrier to healthcare provision is the identification, availability and quality of referral networks and information sources regarding trans medical care (Snelgrove et al., 2012). Identifying trans-friendly colleagues outside their own practice was difficult, because they did not know to what extent the healthcare provider to whom they were referring was available, but also because they did not know how sensitive the provider would be. Usually, they used a trial-and-error technique, where they heard whether it was a pleasant experience afterwards and if not, trans people didn't get referred to the healthcare provider any longer (Snelgrove et al., 2012).

Secondly, in a number of EU Member States there are no formal health protocols on gender reassignment surgery (GRS) and other aspects of trans healthcare, leaving the responsibility entirely with the doctor or sexologist (Fundamental Rights Agency, 2016). Gender reassignment surgery (sex reassignment surgery or gender affirmation surgery)

is surgery to change one's primary or secondary sex characteristics to affirm one's gender identity. For example the Bioethics Council's recommendation "on the Change of Sex by a Person" in Georgia does set general instructions on ethical and professional standards, but the duration, the order, and the priority of medical procedures and the selection of treatment plan are entrusted to the specialist. This raises questions about the quality of medical services available for trans people in Georgia, as well as the consistency with which treatment is provided (Aghdgomelashvili et al., 2015). In the FRA-study public officials also reported that there were no specific public policies in place for addressing trans people's healthcare in a number of countries, including Poland (Fundamental Rights Agency, 2016). In Poland, the diagnostic standards are not binding for practitioners who are not members of the Polish Society for Sexual Medicine and, therefore, private practitioners often skip significant parts of the diagnostic process (Fundamental Rights Agency, 2016). There is also evidence in a minority of countries, including the United Kingdom, Poland and Spain, that senior managers of healthcare organizations block LGBT healthcare work and even some health professionals state that trans-specific protocols are not needed (Fundamental Rights Agency, 2016). Those senior managers of healthcare organizations refer to healthcare providers themselves, those providers who are against trans-specific healthcare. There is also evidence of tensions between healthcare professionals and trans non-governmental organizations (NGO's), making it difficult for NGO's to work with professionals. Additionally, in some countries, such as Romania, there are even laws against GRS that make surgeons criminally responsible for causing for example reproductive inability, so most surgeons refuse to perform such surgery (Fundamental Rights Agency, 2016). Last year, Schechter et al. (2017) did publish an article with the first step in the development of a structured educational program in gender affirmation procedures. Overall, the lack of knowledge does result in providers not being able to give the best attainable healthcare for trans people. This keeps trans people from accessing healthcare, though, as mentioned above; there are other reasons why they feel reluctant to seek care.

As previously stated, trans people often wait long before consulting a healthcare worker due to negative experiences. Research conducted with healthcare providers find similar results, but there still isn't a lot of research in this domain regarding the five countries studied for this study. Qualitative research with healthcare professionals showed that negative attitudes exist in all the EU Member States, including intolerance, fear, and denial of the existence of transsexualism and of different gender identities (Fundamental Rights Agency, 2016). There are some serious misconceptions of professionals working

in the trans field. Some state they think that trans people are mentally ill, associate trans people with sexually transmitted infections (STI's) and view that trans people are violent. Because of these misconceptions, some surgeons refuse to carry out GRS (Fundamental Rights Agency, 2016). In some EU Member States, some healthcare specialists working with trans people stated that their patients often reported unfavourable reactions from doctors. They also reported that many trans people get referred to specialist trans services even when the medical problem is not trans related and some doctors just deny care (Fundamental Rights Agency, 2016). Thereby, experiences of trans people are not always in accordance with the attitudes of health providers. Some providers thought that trans people are especially well cared for, but such attitudes are in direct conflict with experiences of trans people (Fundamental Rights Agency, 2016). Other providers mentioned that the small number of trans people create the impression that there is no need for trans-specific healthcare (Fundamental Rights Agency, 2016). The lack of exposure to trans people in practice due to the small number of clients self-identifying as trans also prevents healthcare providers to develop clinical skills to meet the needs of trans people (Snelgrove et al., 2012). Some healthcare providers reported feeling uncomfortable with influencing a person's choice to pursue treatment or not. Because GRS is so irreversible, they felt distressed by the idea that a patient would possibly regret their decision to transition after the surgery they took part in (Snelgrove et al., 2012). There are also many possible outcomes of hormone therapy and surgeries and that is another reason why healthcare providers are reluctant to provide care because in their opinion, many trans people have unrealistic expectations of what is possible and will be disappointed in the end (Snelgrove et al., 2012). Also, in general, 10% of the healthcare providers in Serbia felt uncomfortable when talking about a person's sexual orientation and/or gender identity and the same percent wouldn't know what to say to a patient with gender dysphoria and would feel uncomfortable in the presence of a trans person (Vidic, 2015). Overall, medical professionals themselves regularly report to feel embarrassed and uncomfortable when addressing sexuality-related issues (Balon & Morreale, 2010; Croft & Asmussen, 1993; Pauly, 1971). This uncomfortableness has the unfortunate consequence that trans people are often designated to do their own research and to present their own treatment options to the healthcare provider (Snelgrove et al., 2012).

Financial limited refunds.

Insurance is a further reason limiting many trans people from accessing healthcare, especially trans-specific healthcare. Healthcare services are not always covered by

insurance, which can lead to postponement of GRS or other medical procedures. For example, on the one hand, in Poland, the medical necessity has been denied since 1999 and all the costs of care now have to be met by the trans person (GRS is available, but only privately) (Fundamental Rights Agency, 2016). On the other hand, trans people are often unable to access healthcare funds when they have not undergone full genital reassignment surgery, because health insurance is provided based on the assigned gender of the individual. So in order to be able to receive funded trans-specific healthcare, they first have to cover all the costs for GRS themselves (Fundamental Rights Agency, 2014). In particular genital surgery still seems to be out of reach for a large majority of trans people, despite being highly desired (Grant et al., 2010). In EU Member States where GRS is not covered by insurance, many trans people travel to non-EU countries for surgeries and obtain hormones from the internet (Fundamental Rights Agency, 2014). The lack of funding was seen as a problem by some healthcare professionals, because they believe that trans people must look like people born in their gender identity and they need to feel comfortable, but at the same time, others raised questions to what extent the public should fund operations (Fundamental Rights Agency, 2016). Overall, financial problems are observed to be an issue for trans people in different studies (see for ex. Fundamental Rights Agency, 2014).

Also, surgeries and other medical procedures (for example hormone therapy) are often linked to legal gender recognition (LGR). The term legal gender recognition refers to the official procedure to change trans people's first name and gender identifier in official registries and documents such as their birth certificate, ID card, passport or driving license (Köhler & Ehrt, 2016). Medical procedures and gender recognition are linked because in many EU Member States GRS is needed before a legal change can be made to a person's identity documents (for example in Spain and Sweden) (Fundamental Rights Agency, 2016). Another requirement is that 31 states in Europe require sterilization before their gender identity can be recognized (including Serbia and Georgia) (Transgender Europe, 2016a). However, The European Court of Human Rights ruled on April 6, 2017 that the sterilization requirement in legal gender recognition procedures violates human rights (Gatineau-Fattaccini, Thouin-Palat, Boucard, Fournier, & Pierrat, 2017). Setting the legal precedent for Europe, this decision will force the remaining countries using the infertility requirement to change their laws. Other requirements may include a mandatory diagnoses of mental disorder, medical treatment and invasive surgery and assessment of time lived in the person's gender identity (Köhler & Ehrt, 2016). At last, healthcare professionals reported that in some EU Member States,

barriers to same sex partnership could cause difficulties for married trans people who need to undergo LGR (what means getting a divorce if married, as is required in Poland and Serbia (Transgender Europe, 2016b)). Requests for GRS are generally accompanied with assessing the reasons for requesting GRS, to determine if there are genuine needs to change one's gender, because GRS is not reversible (Fundamental Rights Agency, 2016). Trans people who can't afford GRS report long waits for legal gender recognition which can lead to working in low-paid jobs where they do not have to submit identity documents (Aghdgomelashvili et al., 2015). A study in Sweden, already mentioned earlier, also showed that no access to legal gender recognition was an important predictor for lower self-reported health and a lower quality of life (Zeluf et al., 2016).

Towards good practices.

In general, the Standards of Care 7 (SOC7), developed by WPATH, put forward an overview for gender affirmative treatment protocols for those trans people seeking care (Coleman et al., 2012). The overall goal of the SOC is to provide clinical guidance for health professionals to assist trans people with safe and effective pathways to achieve lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment (Coleman et al., 2012). However, these guidelines are not mandatory and therefore different options and protocols are available. The SOC7 shows a significant change in approach compared to the previous versions of the SOC, and stresses the informed consent model. The informed consent model puts emphasis on the capability and the autonomy of a person in choosing care options, with the right to seek treatment without the required external evaluation or therapy by mental health professionals (Cavanaugh, Hopwood, & Lambert, 2016). In this model the healthcare provider does not remain his gatekeeping position (a position where they decide if a person is ready to undergo treatment). Through discussions about the risks and benefits of treatment options with the person (taking the current state of scientific knowledge and the social and cultural context of treatment options into account, as well respecting the person's capability for self-knowledge), clinicians work to assist the person in making the best decision (Cavanaugh et al., 2016). This approach does recognize that the person is in the best position to decide about their life, because they have the most knowledge about their life and about which treatments would be the most beneficial (i.e. treatments leading to an increase in welfare) (Cavanaugh et al., 2016). Today's transition related healthcare is still characterized by gate-keeping with little room for trust and individuality. Past research showed that trans people are dissatisfied with

the gate-keeping role of healthcare professionals because that made it difficult to establish a trustful patient-professional relationship, and limited trans individuals' autonomy in transition related decision-making (Bockting, Robinson, Benner, & Scheltema, 2004).

Already based on what is mentioned above, there are sufficient grounds why research on trans people in comparison to healthcare providers may be of interest to policy and good practices. Thereby, there has not been research conducted that compares opinions/attitudes of both groups. In order to substantiate the form of the hypotheses, a theoretical background on the development of opinions and attitudes and the various possible influences in the process of opinion and attitude formation will be given first. Multiple hypotheses based on the literature study will be formulated afterwards.

Theoretical Background: Opinions and Attitudes

In the search for a theoretical background to substantiate the hypotheses, extensive literature was found. On the one hand there is a broad research domain on public opinion. On the other hand, there is a lot of research on attitudes. Although both terms have a different research history and different theories for both concepts were designed, they are often used interchangeably which often makes it difficult to distinguish both concepts. Also, systematic research on attitudes/opinions towards trans people is scarce, with only few studies to refer to in this domain (S. Brown, Kucharska, & Marczak, 2017; Carrera-Fernández, Lameiras-Fernández, & Rodríguez-Castro, 2013; Chapman, Watkins, Zappia, Nicol, & Shields, 2012; Dierckx, Meier, & Motmans, 2017; Hill & Willoughby, 2005). Therefore, a brief introduction on public opinion will be given, followed by an introduction on attitudes. After that, both concepts will be brought together in the introduction of their influences on prejudice, stereotypes, stigmatization, transphobia, and so forth.

Opinions.

Generations of philosophers, lawyers, historians, political theorists and journalists have been annoyed for not finding a clear definition of the concept 'public opinion'. More than fifty definitions for public opinion have been developed (Childs, 1965). On the one hand, it seems to be something that escapes from logic and cannot be defined. On the other hand, everybody seems to know what it is about (Noelle-Neumann, 1984).

Tönnies (1887) was the first to develop a complex theory of public opinion in his book *Gemeinschaft und Gesellschaft*. His theory is very different from other, more well-known authors such as Lippmann and Noelle-Neumann, whom are discussed below. Tönnies

emphasizes more the importance of religion and culture in the formation of public opinion compared to authors after the 1930's, but he was also already talking about the fear of isolation and the influence of the majority (as well as Noelle-Neumann later on) (Splichal, 1999). The early theorists saw public opinion as a communicative process (see for ex. Cooley, 1909). These theorists stated the following: people test their vague opinions through reciprocal public action and communication when there is a shared problem, which makes alternative options or opinions clearer in order to adopt a common opinion (public opinion). So public opinion is assumed to be a communicative process (individual opinions are dependent on other's opinions) (Price, 1989). Thus, the developmental process of public opinion is not the result of detecting a problem and individual decision making, but rather a process of structural organization where gradually different opinion groups arise through interpersonal discussion and mass communication (Price, 1989). These first theorists have laid the grounds of public opinion theory, but theorists like Lippmann and Noelle-Neumann have further expanded the field.

In the beginning of the 20th century, all interest in public opinion was lost until two works appeared, one of which was the important work *Public Opinion* of Walter Lippmann (Lippmann, 1922). In what is especially an extensive narrative on functional democratic governing, he briefly puts forward a theory of public opinion. Lippmann states that it is possible to transform an individual opinion into a public opinion. He states that a realistic opinion based on objective analysis can be changed by characteristics within the individual and between individuals, such as personal interest, tradition and social contact. The latter can eliminate features such as objective observation, measurement, analysis and comparison, which determine realistic opinions (Lippmann, 1922).

Thus, the social aspect in opinion formation is emphasized by Lippmann from the very beginning. He is also one of the first to state that opinions are formed by what others report and by what we can imagine ourselves doing in a specific situation. Even when we have eye-witnessed an event, our opinion can still be influenced by changes of the event that occur in our memory afterwards (Lippmann, 1922; Loftus & Loftus, 1976). Our opinions also influence the way we see things (we do not see things first, but we define things and then we can see things), currently categorized with the terms of attention-, interpretation- and confirmation bias (we see and interpret things according to our own opinions and we also look for information that confirms our opinions) (Nisbett & Ross, 1980). Emotions are also very important determinants in opinions. Lippmann poses the question why people can have so strong opinions about vague events (for example,

vague because they were not present at the event and only heard about it). He himself answers this question by saying that events that activate strong emotions can also lead to strong opinions. So, several stimuli can trigger an opinion. Even when the memory of the events fades afterwards, emotions last longer and this maintains the opinions (Lippmann, 1922). This can explain why cisgender people often have a strong opinion about being trans, because it is a subject that raises strong emotions. Cisgender refers to an adjective used to describe a person whose gender identity and gender expression match their gender assigned at birth (American Psychological Association, 2015). Society itself also changes very slowly and that is why opinions and stereotypes get passed to so-called pupils, from father to son, veteran to cadet, and so on (Lippmann, 1922). Perhaps this is also why stereotypical and negative views of trans people remain crystallized and seem so difficult to change. Overall, all the influences highlighted by Lippmann proved to be important based on research decades later (Noelle-Neumann, 1984).

Noelle-Neumann (1984) talks about the spiral of silence, where two visions lead to opposing reactions. When one vision is perceived as dominant and is held by a majority of people in society, those people who adhere to this vision will make their opinions stronger. The other vision, which is the perceived minority vision, will be swallowed and kept quiet, with the result that it disappears from public awareness. Nevertheless, there will always be people who attach to the last vision, even though they will not be open about it (Noelle-Neumann, 1984). The presence of two opposing visions is often seen in history, for example during elections, where the perceived minority keep quiet in fear of rejection and isolation, which sometimes led to an un-predictable profit of the so-called minority, known as the bandwagon effect (for example, think of the notorious American elections of 1948 where president Truman won from Dewey, despite the fact that polls had predicted Dewey's victory). Noelle-Neumann (1984) emphasizes that two movements are possible when people feel like belonging to the minority opinion. First, she argues that people sometimes adjust their opinion to those of the majority, deriving from a desire to prevent isolation from others. This is especially true for people who already indicate feeling isolated or for people who have low self-confidence. Applied to trans people, this could explain why it takes so long for these people to admit to others, the perceived majority, where gender identity and sex assigned at birth are alike, that their gender identity is different from their sex assigned at birth. On the contrary, people also often choose to stay quiet. They will have the so-called minority opinion, but they do not speak out so that others do not reject them (Noelle-Neumann, 1984). To test if people

adjust their opinion to the majority discourse, different scales have been developed, such as the Marlowe-Crowne Social Desirability Scale (short form) (Reynolds, 1982). To conclude, from all this, a definition of public opinion, appropriate for this study, can be formulated:

“Public opinion are opinions on controversial issues that one can express without isolating oneself.” (Noelle-Neumann, 1984, p. 81)

Sufficient survey research has also confirmed Noelle-Neumann’s hypothesis that people are not inclined to proclaim their opinion when they believe to be in minority, as well that, as people are more sure of victory, they are more likely to express their opinion (Glynn & McLeod, 1984). Nevertheless, Noelle-Neumann’s hypothesis does not mention different types of public opinion. Shiraev and Sobel (2005) did define different types of public opinion such as the majority opinion, the plurality opinion, the elite opinion, ..., and the intense minority opinion.

The type of opinion most important within the research regarding this study may be ‘intense minority opinion’. Some topics, such as allowing abortion by the government, recognition of gay marriage and improving healthcare for trans people, are subjects that strongly affect a number of individuals, but does not interest others. The interested individuals often have a personal share in a particular policy, feel strongly attached to certain values and norms attached to this policy or are simply better informed about certain aspects of life linked to this policy. According to research, this leads to more intense opinions on the subjects, often expressed in the form of political behaviour, such as protests, demonstrations and single-issue voting (voting for a particular candidate based on one political position of this candidate) (Shiraev & Sobel, 2005).

Various research has shown that public opinion does indeed exist. Studies also showed that the formation of public opinion is not an individual, but a social and communicative process. As, to conclude, public opinion is influenced by the direct environment, the media, politics... within each theory, and several theories and models have been developed throughout the years, but none of them are seen as *the* model. The different theories will be taken into account when formulating the hypotheses.

Attitudes.

Empirical research on the psychology of attitudes can be retraced to the beginnings of the 20th century. In the 1920s, a number of authors became interested in measuring mental properties such as attitudes (McGuire, 1985). Two significant researchers from

this period are Thurstone and Likert. They developed various methods for measuring attitudes, of which the most notably were the Equal Appearing Interval Method (Thurstone, 1928) and the Likert scale (Likert, 1932). Thurstone's and Likert's work was highly influential because it showed that attitudes could be quantifiably measured and this paved the way for the development of this study domain. In addition to developing strategies to measure attitudes, early research also focused on the extent to which attitudes predict behaviour (which started with a famous paper of LaPiere (1934)), on which more later on.

The most influential model of attitudes has been the multicomponent model (Haddock & Zanna, 1988). According to this model, attitudes are evaluations of an object and have cognitive, affective and behavioural components. An attitude is generally conceptualized as a learned predisposition to respond in a consistent evaluative manner towards an object or class of objects (Allport, 1935). The consistency of evaluative responses reflects a level of central tendency rather than homogeneity of all responses. Although this variability in evaluative responses is acknowledged, there has been a lot of theorizing and research on the assumption that people strive for homogeneity in their attitudinal responses. This is the underlying assumption in the cognitive consistency theories of attitude (McGuire, 1966). Rosenberg and Hovland (1960), as well as many others before them (see for ex. Allport, 1935) have identified three classes within the evaluative response. Evaluative responses can indeed be categorized by one or a combination of cognitive, behavioural and affective components of attitude.

The cognitive component refers to the beliefs, thoughts and attributes we associate with an object. For example; we may form attitudes towards trans people based on our beliefs about trans people. The affective component refers to emotions and feelings linked to an attitudinal object. The behavioural component is formed through past behaviours and experiences with an attitude object (Maio & Haddock, 2009). For instance, in a response on a survey asking about the opinion on trans people, people might infer that they have a positive attitude because they remember having donated to a trans-specific organization.

Past research focused on consistency between the three components generally found a high correspondence between the three components. Research also showed that the three components are different (Breckler, 1984). Breckler (1984) provided strong evidence that the affective, cognitive and behavioural components of attitude are not the same (the discriminant validity proved to be good), but this does not mean that the

components are completely independent of each other. The three components are usually the same in their evaluative implication, but sometimes they are not all positive or negative (Maio & Haddock, 2009). For example; one can state that trans people are very kind and often help others, implying that the respondent has positive cognitions about trans people. However, if you ask about their feelings about trans people, they possibly can state that they feel a certain disgust towards trans people. They could also recall a negative experience with a trans person, for instance, having called a trans person mentally sick. This is an example of positive cognitions, though negative feelings and past experiences also occur. The position maintained here is that attitude is the sum of cognition, behaviour and affect. Several studies also showed, after it was demonstrated that the components had a good discriminant validity, that different causal factors underlie the three components (because every component had his unique variance) (Ostrom, 1969). However, research also shows that having negative attitudes does not necessarily mean that those people will translate those attitudes into behaviour.

The question facing many researchers was no longer *whether* an attitude of an individual can predict his overt behaviour, but *when*. Different causal factors can predict if an attitude will be translated in behaviour. One study showed that the relationship is responsive to certain aspects of the situation, a good example is for instance the presence or absence of situational constraints and social distance (Warner & DeFleur, 1969). Here, Warner and DeFleur (1969) indicated that low prejudiced respondents tend to show the most consistency between attitudes and behaviour, but not when there are high situational constraints (a situation, in which the individual's behaviour takes place, where it is likely that others significant to him will become aware of it) and when there is a reduced social distance (a situation where they are asked to behave as they think is correct behaviour, but this behaviour would be violating norms on role expectations). In addition, certain qualities of the individual have been suggested to make people more or less likely to act according to their attitudes, such as their self-image as a "doer" (McArthur, Kiesler, & Cook, 1969), presence of other attitudes (Rokeach & Kliejunas, 1972), and competence to engage in a particular behaviour (Ehrlich, 1969), and so on. For example, religious attitudes/beliefs to do no harm to others in a strongly religious person who also feels disgusted by gay people (emotion) can still prevent this person to harm gay people (behaviour). Another study showed that people who learn from direct experience with the attitude object show a greater consistency between attitude and behaviour than people who learn more indirect about the attitude object through other means (Regan & Fazio, 1977). It was suggested that an attitude formed through direct

experience is more clearly, confidently and stable than an attitude formed through more indirect means (Regan & Fazio, 1977).

Research into attitudes has quickly led to different methods to measure these mental states. The multicomponent model showed that attitudes consist of three components: a cognitive, affective and behavioural component. These three can be separated, but often also show overlap. Attitudes also predict behaviour, in which different factors can have an influence on bringing an attitude into action. These matters will also be taken into account when formulating the hypotheses.

Merging the literature.

The reason why opinion and attitude research have a separate history may have to do with the fact that they are being developed within different research domains. Opinion research has more emerged from a social-political angle, attitude research from a social psychological angle. However, the concepts seem to overlap. An opinion could also be seen as a concept consisting of three components. With opinions there also seems to be more emphasis on external influences (from significant others, the media, etc.), but an opinion could also be based on cognition, behaviour and affect. In what follows, the literature on opinions and attitudes will be combined in the discussion of prejudices, transphobia and influential factors on transphobia.

Prejudices, stereotypes and stigmatization.

A **prejudice** is any attitude, emotion or behaviour towards a particular group that directly or indirectly implies a certain negativity or antipathy towards that group (R. Brown, 2010). When people are prejudiced based on their membership of a particular social category, we speak of **stereotypes**. To stereotype someone is to attribute characteristics to a person which are seen as shared by most of his or her fellow group members (R. Brown, 2010). It is sometimes claimed that stereotypes inform us and serve as hypotheses about the world. The problem with these hypotheses is, however, that people start seeking confirmation for these hypotheses (R. Brown, 2010). As a result, when they react quickly and uncontrollably, they should automatically appeal to these hypotheses to understand the context around them (Devine, 1989; Kunda & Spencer, 2003). Other situations where people appeal to those stereotypes are situations where their self-image is compromised. To raise their own sense of self-esteem, they are going to belittle others with negative stereotypes to increase their own sense of superiority (Kunda & Spencer, 2003). In addition, many stereotypes are not so innocent and can be negative. They therefore can lead to discrimination, unequal opportunities, psychological problems and

a low self-esteem (Blanton, Christie, & Dye, 2002). **Stigmatization** is the process in which a personality trait (the stigma) is linked to the negative stereotype. The stigmatized is then considered inferior, failed and/or inadequate (Crocker, 2005; Goffman, 1963). Using this characteristic linked to the negative stereotype, a distinction is made between different social groups, those who have this feature and those who don't ("we" versus "they"). Three different types of stigma can be distinguished (Goffman, 1963). First, there is the aversion towards the body, towards the various physical malformations. Then there are shortcomings of the individual's character that are perceived as weak will, as dominant or unnatural passions, as treacherous and rigid beliefs and as dishonesty, resulting from, for example, radical political behaviour. Finally there are the stigma of race, nation and religion. These are stigmas that are transmitted over generations and affect all members of a family (Goffman, 1963). The stigmatized people experience loss of status and discrimination. This process of stigmatization leads to a difference in opportunities between the different groups. The process of stigmatization based on prejudices and stereotypes is therefore not innocent and just as a multitude of factors can lead to social stigmatization (labelling, discrimination, disagreement), it can also have a lot of personal disadvantages: less opportunities in education and on the labour market, shorter life, poorer housing, etc. (Link & Phelan, 2001).

Finally, those prejudices, stereotypes and stigmata can also lead to behaviour towards LGBT's, such as verbal, physical, material and even sexual violence. These violent incidents can have a profound impact on the physical and mental health of the victims. The consequences for the victim could include poorer self-esteem, a more negative mental health and more suicidal thoughts (D'haese et al., 2014). Men and women have to cope with such experiences. D'haese, Dewaele, and Van Houtte (2015) showed, in a Flemish study, that a number of coping strategies can be used by respondents, of which four could be distinguished: avoidance strategies, assertiveness and confrontation, cognitive change, and social support. Applying different coping strategies and giving meaning to negative experiences helps victims of violence to overcome negative effects, such as fear, shame, or depressive feelings. The presence of a social network also appeared to be an important condition for achieving these positive outcomes.

Attitudes/opinions towards minority groups.

There is not a lot of research researching attitudes/opinions towards minority groups. There is growing research into the attitudes towards ethnic minorities and minorities with a disability (Au & Man, 2006; Bachman, Vedrani, Drainoni, Tobias, & Andrew, 2007;

Coenders, Lubbers, & Scheepers, 2003a, 2003b, 2003c; Devkota, Murray, Kett, & Groce, 2017; Paris, 1993; Pfeiffer et al., 2003; Sabin, Rivara, & Greenwald, 2008; Satchidanand et al., 2012; Thalhammer, Zucha, Enzenhofer, Salfinger, & Ogris, 2001), yet few studies investigating the attitudes towards gender minorities.

In regard to ethnic minorities and minorities with a disability, different studies have been conducted, within and outside healthcare. One special analysis of the Eurobarometer, conducted in 2000 regarding attitudes to ethnic minority groups showed that attitudes had changed between 1997-2000 in a contradictory way. On the one hand, many EU citizens favoured the coexistence of majority and minority groups and support for such policies had already increased. On the other hand, a majority of Europeans had expressed concern about ethnic minority groups because they fear that minority groups will be a danger for social peace and welfare. Also, a small, but relevant part of Europeans felt personally disturbed by the existence of these minorities (Thalhammer et al., 2001). Healthcare research generally shows favourable attitudes towards ethnic and disability minorities, with a number of differences depending on profession, age, place of residence, and sex assigned at birth. For example, research showed that nurses, dentists and mental health/substance abuse providers are often less tolerant towards people with a disability and/or make less effort to offer an easily accessible setting in comparison to other healthcare providers (Au & Man, 2006; Bachman et al., 2007). In contrast, paediatricians appear to have fewer racial attitudes and stereotypes (Sabin et al., 2008). Younger healthcare providers, healthcare providers that work in the city (Devkota et al., 2017), as well as female healthcare providers (Paris, 1993; Satchidanand et al., 2012), showed more positive attitudes towards people with disabilities. Having contact with disability minority groups, both professionally and socially, also promoted positive attitudes (Satchidanand et al., 2012). Research into attitudes towards ethnic and disability minorities is important to mention, given that the theory assumes that prejudices and attitudes towards one group can be generalized to other groups. So, a person who is anti-homosexual has a chance of also being anti-immigrant, anti-black, and so on (Allport, 1954). Research has indeed shown that attitudes and prejudices towards various minority groups are significantly correlated (Ekehammer & Akrami, 2003). As a result, a negative attitude towards ethnic and disability minorities could also generalize to gender minorities.

In addition to research towards ethnic and disability minority groups, one special Eurobarometer study has also been conducted on attitudes towards trans people. In this

study, 45% of Europeans believed that discrimination on the ground of gender identity is widespread (of which 57% in Sweden). This number increased among respondents with transgender friends or acquaintances, with bisexual, gay or lesbian friends or acquaintances and among respondents belonging to a sexual minority group (European Commission, 2012). Within healthcare, there is a lack of research within Europe. Outside Europe, a few studies have been published. One recent review of the literature showed that overall attitudes towards trans people were positive although negative attitudes were more frequent in male, heterosexual, religious, and conservative mental health professionals (S. Brown et al., 2017). Other studies showed similar results (Chapman et al., 2012; Kanamori & Cornelius-White, 2017; Kidd, Bockting, Cabaniss, & Blumenshine, 2016; Willoughby et al., 2010)

Transphobia.

Transphobia are all negative prejudices and attitudes towards trans people (Hill & Willoughby, 2005). Comparative research at European level on attitudes towards transgender people is non-existent, with exception of one Special Eurobarometer study (European Commission, 2012).

LGBT people are all confronted with stigmatization within the heteronormative society where binary gender roles are still the norm (Walch, Ngamake, Francisco, Stitt, & Shingler, 2012). In the current social context, one still assumes that people are either female or male and heterosexual. Those who do not fit in this rigid thinking frame often undergo sexual stigma. Sexual stigma is described by Herek, Chopp, and Strohl (2007, p. 906) as: "*the negative regard, inferior status, and relative powerlessness that society collectively accords to any non-heterosexual behaviour, identity, relationship, or community*". In contrast to research on sexism and homophobia, the research on transphobia is still very much in its infancy. Hill and Willoughby (2005) described transphobia as an emotional disgust to people who do not meet the social expectations of gender (Hill & Willoughby, 2005). Gender bashing is the behavioural component (Carrera-Fernández et al., 2013). Genderism, namely the belief in the two sexes and the behaviour that accompanies it, as well the aversion to any deviant form of this behaviour is, like homophobia, often the basis of transphobic attitudes and behaviour (Hill & Willoughby, 2005). In short, genderism (which consists of cognitive attitudes) leads to transphobia, which could give rise to gender bashing (behaviour) (Willoughby et al., 2010).

Transphobia points to a collision with someone's own values and standards. Trans negativity is more subtle and refers to discrepancies between attitude and behaviour (for example: "*it is a good thing that transgender people can express themselves, but I would rather not find them in my own personal environment*") (Motmans, Meier, & T'Sjoen, 2013). This transphobic and trans negative behaviour, just like homophobic behaviour, seems to be rooted in an aversion to gender non-conforming behaviour, behaviour that does not correspond with the sex assigned at birth. Research found that transgender people behaving conform to gender roles (for example, a trans person born as a man who expresses himself medically and socially fully as a woman) encountered less resistance than transgender people who did not behave conforming to their assigned gender. It is not, therefore, being trans itself which causes aversion, but the ambivalence between the two social genders (Carrera-Fernández et al., 2013).

Demographic and social determinants in predicting transphobia.

Demographic variables prove to be good predictors for transphobic attitudes to some extent. Higher education is associated with more positive attitudes towards minority groups in general (Thalhammer et al., 2001). However, the Belgian study of Dierckx et al. (2017), directed at specifically transphobia, did not find any significant effect of education on transphobia. Age is also an important factor. Negative attitudes seem to increase with age (Dierckx et al., 2017). Younger age groups have benefitted from better education systems and raising education standards in recent decades. This means that older people are often also less educated than the younger ages, hence, the age effect could be partly an effect of education (Thalhammer et al., 2001). Regarding ideological beliefs, it is clear that beliefs about the origin of gender differences have a major influence on whether or not people disapprove transgenderism. Those who believe transgenderism has a genetic origin, are more tolerant of transgender people than those who assume that it is a lifetime choice (Haider-Markel & Joslyn, 2008; Tee & Hegarty, 2006). If people want to tackle transphobia, they should also focus on other matters when working with men, and when working with women, because the experience of one's gender (to what extent one feels male/female) and the gender roles associated with it (to what extent they behave as a man/woman) have been shown to have a greater influence on men's attitudes and only to a limited extent on women's attitudes. On the other hand, religion only had a significant effect on women's attitudes and not on men. Transphobia originates in men rather from gender norms, in women from ideological beliefs (Dierckx et al., 2017). The social environment also has an influence. Simply: those who know a transgender person will take a more positive attitude towards this group (Chapman et

al., 2012; Dierckx et al., 2017). Family relations (having a parent or grandparent belonging to a minority group), increases positive attitudes towards minority groups as well, but there are always exceptions (Thalhammer et al., 2001). A critical question can be made here, because it is not clear if knowing sexual and/or gender minority people is the result of being more tolerant towards these groups or is the cause of becoming more tolerant (Herek & Capitano, 1996). Cultural-geographic factors also play a role. For example, people living in rural areas are usually less tolerant of sexual minority groups (van Wijk, van de Meerendonk, Bakker, & Vanwesenbeeck, 2005). Other non-European studies on attitudes of healthcare providers and medical students towards LGBT (see for ex. S. Brown et al., 2017; Chapman et al., 2012; Kidd et al., 2016), already mentioned before, also showed that race, political voting behaviour, gender, sexual orientation and conservatism had an influence on attitudes. Overall attitudes were positive although negative attitudes were more frequent in male, heterosexual, religious, conservative and liberal respondents. Also, respondents who had no friends or acquaintances who were LGBT had more negative attitudes towards this group.

Research Purpose & Hypothesis Development

Research Question: “Are there differences in opinions/attitudes regarding healthcare between trans people and healthcare providers?”

Different studies showed that trans people report negative experiences when accessing healthcare. Studies also indicated that healthcare providers often have negative attitudes/opinions regarding trans people or they are positive, but, for example, they do not want trans-specific healthcare to be funded. Also, one FRA-study mentioned that some healthcare providers believe trans people are especially well cared for, what is in direct conflict with most experiences of trans people (Fundamental Rights Agency, 2016). This is why the hypotheses assume more negative attitudes and opinions of healthcare providers in comparison to trans people. Based on the theoretical background, the assumption is that trans people will have a more pronounced opinion/attitude than healthcare providers. Trans people are a minority group and often identify strongly with their trans identity. As a result, they could have developed an intense minority opinion. With the healthcare providers, we expect a less pronounced opinion, because they may have positive opinions, but for example rather deny them out of fear of rejection and isolation. Further elaboration of the hypotheses in combination with the results will be considered in the discussion and could possibly contribute to current theories.

Hypotheses regarding opinions/attitudes towards the evaluation of healthcare.

Hypothesis 1: More healthcare providers than trans people a) see gender incongruence as a psychiatric disorder, b) think a psychiatric diagnosis does not have a stigmatizing effect on a person, c) think that a medical diagnosis would not necessarily be a better option for trans people than a psychiatric diagnosis, and d) think that being trans is accompanied with more mental health problems than people who are not trans.

Hypothesis 2: Healthcare providers are less in favour of the informed consent model than trans people.

Hypothesis 3: In both groups, there is a significant influence of age, country of residence, educational level, and sex assigned at birth.

Method

Procedure

Firstly, TGEU conducted a survey for all its affiliated groups in Europe, and based on the following criteria: whether or not the country was a member of the EU, the geographical spread across Europe, a well-developed trans healthcare system or not, the social position of trans people in society (for instance regarding legal gender recognition) and the amount of experience in community driven research projects. On the basis of those criteria, the five countries were selected. Three countries are a member of the EU (Poland, Spain and Sweden), two are not (Georgia and Serbia). All countries were spread across Europa (for example, Serbia is more in the south-east and Spain in the south-west). In regard to the development of the healthcare system, healthcare in Sweden, for example, is very well arranged and up to date. In the European rankings, they remain at number 12 in contrast to Poland, where healthcare is much less well arranged and up to date (number 31 of all 35 countries included). Georgia was not included in this study of Bjornberg (2016). Regarding the amount of experience in community driven research, it was important that there was already some knowledge about the situation of trans people in each of the selected countries.

We, at Ghent University (Prof. dr. Joz Motmans and myself) were contracted by TGEU. Prof. dr. Joz Motmans helped with the construction of the questionnaire, the collection of the data and helped in the performance of data-analysis for different research questions. I helped with the collection of the data and performed data-analysis for the research questions, including the ones for this study. The survey was constructed using SurveyMonkey. Two different online questionnaires were designed: one for healthcare users and one for healthcare providers. The questionnaires were designed based on previous studies, and in close collaboration with the five partners. Their expertise and knowledge, as well as previous studies in their countries, contributed to the selection of topics. The overall process was coordinated by TGEU and advised by a senior expert in the field of transgender health, contracted for this study.

The data collection for the trans healthcare users was conducted between September and November 2016. For the healthcare providers the data collection took place between November 2016 and February 2017. The information gathered for the study was anonymous.

Design

The aim of this study is to compare the opinions/attitudes of trans people and healthcare providers in five European countries (Georgia, Poland, Serbia, Spain and Sweden) on different health-related topics, such as access to healthcare, diagnostic measurements and psychiatric labelling. There is already one study examining the views of the membership of the World Professional Association for Transgender Health (Winter et al., 2016) regarding diagnosis and pathologisation and some non-European studies (see for ex. S. Brown et al., 2017; Chapman et al., 2012; Kanamori & Cornelius-White, 2017) already mentioned above, but no study comparing views from both sides (healthcare users and healthcare providers). Since there is little research on the difference between those opinions/attitudes, they were gathered and examined as part of a larger study conducted by Transgender Europe (TGEU), the European umbrella organization for transgender organizations in Europe. TGEU conducted a two part quantitative survey in which first the experiences and views of transgender healthcare users were collected, and in second part the knowledge and views of the healthcare providers were collected. For both groups, a questionnaire was designed. The length of the trans healthcare users questionnaire was estimated at 30 minutes, while the healthcare providers questionnaire was deliberately kept shorter (estimated at 15 minutes) to obtain as much collaboration as possible. In comparing similar items in both surveys, we can compare views of both parties taking into account the socio-economic context, the living circumstances and the socio-political settings in which the respondents are embedded.

Participants

Trans-led organizations recruited participants, mostly via social media (specific advertisements placed on Facebook) and through emails send to relevant listservs. See annex 1 and 2 for the texts to encourage people to participate in the survey.

Transgender people.

Self-identified trans people were recruited through different organizations in five different European countries (Georgia, Poland, Serbia, Spain and Sweden). The organizations who spreaded the questionnaire to trans people were TGEU, Women's Initiative Supporting Group (WISG) in Georgia, Trans-fuzja in Poland, Gayten-LGBT in Serbia, Daniela Fundación in Spain, and the Riksförbundet för sexuellt likaberättigande (RFSL) in Sweden. The questionnaire addressed all trans people older than 16 and living in (or had lived in during the last 12 months) one of the five countries.

Healthcare providers.

The providers were also recruited through different organizations in the five European countries. All interested healthcare providers living in Georgia, Poland, Serbia, Spain and Sweden, regardless of whether they had experience with providing healthcare to trans people, were invited to take part. The organizations who spread the questionnaire to the healthcare providers were the same as above.

Both surveys started with an explanation of the goal of the survey (see annex). Prior to completing the questionnaire, the participants included in the study needed to give their electronic informed consent on a voluntary base. Participants who did not give their consent were excluded from the analysis.

Materials

The healthcare users questionnaire consists of 80 questions (including one question for the informed consent) and was available in six languages (English, Georgian, Polish, Serbian, Spanish and Swedish). The English questionnaire was compiled by TGEU and the five partners, under supervision of Prof. dr. Joz Motmans. Thereafter, each of the five partners translated the questionnaire into his/her mother tongue. Those who chose to participate could link to the (anonymous) survey in their preferred language, regardless of their country of residence.

The questionnaire consisted mainly of questions with closed answer options. For some topics open answer fields were included to generate more context. Topics were organized in different sections: (1) demographics: this included the socio-economic background of the respondent, gender status (background regarding the gender and sexual identity, including level of openness, reactions, social support, etc.), and their mental health (2) healthcare experiences; including experiences in trans-specific related healthcare, general healthcare and (3) their views and opinions/attitudes. The questionnaire contained various standardized scales, including the *Pride* subscale from the 'Gender minority Stress and Resilience (GMSR) scale' (Testa, Habarth, Peta, Balsam, & Bockting, 2015), the WHO-5 Well-being Index (Regional Office for Europe WHO, 1998) and different items from the European Quality of Life Survey (Eurofound, 2012). One standardized scale was used within this research:

- ISCED codes were used to measure the educational level of the participants. The International Standard Classification of Education (ISCED) is the reference classification for education programmes and related qualifications by education levels and fields (UNESCO Institute for Statistics, OECD, & Eurostat, 2015). One

question with five options ('No formal education', 'Primary education', 'Secondary education', 'Post-secondary education other than college/university', 'College/university/higher academic education') was presented.

The healthcare users questionnaire was considered a reliable and valid instrument for assessing several topics about health and well-being as a trans person, experiences with healthcare and an evaluation of the healthcare system in the country under study.

The healthcare providers questionnaire consists of 42 questions (including one question for the informed consent) and was available in the same six languages mentioned before. The questionnaire consisted of mostly closed questions with 2 to 12 response options, and a few open questions. The questionnaire was organized in different sections: (1) demographics (including the educational background and professional settings, experiences and need for training on trans-specific topics), (2) organization of care (both trans-specific healthcare as general healthcare), and (3) their thoughts and views on different aspects related to trans-specific healthcare. The same standardized scale that was used for the users questionnaire, from the European Quality of Life Survey, to measure educational level (Eurofound, 2012). The Beliefs about Gender Scale (Tee & Hegarty, 2006) was also included in the questionnaire, but was not used for this thesis.

The providers questionnaire was also considered, according to the research team, reliable and face valid to assess the experiences and views on how healthcare for trans people is organized in the country under study, what needs for education the provider sees, and their thoughts on the organization of trans healthcare.

Analytic Strategy

A quantitative analysis of the data was selected based on the design of the study. The data-analysis was conducted using the statistical program SPSS for Windows, version 24 (IBM Corp, 2016). Firstly, the dataset was cleaned and verified.

In total, 15 attitude/opinion items were presented to both healthcare users and healthcare providers. The first seven items questioned the attitudes/opinions regarding diagnosis and pathologisation (for example item 3: *"Having a psychiatric diagnosis in general has a stigmatizing effect on a person"*). The next eight items questioned attitudes/opinions regarding informed consent (for example item 9: *"A mental health professional should decide if a person is ready for surgery"*). Each item consisted of six answer options (from 'Strongly agree' to 'Strongly disagree' and an answer option 'I don't know'). The option 'I don't know' was recoded as missing. In this way a continuous Likert-scale with five

answer options was created, ranging from 1 'Strongly agree' to 5 'Strongly disagree' (Likert, 1932). Significance was set at a p-value less than .05. See annex 3 and 4 for all items (Q60-61 for the healthcare users questionnaire and Q37-38 for the healthcare providers questionnaire).

Secondly, the two datasets were merged to be able to compare the attitudes. To investigate the difference in attitudes between trans people and healthcare providers Mann-Whitney Tests were performed with the specific attitude item as the dependent variable and belonging to the group of healthcare users or healthcare providers as the independent variable. Mann-Whitney tests were chosen because the data did not meet all assumptions for parametric tests. The attitude items did not all show a normal distribution and because the assumption of homoscedasticity between the two groups on almost no single item was met, it was decided to work with non-parametric tests.

When an attitude was significantly different between the two groups, these items were used for further analysis. Firstly, all items were put in the same direction. Secondly, factor analysis was applied to see which items fit together. In this way, when construct validity proved to be good, a scale was designed to compare the attitudes of healthcare users and healthcare providers, on the basis of an independent t-test. A scale will be designed because there are no validated scales available yet to measure attitudes/opinions regarding these topics. Thereafter, different control variables were included in the analysis to see if they could possibly explain a difference in attitude/opinion instead of or next to the group to which the respondents belonged. This was measured with ANCOVA. The control variables taken into account for this study were:

- **Age** was measured by birth year. This variable was included as a covariate in the analysis.
- **Country of residence** was measured with one question, six answer options. The healthcare users were asked whether they lived, or had lived in the past 12 months, in one of the five countries. Healthcare providers were asked where their work was situated ('Georgia', 'Poland', 'Serbia', 'Spain', 'Sweden' or 'No/Another country'). Respondents who gave up 'No/Another country' were excluded from the analysis.
- **Educational level:** The ISCED variable was recoded into a CISCED variable with two categories, where the first three options and the last two were taken together ('Low educational level' and 'High educational level').

- **Sex assigned at birth (SAAB)** was measured with one question asking respondents what their sex assigned at birth was, meaning their sex on their original birth certificate ('Female' or 'Male').

Results

A descriptive overview of the results with regard to missing data and the background characteristics of both groups will be presented. Subsequently, an analysis will be carried out in several steps. Firstly, there will be examined whether there are differences between the two groups on the 15 attitude/opinion items. Secondly, a factor analysis will be applied to see if multiple items measure the same underlying concept. Thirdly, a scale will be designed to investigate whether both groups differ significantly with respect to certain themes. Finally, different control variables, in particular age, country of residence, educational level and sex assignment at birth, will be included in the analysis to determine their effect on attitudes/opinions.

Descriptive Statistics

Missing data.

1170 trans people filled in the questionnaire or part of the questionnaire. Of these, 11 trans people but did not sign the informed consent and were removed from the dataset. Of the 1159 people who did consent, 40 were not from one of the five countries in the study, 70 only gave consent but didn't fill in the questionnaire, 97 stopped after listing the country they were living in, 28 participants stopped after the question about ones gender identity and 18 used less than 10 minutes to fill in the questionnaire. In addition, the group of intersex people were excluded because the group was too small (n = 21). This resulted in a final sample of 885 trans people.

A total of 1090 healthcare providers filled in the questionnaire or part of the questionnaire. Of these, 3 healthcare providers did not sign the informed consent, and were removed from the dataset. Of the 1087 people who did consent, 23 were not from one of the five countries under study, 48 only gave consent but did not fill in the questionnaire, 41 stopped after listing the country they were living in and 78 stopped after the question whether they belonged to a minority group. To avoid a lack of clarity, trans healthcare providers (n = 59) were also removed from the analyses for this study. This resulted in a final sample of 829 healthcare providers.

Characteristics of the target group.

See Table 1 for the background characteristics of both groups.

Table 1. *Background characteristics of Healthcare Users and Healthcare Providers*

	HU	HP
Age M in years (SD)	26.5 (9.84)	42.2 (11.87)
Sex assigned at birth % (n)		
AMAB	34.2 (303)	20.1 (167)
AFAB	56.8 (582)	79.9 (662)
Country of residence % (n)		
Georgia	2.6 (23)	2.1 (17)
Poland	8.6 (76)	10.4 (86)
Serbia	4.3 (38)	6.6 (55)
Spain	31.2 (276)	27.0 (224)
Sweden	53.3 (472)	53.9 (447)
Place of residence % (n)		
City, suburbs, or outskirts of a city	88.6 (685)	77.1 (632)
town, village, or on the countryside	11.4 (88)	22.9 (188)
Education % (n)		
low education	50.6 (448)	3.3 (27)
high education	49.4 (437)	96.7 (802)
Minority group % belonging to (n)		
Ethnic minority	9.0 (67)	6.4 (51)
Religious minority	10.9 (82)	7.8 (62)
Sexual minority	80.9 (615)	22.8 (182)
Minority due to ability status	27.3 (205)	4.4 (35)

Note: HU (Healthcare Users), HP (Healthcare Providers); AMAB (Assigned Male At Birth), AFAB (Assigned Female At Birth); M (Mean); SD (Standard Deviation)

Throughout the results, the degrees of freedom can vary due to the lack of data for some participants, since not all questions were mandatory.

Attitudes of Healthcare Users (HU) versus Healthcare Providers (HP)

Step 1: differences between the two groups on the different attitude/opinion items.

Mann-Whitney tests with group (healthcare users versus healthcare providers) as independent variable and the attitude/opinion item as a dependent variable were used. All 15 attitude/opinion items, except for three, showed a significant difference between the two groups. In table 2 the mean scores and standard deviations for each group and p-values for each attitude/opinion item are summarized. Significant p-values ($p < .05$) indicate that there is a significant difference in attitude/opinion between the two groups (healthcare users and healthcare providers).

Table 2. Mean scores, standard deviations per group and p-values per item

	HU	HP	p
	M (SD)	M (SD)	
1. Gender incongruence among adolescents or adults is a psychiatric disorder	4.64 (0.77)	4.34 (0.85)	p < .001***
2. Gender incongruence among children (before puberty) is a psychiatric disorder	4.64 (0.77)	4.37 (0.80)	p < .001***
3. Having a psychiatric diagnosis in general has a stigmatizing effect on a person	2.19 (1.17)	2.23 (1.06)	p = .113
4. Having a psychiatric diagnosis of gender identity disorder, transsexualism, or gender dysphoria has a stigmatizing effect on a person	2.29 (1.21)	2.24 (1.07)	p = .990
5. Having a psychiatric diagnosis is more stigmatizing for children than for adults	2.82 (1.15)	2.88 (1.10)	p = .260
6. Having a diagnosis which is not psychiatric but only medical would be a better option for trans people	2.02 (1.10)	2.39 (1.07)	p < .001***
7. Trans people have more mental health problems than people who are not trans	2.71 (1.33)	2.36 (1.20)	p < .001***
8. A mental health professional should decide if a person is ready for hormone treatment	3.84 (1.13)	2.92 (1.03)	p < .001***
9. A mental health professional should decide if a person is ready for surgery	3.78 (1.17)	2.91 (1.04)	p < .001***
10. Hormone blockers/puberty blockers should be available to adolescents who enter puberty	1.4 (0.73)	2.28 (1.06)	p < .001***
11. Cross-sex hormones (such as estrogen or testosterone) should be available to adolescents in puberty	1.62 (0.86)	2.38 (1.04)	p < .001***
12. A real life experience/test (required living for a period of time presenting according to your gender identity) should be included in the transition process	3.42 (1.36)	2.47 (0.90)	p < .001***
13. Non-binary or genderqueer people should have access to trans-specific healthcare	1.56 (0.94)	2.06 (0.87)	p < .001***
14. Everyone should be able to freely choose treatment paths and options	1.59 (0.88)	2.13 (1.02)	p < .001***
15. The way a person expresses themselves should not influence their access or how they are treated	1.27 (0.72)	1.38 (0.65)	p < .001***

Note: HU (Healthcare Users), HP (Healthcare Providers); M (Mean); SD (Standard Deviation); Higher scores indicate more disagreement with the statement; p < .05* p < .01** p < .001***

With regard to items 3, 4 and 5, no significant difference was found between the two groups. The scores for all three items were between 2 and 3. For items 3 and 4 the

scores were closer to 2, which means that both groups were indeed on average agreeing with the fact that a psychiatric diagnosis in general, and a psychiatric diagnosis of gender identity disorder or transsexualism or gender dysphoria has a stigmatizing effect on a person. For item 5, the scores leaned more towards 3, which means that both groups are on average neutral with respect to the statement that a psychiatric diagnosis is more stigmatizing for children than for adults. Because items 3, 4 and 5 showed no significant differences, these items are omitted for further analysis.

Step 2: factor analysis.

In order to apply factor analysis to prove good construct validity, all items were first put in the same direction. More specifically items 6, 10, 11, 13, 14 and 15 were reversed. A higher score would then mean that respondents have a more negative attitude towards a 'psychiatric' diagnosis and align more with the informed consent model, broadly. A low score would mean that one is more in favour of a 'psychiatric' label and less in favour of an informed consent model.

Firstly, a factor analysis was applied to all of the items together. The factor analysis abstracted four components. All items, except items 6 and 7, charged heavily on the first component. However, item 6 did not show a strong load anywhere, and items 1, 3, 7, 11 and 13 charged strongly on two components simultaneously. As a result, the choice was made to divide the items into two groups on a theoretical basis: four items (item 1, 2, 6 and 7) regarding diagnosis and pathologisation and 8 items (item 8-15) regarding the informed consent model.

When factor analysis was applied to the first four items, a clear component structure was found. The analysis revealed two clear components: on the first component, the first two items loaded strongly and seemed to pulse to the attitude/opinion towards gender incongruence as a psychiatric disorder. The last two items charged heavily on the second component and seemed to ask about mental well-being of trans people. When the reliability of these two groups of items was calculated, we found for the first two items a Cronbach's α of .95, which is excellent. However, for the last two items combined, a Cronbach's α of .04 was found, which is unacceptable and suggests that those two items should not be taken together in a scale to measure the same attitude/opinion because internal consistency is low. See table 3 for an overview.

Table 3. *Factor analysis applied to the four items regarding diagnosis and pathologisation*

	Component 1	Component 2	Cronbach's α
Gender incongruence among adolescents or adults is a psychiatric disorder	.957	.007	
Gender incongruence among children (before puberty) is a psychiatric disorder	.957	.032	.953
Having a diagnosis which is not psychiatric but only medical would be a better option for trans people	.368	-.585	
Trans people have more mental health problems than trans people who are not trans	.215	.826	.043

Afterwards, factor analysis was applied to the 8 items about informed consent. A clear structure was found here. Two items were abstracted from the factor analysis, of which all items loaded strongly on the first component and the first two items as well as the last item also loaded to some degree on the second component. When the reliability of all eight items was calculated, good reliability with a Cronbach's α of .82 was found. All items seem to measure the same, being the attitude/opinion regarding informed consent. The reliability of the items that loaded heavily on the second component was .73 (which is acceptable), but when the last item was removed the internal consistency increased to .93 (which is much better). This showed that the first two items are measuring the same, being the attitude/opinion regarding gateway keeping of a mental health professional. See table 4 for an overview.

Table 4. *Factor analysis applied to the eight items regarding informed consent*

	Component 1	Component 2	Cronbach's α
A mental health professional should decide if a person is ready for hormone treatment	.770	.514	
A mental health professional should decide if a person is ready for surgery	.747	.518	
Hormone blockers/puberty blockers should be available to adolescents who enter puberty	.774	.241	
Cross-sex hormones (such as estrogen or testosterone) should be available to adolescents in puberty	.750	.218	
A real life experience/test (required living for a period of time presenting according to your gender identity) should be included in the transition process	.539	.402	
Non-binary or genderqueer people should have access to trans-specific healthcare	.590	.394	Item 1, 2, 8 = .731
Everyone should be able to freely choose treatment paths and options	.662	.286	Item 1-2 = .932
The way a person expresses themselves should not influence their access or how they are treated	.482	.470	Item 1-8 = .818

Step 3: calculating a scale score and independent t-test.

Because the factor analysis showed that the 8 items around informed consent seemed to measure the same (a good reliability or internal consistency was found), it was decided to add the scores of the items to a scale based on attitudes towards informed consent. The higher the score, the more one adheres to the informed consent model. This total score was included as a continuous dependent variable, with group (healthcare users versus healthcare providers) as an independent variable. When looking at the distribution of the scores of all respondents on the total scale, this distribution appeared to follow a normal distribution. Levene's test for equality of variances was not found to be violated for the present analysis, $F(1, 1513) = 1.24, p = .266$. On the basis of these assumptions, in combination with the independence of the respondents and the scale of interval level, an independent t-test was used to see whether there was a significant difference in attitude. The difference was significant according to a t-test for independent samples ($t(1513) = 21.72, p < .001$). Figures 1 and 2 clearly show how trans healthcare users generally score higher than healthcare providers.

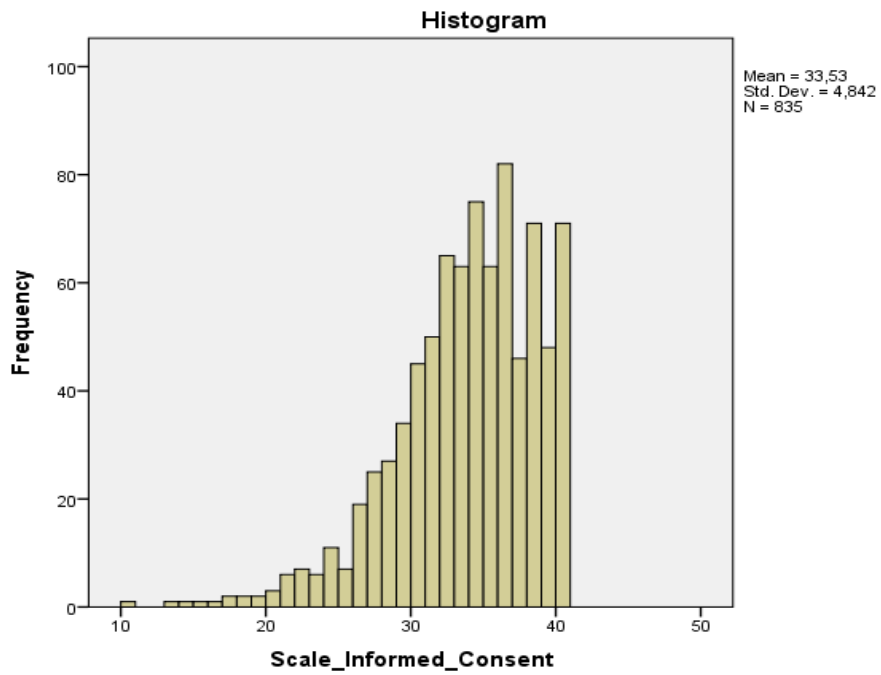


Figure 1. Histogram of scores on the attitude/opinion scale towards informed consent, healthcare users

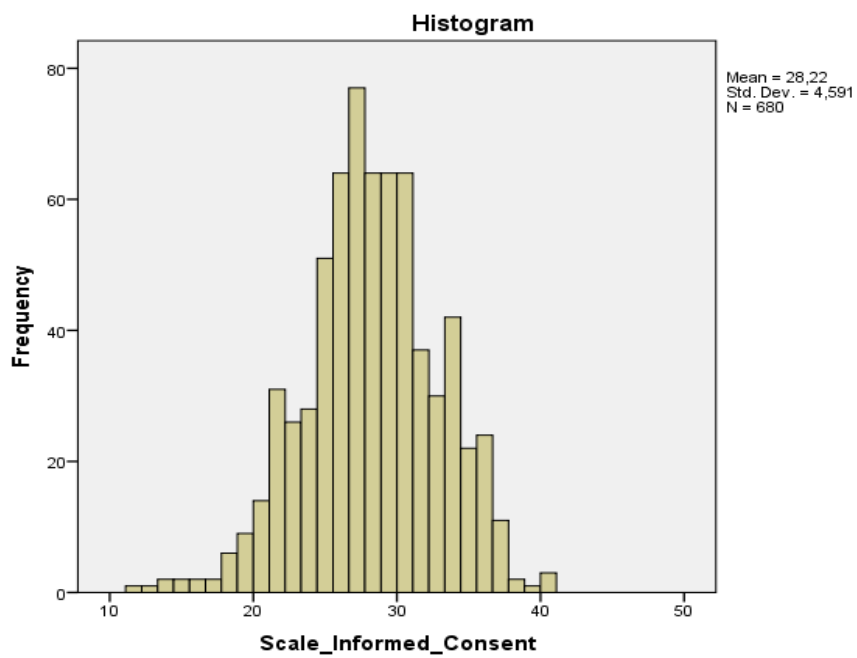


Figure 2. Histogram of scores on the attitude/opinion scale towards informed consent, healthcare providers

Step 4: taking into account age, country, education and sex assigned at birth.

Different control variables were subsequently included in the analysis to see whether the difference in attitude can be partly or fully explained by these variables. The control variables used for this study are: age, country of residence, educational level and sex assigned at birth (SAAB). Firstly, it was examined whether there was a significant effect of these control variables, as well as possible interaction effects with the group to which the respondents belonged (trans healthcare users or healthcare providers). The data were analysed with four separate ANCOVA-tests with group (healthcare users versus healthcare providers) and the specific control variable as independent variables (age as covariate, and educational level, country of residence and SAAB as fixed factors) and the attitude-scale as dependent variable.

The main effects of gender and age were significant; $F(1, 1511) = 29.84, p < .001$ and $F(1,1511) = 8.03, p = .005.$, respectively. The interaction of these two factors was not significant, $F < 1$. The main effects of group and country of residence were also significant; $F(1, 1505) = 102.98, p < .001$ and $F(4,1505) = 23.6, p < .001$, respectively. The interaction of these two factors was again not significant, $F < 1$. The same trends were found for educational level and SAAB. Significant main effects of group and educational level ($F(1, 1511) = 130.28, p < .001$ and $F(1,1511) = 6.08, p = .014$) on the one hand, and group and SAAB ($F(1, 1511) = 358.77, p < .001$ and $F(1,1511) = 5.88, p = .015$) on the other, and again no significant interactions between the two, $F < 1$. For age, the older the respondents, the lower their score on the whole scale. A lower score indicates that people are more conservative and less tolerant towards the informed consent model, as they get older. Attitude scores were higher in countries such as Spain and Sweden, showing a more tolerant attitude towards the informed consent model than countries such as Georgia and Serbia. Higher-educated respondents and respondents assigned female at birth (AFAB) also showed a significantly higher score than the lower educated respondents and respondents assigned male at birth (AMAB). Trans people also retained their significantly higher scores in all analyses. This means that when each of the control variables were included in the separate analyses, a significant effect of group (healthcare users or healthcare providers) on the attitude/opinion scale remained. The score of trans people was higher in each analysis, indicating that they are generally more tolerant towards the informed consent model.

When all significant effects were included in one model (ANCOVA) the effect of group (healthcare users versus healthcare providers) on the attitude/opinion scale remained, but the main effect of SAAB disappeared when all other control variables were taken into account ($F(1, 1506) = 1.99, p = .159$). However, trans people still have a more positive attitude/opinion towards informed consent ($F(1, 1506) = 231.53, p < .001$) and there is more tolerance with regard to informed consent in countries such as Spain and Sweden ($F(4, 1506) = 25.35, p < .001$). The attitude score also decreases (less in the direction of informed consent) as the respondents are older ($F(1, 1506) = 10.53, p = .001$) and when the respondents have a low educational level ($F(1, 1506) = 4.53, p < .001$).

Summary of Results

When we return to the above-mentioned hypotheses, a number of conclusions can be drawn.

Hypothesis 1 predicted that more healthcare providers than trans people a) see gender incongruence as a psychiatric disorder, b) think a psychiatric diagnosis does not have a stigmatizing effect on a person, c) think that a medical diagnosis would not necessarily be a better option for trans people than a psychiatric diagnosis, and d) think that being trans is accompanied with more mental health problems than people who are not trans. This hypothesis was rejected since one of the four sub-hypotheses was proven to be incorrect. The hypothesis referred to the first seven attitude/opinion items. However, these items were not used to calculate a scale because factor analysis showed that they did not all seem to measure the same. This was also assumed in advance, so the hypothesis was divided into four parts.

- The first part stated that healthcare providers more often see gender incongruence as a psychiatric disorder. This was measured on the basis of items 1 and 2. This hypothesis was confirmed because the average score of healthcare providers was significantly lower than that of trans people and this difference was significant according to a Mann-Whitney test (see table 2). This means that they significantly more than trans people agreed that gender incongruence among children, adolescents and adults is a psychiatric disorder.
- The second part of the hypothesis stated that healthcare providers less often think that a psychiatric diagnosis has a stigmatizing effect. This was measured on the basis of items 3, 4 and 5. However, this hypothesis was rejected, as both groups did not differ significantly in attitude/opinion at the level of these items ($p = .133$ for item 3, $p = .990$ for item 4 and $p = .260$ for item 5).

- The third part of the hypotheses predicted that healthcare providers less often think, in comparison to trans people, that a medical diagnosis and not a psychiatric diagnosis would be a better option for trans people. This was measured on the basis of item 6. The null hypothesis could be rejected. Healthcare providers had a significantly higher mean score ($M = 2.39$) compared to trans people ($M = 2.02$). This means that the first group significantly more disagreed with the fact that only a medical diagnosis and no psychiatric one would be a better option for trans people, compared to the second group ($p < .001$).
- The last part of hypothesis 1 stated that healthcare providers more often think that trans people have more mental health problems than non-trans people. This was measured on the basis of item 7. The hypothesis could be rejected: healthcare providers scored significantly lower on average ($M = 2.36$) compared to trans people ($M = 2.71$), according to the Mann-Whitney test ($p < .001$). This shows that healthcare providers agree more with this statement and significantly more often assume that trans people have more mental health problems than non-trans people, compared to the attitude/opinion of trans people themselves.

Hypothesis 2 stated that healthcare providers are less in favour of the informed consent model than trans people. Based on factor analysis, a total scale score was calculated on the basis of all the attitude/opinion items that seemed to evolve towards the same attitude/opinion as the informed consent model (Cronbach's $\alpha = .82$). Based on an independent t-test, the null hypothesis, which stated that the attitude between the two groups was the same, could be rejected on an $\alpha = .05$ significance level ($t(1513) = 21.72$, $p < .001$). Healthcare providers scored significantly lower on average ($M = 28.22$) compared to trans people ($M = 33.53$). The higher the score, the more one adheres to the informed consent model. Healthcare providers therefore seem to be less in favour of this model than trans people.

Hypothesis 3 predicted a significant influence of age, country of residence, educational level, and sex assigned at birth. This hypothesis was only applied to the scale of informed consent because when factor analysis was applied all eight items seemed to measure the same underlying concept (more specifically the attitude/opinion towards the informed consent models), which was not found when factor analysis was applied to the four items around diagnosis and pathologisation. This hypothesis was rejected since no effect of sex assigned at birth could be found, when controlling for all other relevant variables.

When all variables were included in one model, a main effect of group (healthcare users/trans people versus healthcare providers), age, country of residence and educational level remained, according to an ANCOVA test. Only the effect of sex assigned at birth was lost ($F(1, 1506) = 1.99, p = .159$). Sex assigned at birth thus appeared to have no influence on the attitude/opinion with respect to the informed consent model, when controlled for all the other relevant control variables and group. However, it appeared that the trans respondents ($F(1, 1506) = 231.53, p < .001$), younger respondents ($F(1, 1506) = 10.53, p = .001$), respondents from Spain and Sweden ($F(1, 1506) = 231.53, p < .001$) and respondents with a high level of education ($F(1, 1506) = 4.53, p < .001$) usually had a higher score and more agreed with an evolution towards an informed consent model.

Discussion

Over the last years, various studies have shown that transgender people face considerable problems when accessing healthcare. Research has mainly focused on the experiences of trans people within the healthcare system (see for ex. Balzer & Hutta, 2015; Fundamental Rights Agency, 2014; Grant et al., 2010; Motmans, 2010; Whittle et al., 2007), which barriers for general healthcare and trans-specific healthcare they face (see for ex. Bauer et al., 2015; Dy et al., 2016; Fundamental Rights Agency, 2016; Morrison et al., 2017; White Hughto et al., 2017). Few studies however, have tackled the view of healthcare providers themselves or compared views of trans people with those of healthcare providers. This study aimed to compare the difference in attitudes/opinions between trans people and healthcare users on the one hand and healthcare providers on the other hand to determine if significant differences in attitudes/opinions between these two groups existed and to what variables this difference could possibly be attributed.

In the study, we used Mann-Whitney tests, an independent t-test and ANCOVA tests to investigate the relationship between belonging to a specific group (trans people/healthcare users versus healthcare providers) and attitudes/opinions. We further investigated the influencing role of age, sex assigned at birth, educational level and country of residence. We hypothesized that (1) healthcare providers more often see gender incongruence as a psychiatric disorder, think a psychiatric diagnosis does not have a stigmatizing effect on a person, think that a medical diagnosis would not necessarily be a better option for trans people than a psychiatric diagnosis and think that being trans is accompanied with more mental health problems than people who are not trans, (2) healthcare providers are less in favour of the informed consent model than trans people, and (3) based on previous research there is a significant influence of age, country of residence, educational level, and sex assigned at birth.

The results seem to be in line with existing theories and partially supported our hypotheses. Results pertaining to hypothesis 1 showed that healthcare providers significantly more agreed that gender incongruence was a psychiatric disorder, significantly more disagreed that a medical diagnosis (which is not psychiatric) would be a better option for trans people and significantly more agreed that trans people have more mental health problems than people who are not trans. Hypothesis 2 was also not rejected. Specifically, the results showed that healthcare providers appeared to be more conservative than trans people. Healthcare providers had a less positive attitude towards

the informed consent model, compared to trans people. When different control variables were included in the analysis, hypothesis 3 was also refuted. We found that while there was no main effect of sex assigned at birth, age, educational level and country of residence did significantly influence attitudes/opinions.

Considering the theory of Shiraev and Sobel (2005), it was predicted that trans people would have a more intense opinion, based on their belonging to a gender minority group. Because trans people have a personal share in a particular policy, such as an evolution towards an informed consent model, they feel strongly attached to certain values and norms attached to this policy. Given the lack of knowledge of many healthcare providers (see ex. Bauer et al., 2009; Bauer et al., 2015; Đurić & Todorić, 2006; Rondahl, 2009; Whittle et al., 2008), trans people could also simply be better informed about aspects linked to this policy. The other theory of Noelle-Neuman states that two movements are possible when people feel like belonging to the minority opinion (in comparison to the majority opinion). On the one hand, people can adjust their opinion to those of the majority. On the other hand, people can choose to stay quiet. Based on this theory and previous research on the experiences of trans people within healthcare (see ex. Fundamental Rights Agency, 2014; Motmans, 2010; Whittle et al., 2007), as well the slow change of opinions within society (Lippmann, 1922), it was expected that the perceived majority opinion of healthcare providers would force healthcare providers with a perceived minority opinion to adjust their opinion or stay quiet and respond more negative than trans people. Another influential theory is the multicomponent theory of Haddock and Zanna (1988), where attitudes consist of a cognitive, affective and behavioural component. This study examines how respondents think about certain topics and thus appears to be mainly focused on the cognitive component. Future research can compare attitudes across all three domains.

Our findings can be linked back to the different proposed theories. The results suggest that trans people indeed seem to have a more intense attitude/opinion for each item (outside items 3, 4 and 5) compared to healthcare providers. The theory of Shiraev and Sobel (2005) suggests an explanation by differentiating different types of opinions, including the intense minority opinion. Conversely, healthcare providers can adopt a milder attitude/opinion because they adjust their true attitude/opinion to the majority discourse or because they keep their attitude/opinion quiet (by responding more often 'neither agree nor disagree') (Noelle-Neumann, 1984). It is intriguing that our findings regarding sex assigned at birth were not significant, since the study of Dierckx et al. (2017) and S. Brown et al. (2017) suggested a difference should be made between

respondents AMAB and respondents AFAB. One possible, but highly tentative explanation for these findings, is that sex assigned at birth does not have a significant influence on attitudes concerning informed consent, but does have an influence on transphobic attitudes.

The results were in line with the study of Thalhammer et al. (2001) where higher education was associated with more positive attitudes and the study of Dierckx et al. (2017) where negative attitudes seem to increase with age. Also the study of Snelgrove et al. (2012) where healthcare providers thought that being trans puts a person at higher risk of other mental illnesses, is in line with this study. For items 3, 4 and 5, no significant difference was found, but the results do show that both groups on average agree that a psychiatric diagnoses is accompanied with stigma. Soon to be published diagnostic manuals (such as the ICD-11 (World Health Organisation, 2018)) could take this into account, since stigmatized are considered as inferior, failed and/or inadequate (see for ex. Crocker, 2005; Goffman, 1963) and experience different personal disadvantages (Link & Phelan, 2001).

The present findings may be theoretically and clinically relevant. In terms of theoretical implications, our findings suggest that trans people might adhere to an intense minority opinion, and that healthcare providers may adapt their attitude/opinion to the prevailing discourse (which is not always positive given the many studies on discrimination and lack of knowledge). In terms of practical implications, our findings not only attest to the importance of attitudes/opinions of healthcare providers towards topics that relate to trans-specific care. It also suggests that there is a need to create environments where attitudes/opinions against diagnosis and pathologisation, as well as attitudes/opinions in favour of an informed consent model become the majority discourse. In addition to the interesting results, this study is still susceptible to improvement, which will now lead to exploring the strengths and limitations of this study and suggesting possibilities for future research.

This study has limitations. First, data may be skewed by the demographics. The survey was conducted online; it could be filled in by paper, but some people are more difficult to reach (for example individuals who live in rural areas and individuals who do not tend to get in contact with places/organizations focused on transgender identity). Second, the trans healthcare users sample was rather young, which might underrepresent the experiences of the older generations. Third, four control background variables have been taken into account for the analyses, but the study may have allowed for additional control

variables on certain aspects of the data (for example the effect of training on attitudes/opinions). Another limitation concerning the control variables: the number of respondents living/working in Georgia ($n = 40$) was relatively small, so the conclusions based on this country (namely that attitudes towards the informed consent model are more positive in countries such as Spain and Sweden compared to countries such as Georgia and Serbia) may not be representative for the general Georgian population. However, previous studies conducted in Georgia also indicate problems regarding trans-specific healthcare and showed that the duration, order, and priority of medical procedures and the selection of treatment plan is indeed entrusted to the specialist (see for ex. Aghdgomelashvili et al., 2015). Also, the proportion of healthcare providers with a low educational level is relatively small, which seems logical regarding their professional position. The entire group with a low level of education ($n = 464$) only contains 27 healthcare providers (5.82%). As a result, the effect of educational level may be an effect of gender identity group because the respondents with a low educational level are almost all trans people. However, when looking at the effect of education within the healthcare providers group, the effect remained. Healthcare providers with a high educational level had a significant higher score on the informed consent scale than healthcare providers with a low educational level ($F(1, 678) = 4.94, p = .027$).

As mentioned above, different theories explain the response behaviour of people on the basis of their attitudes/opinions (Noelle-Neumann, 1984; Shiraev & Sobel, 2005; Tönnies, 1887). However, this study has not been able to prove that trans people adhere to an intense minority opinion, or that healthcare providers have adapted their true attitude/opinion to the prevailing majority discourse. This can be done by adding an extra scale to, for example, assess the extent of social desirability by including the Marlowe-Crowne Social Desirability Scale (short form) (Reynolds, 1982). The various components of an attitude (cognitive, affective, behavioural) (Haddock & Zanna, 1988) are also not all included in this study, which may also be interesting for future research.

Despite these limitations, this study adds to the limited number of studies currently available on attitudes/opinions of trans people and healthcare providers in different ways. First, this is the first study to compare the attitudes/opinions of trans healthcare users and healthcare providers towards different topics relating to trans healthcare that we are aware of. Secondly, the statistical analysis in this study was able to differentiate between the attitudes/opinions of trans people/healthcare users and healthcare providers, which is certainly a strength compared to most research which does not make this comparison

yet. Thirdly, another strength of this study is the amount of respondents that participated in the survey (885 healthcare users and 829 healthcare providers, after data-cleaning), which increases the power of the study.

When designing the study, all researchers wanted to ensure the best possible survey design and establish internal validity. Trans people and healthcare providers were all provided with the same information about the study, and both surveys were conducted in the same period. The attitude/opinion-items were exactly the same in both questionnaires to minimize the differences between both questionnaires. A degree of external validity was also achieved by choosing to ask about experiences and attitudes/opinions of trans people and healthcare providers themselves. Asking about experiences is a strength in the sense that it ensured external validity but also presents its limitations. As gathered from feedback given by several respondents (provided in the open answer fields of the survey), some questions were overwhelming and especially some trans respondents had difficulty to answer all the questions. This is also why not all questions were mandatory, because respondents were given the opportunity to leave a question open if it was too difficult to answer or when they simply did not want to answer the question.

Based on our findings, we believe different aspects would be fruitful for further research. First, the same survey questions could be used to test the generalizability of the results. However, if the same study is repeated, other scales can be included (such as a scale to measure social desirability (Reynolds, 1982)), so that more clarity can be provided about the origins of the response behaviour of respondents. Also, within this study, a scale has been designed to measure attitudes towards informed consent. Together these items had a reliability of $\alpha = .82$. Future research can focus on validating a scale to reliably measure attitudes/opinions around the organization of trans-specific healthcare, diagnosis and pathologisation and/or the informed consent model.

Second, this study targeted five European countries, which means that the results are not yet generalizable to other European countries. The advantage of working with different countries was that a comparison could be made, improving the internal validity of the study. Future research could focus on other European countries as well as taking into account other possible relevant control variables (such as gender identity, sexual orientation, profession, belonging to specific minority groups, years of experience, and so on).

The current findings extend our understanding and provide an initial mapping of attitudes/opinions of trans people in comparison to healthcare providers in five European countries. Specifically, findings attest to the importance of differences between respondents belonging to a minority group to which the topics relate and respondents who provide care to these minority groups. Future research is required to examine the generalizability of the findings and to examine more the specific needs of trans populations with regard to healthcare to ensure that they can be adequately supported in their journey.

Conclusion

This study was the first to analyze the difference in attitudes between trans people and healthcare providers. The study aimed to compare the difference in attitudes towards different topics (diagnosis, pathologisation, informed consent), while taking into account different control variables (age, sex assigned at birth, educational level, country of residence) for some items. Participants took part in the survey on a voluntary base. Significant differences were found and thus the results were statistically conclusive. Based on the results, different predicted trends were followed. Healthcare providers viewed gender incongruence significantly more often as a psychiatric disorder, did not see a medical diagnosis (without a psychiatric diagnosis) as a better option for trans people and believed significantly more often that trans people had more mental health problems than non-trans people. Trans people are also significantly more in favour of an informed consent model. At last, a significant effect of age, educational level and country of residence on attitudes towards informed consent was also found.

To our knowledge this type of comparison had never been studied before and therefore further research can yield interesting insights. Furthermore, the response behaviour could have been influenced by different factors not yet included in the survey (social desirability, belonging to a gender minority or other minority group, and so on). Therefore, it is suggested to include more and different variables in future research.

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Annex

Annex 1: Text to Motivate Trans Healthcare Users to Participate

Help TGEU improve access to healthcare for trans people in Europe!

TGEU is conducting a survey on healthcare for trans people who are **16 and older** in **Georgia, Poland, Serbia, Spain, or Sweden**, and would like to hear from you!

For the purpose of this survey, we use “trans people” as an umbrella term to refer to people whose gender identity and/or expression differ from the sex they were assigned at birth, including, but not limited to, non-binary, genderqueer, and gender non-conforming people.

Please continue reading to find out more about the survey:

<<next>> can be selected here for those interested

WHY TAKE PART?

Your participation will help us assess the current healthcare situation for trans people in your country.

The information gathered from this study is **anonymous**: We will not ask for any details that will make it possible to identify you, including your name or address.

We will evaluate the responses from the questionnaire and use your feedback to recommend changes to improve healthcare access. After we make recommendations, we will determine where improvements are needed and will create training programs for healthcare providers.

Before you start, please carefully read the background information about the survey.

Once you have finished reading, you can start the survey by clicking on the links below which will lead you to the survey. We thank you in advance for your valuable contribution!

WHO CAN TAKE PART?

This survey is intended for **all trans people aged 16 or older** living in (or having lived in during the past 12 months) **Georgia, Poland, Serbia, Spain, or Sweden**.

WHAT IS THE SURVEY ABOUT?

The survey asks about your general health and well-being. We also ask about the experiences you have with **general healthcare**, and if applicable, with **trans-specific healthcare**.

With “general healthcare” we mean going to a medical professional like a general practitioner or a family doctor for everything that is not related to being trans. This could include primary care situations such as getting a flu shot, being treated for an ear infection, or having a physical examination. It could also include going to the dentist, or seeing a specialist like a cardiologist.

With “trans-specific healthcare” we mean everything related to your social and medical transition. This includes mental health consultations or counseling; taking cross-sex hormones (like estrogen or testosterone); or physical procedures or surgeries (like chest or genital surgery).

To evaluate how healthcare is accessed and how different trans people are treated within healthcare, we also need information about your background and gender identity or history. We have developed these questions with great care, knowing that these topics are possibly intimate and sensitive.

HOW CAN I TAKE PART?

This questionnaire is available online and is totally anonymous. You can fill it in at any time you like, but we will close the collection of responses on October 31.

The survey is available in these languages: English, Georgian, Polish, Serbian, Spanish, and Swedish. You can choose the language that you feel most comfortable with.

It will take about **30 minutes** to complete this questionnaire. While you are completing the questionnaire, the progress bar will allow you to see how much you have completed. **There is no option to stop the survey and continue later**, so please make sure you're in a comfortable place where you have enough time to complete the survey.

If you have no internet connection, or you have difficulties with any of the terms in the survey, please contact your local trans organization. They can help you to fill in the survey, or offer you a printed version. Contact details for the organization conducting the survey in your country can be found below.

Most questions are multiple choice questions which will allow us to compare answers across all 5 countries. There are no right or wrong answers; the questionnaire concerns what you personally think, feel or do at this time. We have included a few open answer questions to give you the opportunity to tell us your experiences in more detail. Completion instructions are provided with each question. Where necessary, we explain the terms we have used to avoid confusion.

Not all answer options may be relevant to the situation in your country. Please answer to the best of your knowledge based on your country.

<<I WANT TO CONTRIBUTE>> can be selected.

Thank you for contributing. [Click here](#) to go to the survey in the language that you prefer, no matter where you actually live now:

English

Georgian

Polish

Serbian

Spanish

Swedish

Annex 2: Text to Motivate Healthcare Providers to Participate

Dear healthcare providers!

Transgender Europe, TGEU, a European human rights organisation, is conducting European research on healthcare for trans people in 5 countries: Georgia, Poland, Serbia, Spain, and Sweden. The goal of this study is to increase knowledge on the healthcare situation of trans people.

If you are a healthcare provider in Georgia, Poland, Serbia, Spain, or Sweden, regardless of whether you have experience with providing healthcare for trans people, we want to hear from you. We want to learn from your experiences and views on how healthcare for trans people is organized in your country, what needs for education and training you see, and your thoughts on trans healthcare.

<<I WANT TO CONTRIBUTE>> can be selected.

Thank you for contributing. Click here to go to the survey in the language that you prefer, no matter where you actually live now:

English

Georgian

Polish

Serbian

Spanish

Swedish

Annex 3: Questionnaire Healthcare Users

Help us improve access to healthcare for trans people in Europe!

If you are 16 years or older and currently live in (or have lived in during the past 12 months) Georgia, Poland, Serbia, Spain, or Sweden, we would like your feedback on how you experience accessing healthcare.

Transgender Europe, TGEU, is working together with trans and LGBTI organizations in these 5 countries to improve healthcare for trans people by identifying discriminatory treatment and improving conditions.

For the purpose of this survey, we use “trans people” as an umbrella term to refer to people whose gender identity and/or expression differs from the sex they were assigned at birth, including, but not limited to, non-binary, genderqueer, and gender non-conforming people.

The information gathered from this study is anonymous. We will evaluate the responses from the questionnaire and use your feedback to recommend changes for improving healthcare access. After we make recommendations, we will determine where improvements are needed and will create training programs for healthcare providers. In order to make recommendations, we first need to access the current situation, and that’s why your participation is so important!

It will take about 30 minutes to complete this questionnaire. While you are completing the questionnaire, the progress bar will allow you to see how much you have completed. Please note you cannot stop the survey and continue at a later time, so please allow enough time to complete it in one session.

The questionnaire will address several topics about your health and well-being as a trans person, your experiences with healthcare and your evaluation of the healthcare system in your country.

There are no right or wrong answers; the questionnaire concerns what you personally think, feel or do at this time. Completion instructions are provided with each question, and not all questions are mandatory.

Not all answer options may be relevant to the situation in your country. Please answer to the best of your knowledge based on your country, but do not worry if some of the terms are unfamiliar to you or not part of your own experience.

We realize answering this questionnaire takes your valuable time. Thank you in advance for helping us improve healthcare for trans people.

*1. I have read the above information and agree to participate in this anonymous study.

Yes

No

<<>> indicates that every respondent needs to respond to this question in order to go on with the rest of the survey*

Please tell us about yourself

*2. In what year were you born?

*3. Do you currently live, or have you in the past 12 months lived, in one of the following countries? If you have lived in more than one of these countries, please choose the country in which you have the most healthcare experience.

- Georgia
- Poland
- Serbia
- Spain
- Sweden
- No

If Q3 << No>> is selected : end of questionnaire.

Please tell us about yourself.

Please remember that this is an anonymous questionnaire.

*4. We would like to know how residence status affects access to healthcare. Do/did you have citizenship in or a valid residence permit for (Q3)?

- Yes
- No

*5. Do/did you have any health insurance in (Q3)? Please select all answers that apply to you.

- Yes, national/public insurance
- Yes, private insurance
- Yes, in another way/another type
- No, none

*6. What is the highest level of education you have achieved?

- No formal education
- Primary education
- Secondary education
- Post-secondary education other than college/university
- College/university/higher academic education

The following focuses on your gender identity and gender background. We took great care in shaping these questions, but understand that still some of these questions might be problematic, and perhaps even offensive to some of you. We would prefer not to ask these questions, but we need the information to assess whether your legal gender, your gender identity, or your gender expression might affect your access to healthcare. Please help us by answering the best you can, even if you agree with us that in an ideal world we would not need to ask.

By “gender identity” we mean every person’s deeply felt internal and individual experience of gender. By “gender expression” we mean the manifestation of a person’s gender identity, which is perceived by others, for example through dress, mannerisms, speech.

*7. How do you describe your gender identity at the current moment? Please select the option that fits you best:

- Female
- Male
- Transfeminine/Trans Woman/Male-to-female (MTF)
- Transmasculine/Trans Man/Female-to-male (FTM)
- Non-binary/genderqueer/gender non-conforming
- Other (please specify)

*8. What sex were you assigned at birth, meaning on your original birth certificate?

- Female
- Male

*9. Have you changed (or are you in the process of changing) your legal gender marker?

- Yes
- No

If Q9 <<Yes>> is selected: straight to Q12, otherwise to Q10

*10. Would you like to change your legal gender?

- Yes
- No
- I don't know

If Q10 <<Yes>> is selected: straight to Q12, otherwise Q11

*11. Can you please explain why not, or why you are uncertain? Please select all answers that apply to you.

- Because I don't feel I need to
- Because the legal gender I want is not available
- Because I cannot afford it
- Because I do not want to get divorced
- Because of my family
- Because I don't want to be sterilized
- Because I don't fulfil other legal criteria to do so
- Other (please specify)

Some people who fell under the trans umbrella definition are also intersex. Intersex individuals are born with sex characteristics (such as chromosomes, genitals, and/or hormone structure) that do not belong to male or female categories, or that belong to both at the same time.

*12. Are you intersex?

- Yes
- No
- I don't know

If Q12 <<Yes>> is selected: straight to Q13, otherwise to Q15

13. Did you receive a medical diagnosis and treatment for being intersex? (Doctors may have used the medicalised term DSD instead of intersex)

- Yes
- No
- I don't know

14. If you wish to tell us, and if you know this information, please describe the form of intersex/DSD that was documented for you:

*15. At the present time, how often are you able to live according to your gender identity?

Never	Occasionally	Almost always	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If Q15 <<Almost always>> or <<Always>> is selected: straight to Q18, otherwise to Q16

*16. What are your reasons for not (always) living according to your gender identity?

Please select all answers that apply to you.

- My work
- My partner/my partners
- My children
- My family
- My parents
- General reactions from society
- Previous negative experiences
- Fear of discrimination
- Other (please specify)

*17. Do you intend to do so more frequently in the future?

- Yes
- No
- I don't know

*18. At the present time, how open are you about your gender identity around the following people? In each case, please select the option which is most applicable in your life nowadays:

	Fully open	Partially open	Not open at all	Doesn't apply to me
With close family/relatives (parents, siblings, partners, children)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
With other relatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Among close friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In healthcare settings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At work/school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In my religious community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*19. At the present time, how do the following people react to your gender identity? In each case, please select the option which is most applicable to your life nowadays:

	Strongly disapproving	Disapproving	Neutral	Supportive	Strongly supportive	I don't know yet	Doesn't apply to me
Close family / relatives (parents, siblings, partners, children)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other relatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Close friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Healthcare providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People at work/school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My religious community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*20. At the present time, how often do strangers (shop assistants, people on the street, etc.) address you as someone of the sex you were assigned at birth?

- Never
- Rarely
- Half of the time
- Most of the time
- Always

*21. At the present time, when you are in public places, how often do you think that other people know you have a trans background or identity?

- Never
- Rarely
- Half of the time
- Most of the time
- Always

22. Do you want to tell us anything else regarding your experiences with being open and reactions from the environment?

23. **(GMSR, section P; the Pride subscale from the Gender Minority Stress and Resilience scale)** Please indicate how much you agree with the following statements:

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
My gender identity or expression makes me feel special and unique.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is okay for me to have people know that my gender identity is different from my sex assigned at birth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is a gift that my gender identity is different from my sex assigned at birth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am like other people but I am also special because my gender identity is different from my sex assigned at birth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am proud to be a person whose gender identity is different from my sex assigned at birth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am comfortable revealing to others that my gender identity is different from my sex assigned at birth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I'd rather have people know everything and accept me with my gender identity and my gender history.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am happy with the way society perceives my gender identity and expression.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

We have taken the following questions from other surveys to be able to compare data. We are therefore unable to change the wording of the following questions in this section.

***24. (EQLS: European Quality of Life Survey):** In the next section, we would like to ask a few questions about your health. In general, would you say your health is...

Very good	Good	Fair	Bad	Very bad	Don't know
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

***25. (EQLS: European Quality of Life Survey):** Do you have any chronic (long-standing) physical or mental health problem, illness or disability? By chronic (long-standing) we mean illnesses or health problems which have lasted, or are expected to last, for 6 months or more.

- Yes
- No
- I don't know

If Q25 <<Yes>>: Straight to Q26, otherwise to Q27

26. (EQLS: European Quality of Life Survey): Are you limited in your daily activities by this physical or mental health problem, illness or disability?

- Yes, severely
- Yes, to some extent
- No
- Don't know

A person’s mental health may affect their access to healthcare. In this section we will ask a few questions about your mental health and wellbeing, including suicidal ideation and attempts.

27. (WHO-5 Well-Being Index): Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks.

	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
I have felt cheerful and in good spirits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt calm and relaxed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt active and vigorous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I woke up feeling fresh and rested	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My daily life has been filled with things that interest me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*28. Have you ever thought seriously about ending your life?

- Yes, multiple times
- Yes, once
- No, never

If Q28 <<No, never>> is selected: straight to Q33, otherwise to Q29

*29. In the past 12 months have you had thoughts of ending your life?

- Yes
- No

*30. Have you ever attempted suicide?

- Yes, multiple times
- Yes, once
- No, never

If Q30 <<No, never>> is selected: straight to Q32, otherwise to Q31

*31. In the past 12 months have you attempted suicide?

- Yes
- No

*32. Where did you turn to for help when you had suicide thoughts/attempts? Please select all answers that apply to you.

- I did not seek any help/dealt with it myself
- I looked for help among peers, friends, or family
- I looked for professional help (mental healthcare)
- I looked for anonymous help (hot lines, etc)
- I looked for trans-specific help lines, trans services, or trans organizations
- Other (please specify)

*33. All things considered, how satisfied would you say you are with your life these days? Please tell us on a scale of 1 to 10, where 1 means very dissatisfied and 10 means very satisfied.

1 - Very dissatisfied	2	3	4	5	6	7	8	9	10 - Very satisfied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

34. Do you want to tell us anything else regarding your mental health and wellbeing?

We would now like to ask about your sexual health and risk of HIV. We have tried to make the questions as inclusive as possible while still making them understandable.

35. Did you ever receive any trans-specific information about STI prevention or safer sex? Please select all answers that apply to you.

- Yes, from healthcare providers
- Yes, from trans or LGBTI organizations
- Yes, I looked it up myself/got information from my peers
- No, and I don't need it
- No, but I would like to

36. Do you know your HIV status?

- Yes, I am HIV positive (I am living with HIV)
- Yes, I am HIV negative (I am not living with HIV)
- No, I don't know my current HIV status

*37 When was your last HIV test?

- I have never tested for HIV
- More than 5 years ago
- 1-5 years ago
- 6-12 months ago
- Fewer than 6 months ago

If Q37 <<I have never tested for HIV>> is selected: straight to Q38, otherwise to Q39

38. Can you tell us why you have never had an HIV test? Please select all answers that apply to you.

- I have never had unprotected sex
- I'm in a monogamous relationship with a person who does not have HIV
- I don't know where to go for a test
- I have been rejected by healthcare to take a test when I wanted to
- I am worried to be badly treated when testing due to my gender identity or expression
- I don't trust that my results will be kept confidential
- I'm afraid to be recognized by staff or other patients at the testing clinic
- I don't want to know my HIV status
- I am afraid of the result
- I am afraid I will lose my partner if my test is positive
- It is too expensive to take the test
- Medication would be too expensive for me
- Other (please specify)

Little research has been done on trans sex workers, but they are a population which faces many additional obstacles. Please help us by stating whether you have ever been engaged in sex work so that we can focus more specifically on the needs of sex workers.

*39. Have you ever been engaged in sex work?

- Yes
- No

If Q39 "Yes" is selected: straight to Q40, otherwise to Q42

40. Have you been engaged in sex work in the last 12 months?

- Yes
- No

41. Can you tell us why you are/were engaged in sex work? Please select all answers that apply to you.

- Because of lack of other opportunities
- Because I prefer sex work over other kinds of work
- Because I am accepted for who I am in sex work
- Because it is how I earn my living
- Because it is how I earn additional income
- Other (please specify)

We will first ask you about trans-specific healthcare settings. Afterwards we would like to know your general experiences in healthcare.

Trans-specific healthcare means everything related to your social or medical transition. This could mean taking hormones like estrogen or testosterone, or having physical procedures or surgery related to your gender identity or expression.

*42. Have you ever sought psychological or medical help for being trans?

- Yes
- No

If Q42 "No" is selected: straight to Q43, otherwise to Q44

43. Can you tell us why not (for you personally)? Please select all answers that apply to you.

- It is not available in the country where I live
- It is not covered by my country's public health insurance
- I do not want/need help
- I cannot afford it due to financial reasons
- I am afraid to
- I do not have confidence in the services provided
- I do not know where to go
- I do not know what to expect/I'm not familiar with the procedures
- Because of my partner(s)/because of my child(ren)
- Because of my wish to have children
- It takes too much time (including waiting lists)
- I am afraid of prejudice from healthcare providers
- I might want to, but I have not yet
- Other (please specify)

Please remember that trans-specific healthcare means everything related to your social or medical transition.

*44. Can you tell us what type of trans-specific healthcare you have already undergone, and how long ago this took place?

	In the past 12 months	Between 1-2 years ago	More than 2 years ago	Might consider/am planning to	I would like to/would have liked to, but it is/was not available	I'm not interested
Assessment and/or monitoring by a mental health professional (psychologist/psychiatrist)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hormone blockers/puberty blockers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cross-sex hormone treatment (such as estrogen or testosterone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Chest surgery: reducing or removing breasts (mastectomy)/making breasts larger (breast augmentation)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Removal of uterus/ovaries or of testes (hysterectomy/ovariectomy or orchidectomy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genital surgery (vaginoplasty, metiodioplasty/phalloplasty)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Facial feminising surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Voice surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Removal of hair using laser or electrolysis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Reshaping or removal of adam's apple (tracheal shave or removal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other gender-related surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

45. If you selected "other gender-related surger(ies)", please describe which type of procedure:

46. How was your experience? Please assess how each group/provider responded.

	Was informative and helpful	Wanted to help but could not offer everything I needed	Wanted to help, but I did not consent to the treatment proposed	Did not seem to want to help me	Refused to help me	No experience with
Support groups/trans support groups/NGO or advocacy groups	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
General practitioner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health professional (psychologist/psychiatrist/sexologist)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hormone prescriber (endocrinologists/sexologist/...)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Surgeons	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other medical specialist or healthcare provider	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

47. Could you tell us more about these experiences, for example the name of the healthcare provider, clinic name, or any other information you would like to share in this regard?

*48. How old were you when you first approached a healthcare provider for your gender identity or gender expression? I was ...

Please tell us about your experiences with reproductive health.

49. Did you ever receive any information about your reproductive abilities as a trans person? With reproductive abilities we mean your options for having children and/or for preserving your eggs/sperms. Please check all answers that apply to you.

- Yes, from healthcare providers
- Yes, from trans or LGBTI organizations
- Yes, I looked it up myself/got information from my peers
- No, and I don't need it
- No, but I would like to

*50. Has the loss of your fertility that comes with certain medical interventions ever been an issue for you?

- Yes
- No
- I don't know

If Q50 <<Yes>> is selected: straight to Q51, otherwise to Q52

51. If yes, can you tell us why ? Please select all answers that apply to you.

- I find it emotional (hard to deal with)
- I want(ed) to have kids first
- My partner want(ed) kids
- Other (please specify if you wish)

*52. If sterilisation were not necessary/had not been necessary to change your gender marker, would you do it anyway / would you have done it anyway ?

- Yes
- No
- I don't know

If Q52 <<No>> is selected: straight to Q53, otherwise to Q54

53. Why not? Please select all answers that apply to you.

- It is not necessary for my sense of my identity
- In order to avoid non-necessary surgery
- Because of the loss of fertility
- Other (please specify)

54. Did you ever receive information about any preventive cancer screenings? (cervix, breast, prostate, ...). Please select all answers that apply to you.

- Yes, from healthcare providers
- Yes, from a trans or LGBTI organization
- Yes, I looked it up myself/got information from my peers
- No, and I don't need it
- No, but I would like to

55. Do you want to tell us anything else regarding **your experiences** with trans-specific healthcare?

The following questions ask about your overall knowledge of trans-specific healthcare in your country. We ask you to respond, even if you have not undergone, or have no interest in undergoing trans-specific healthcare.

Please remember that trans-specific healthcare means everything related to your social or medical transition.

56. Do you know who to contact if you want to access trans-specific healthcare?

- Yes
- No

57. To your knowledge, is there a protocol in place (are there any guidelines) for trans-specific healthcare in your country?

- Yes
- No
- I don't know if there is a protocol

58. All things considered, how would you describe the provision of trans-specific healthcare in your country?

	Very good	Good	Fair	Bad	Very bad	I Don't know	Not offered
In general	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hormone blockers/puberty blockers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chest surgery: reducing or removing breasts (mastectomy)/making breasts larger (breast augmentation)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Removal of uterus/ovaries or testes (hysterectomy/ovariectomy or orchidectomy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genital surgery (vaginoplasty, metoidioplasty, phalloplasty)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Facial feminising surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Voice surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Removal of hair using laser or electrolysis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reshaping or removal of adam's apple (tracheal shave or removal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

59. In your opinion, how widespread are the following in trans-specific healthcare in the country in which you live:

	Very rare	Fairly rare	Fairly widespread	Very widespread	I don't know
People feel they must prove they are "trans enough" to receive treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<p>People feel forced into the gender binary (the concept that there are only two genders, masculine and feminine)</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>People feel that healthcare professionals do not respect their gender identity or expression (for example being misgendered intentionally)</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>People experience transphobia or hatred in a healthcare setting</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>People are afraid or anxious to access healthcare</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The term “gender incongruence” in the question below refers to the proposed name for the diagnosis for trans people for the next version of the World Health Organization’s International classification manual of diseases, the ICD.

60. Please tell us to what extent do you agree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	I Don't know
Gender incongruence among adolescents or adults is a psychiatric disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gender incongruence among children (before puberty) is a psychiatric disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a psychiatric diagnosis in general has a stigmatizing effect on a person	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a psychiatric diagnosis of gender identity disorder, transsexualism, or gender dysphoria has a stigmatizing effect on a person	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a psychiatric diagnosis is more stigmatizing for children than for adults	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a diagnosis which is not psychiatric but only medical would be a better option for trans people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Trans people have more mental health problems than people who are not trans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A mental health professional should decide if a person is ready for hormone treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A mental health professional should decide if a person is ready for surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

61. Can you tell us to what extent you agree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	I don't know
Hormone blockers/puberty blockers should be available to adolescents who enter puberty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cross-sex hormones (such as estrogen or testosterone) should be available to adolescents in puberty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The real life experience/test (required living for a period of time presenting according to your gender identity) should be included in the transition process	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-binary or genderqueer people should have access to trans specific healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Everyone should be able to freely choose treatment paths and options	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The way a person expresses themselves should not influence access or how they are treated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

62. Can you tell us to what extent do you agree with the following statements
(continued)?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	I don't know
Sterilization should be removed as a requirement for legal gender recognition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It would be good to have a third legal gender in our country	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People under 18 years of age should be able to access legal gender recognition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Access to legal gender recognition should be possible without any medical (diagnosis/hormones/surgery) requirements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Access to legal gender recognition should be restricted to those with a diagnosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Every person should have the right to decide their own legal gender, regardless of age	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Every person should have the right to change their own name, regardless of age	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

63. In your opinion, what would improve access to trans-specific healthcare in your country?

	Improvement is necessary	The situation is fine as it is	I Don't know or have no opinion
Removing the need for a diagnosis to get hormones or surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Removing the diagnosis completely from international classification manuals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Removing the diagnosis from mental health disorder categories	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allowing access to hormone treatment without psychological/psychiatric assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allowing access to surgery without psychological/psychiatric assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allowing non-binary people access to treatment in trans-specific healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Providing hormone blockers/puberty blockers to adolescents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Providing cross-sex hormone treatment to adolescents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Providing individualized treatment according to individual needs and wishes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

64. In your opinion, what would improve access to trans-specific healthcare in your country (continued)?

	Improvement is necessary	The situation is fine as it is	I don't know or have no opinion
Basing access to treatment on whether an individual determines that they want to have it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Basing access to treatment on whether an individual gives their consent for the effects of treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increasing the number of healthcare providers in trans-specific healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shortening the waiting times for trans-specific healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decreasing costs for treatments in trans-specific healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Adoption of a binding national protocol (guidelines) for trans-specific healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Providing training to healthcare professionals on trans-specific healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increasing knowledge on needs of non-binary people among trans-specific healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Full cost coverage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

We would now like to ask about general healthcare.

With “general healthcare” we mean going to a medical professional like a general practitioner or a family doctor for everything that is not related to being trans. This can include primary care situations like getting a flu shot, being treated for an ear infection, or having a general examination. It could also include going to the dentist, or seeing a specialist like a cardiologist.

*65. Have you ever delayed going to the doctor **for general healthcare** because of your gender identity?

- No, never
- Yes, sometimes
- Yes, regularly
- Yes, all the time

If Q65 “Yes” is selected: straight to Q66, otherwise to Q67

66. Please tell us why you delayed going to the doctor for general healthcare because of your gender identity? Please select all answers that apply to you.

- Because I think I will be treated badly
- Because I’m afraid
- Because I do not want to disclose my trans identity/background
- Other (please specify)

67. In general, would you know of trans-friendly healthcare providers **for general healthcare**?

- Yes
- No

68. Would you go to a **trans-specific or LGBT-specific** medical center for general healthcare issues if one were available?

- Yes
- No
- I don’t know

69. Can you please explain why/why not?

70. Have you ever experienced any of the following situations when using or trying to access **general healthcare services as a trans person**? Please check all answers that apply to you.

	Never happened to me	Happened to me by my GP	Happened to me by a medical specialist (cardiologist, dentist, etc)	Happened to me by a mental health professional	Happened to me by non-medical staff
Inappropriate curiosity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specific needs ignored (not taken into account)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pressure or being forced to undergo medical or psychological testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having to change general practitioners or other specialists due to their negative reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of knowledge on trans issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not using the right name or pronoun for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sharing of information about my gender identity without my consent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refusing to provide treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consciously/purposefully delaying treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being subjected to verbal abuse (being called names, ridiculed, yelled, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other things happened to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*71. During the past 12 months, have you personally felt discriminated against because of your gender identity or expression by a healthcare provider in **general healthcare**?

- Yes
- No
- I don't know

If Q71 "Yes" is selected: straight to Q72, otherwise Q73

72. Can you tell us what happened?

73. In your opinion, what would improve access to general healthcare for trans people in your country?

	Improvement is necessary	Current situation is fine as it is	I don't know / I don't have an opinion
Finding alternative ways of registering trans people at doctor's offices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Issuing temporary health insurance cards or other forms of ID, even if legal names and gender markers have not been changed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having lists of trans-friendly doctors or clinics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having peer mentoring and support groups to contact	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having allies or peers to accompany trans and non-binary people to the doctor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Making training for all staff members mandatory and regular	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a binding protocol (guidelines) for how to address trans people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having LGBTI- or trans-focused healthcare clinics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

74. Have any of the following circumstances had a positive effect on your experiences with accessing **general** or **trans-specific** healthcare?

- Pressure from the EU or the Council of Europe on your government to be more supportive of trans people
- National legislation to support human rights for trans people
- Civil society organizations or trans groups working with national or regional governments
- Trans groups training practitioners or being invited to participate in training
- Certified doctors/specialists who offer LGBTI-inclusive healthcare
- Doctors and specialists sharing consensual information about your healthcare provision
- Public information informing trans people about rights regarding healthcare
- Medical professional groups which are supportive of trans people's needs
- Having more visible trans people in the public sphere (politicians, media, ...)
- Having a national protocol for trans-specific healthcare
- Other (please specify)

Please give us some more background information about yourself.

75. Where do you currently live?

- City or the suburbs or outskirts of a city, or town
- A country village, farm or home in the countryside

76. (**EQLS: European Quality of Life Survey**) A household may have different sources of income and more than one household member may contribute to it. Thinking of your household's total monthly income: is your household able to make ends meet...?

Very easily	Easily	Fairly easily	With some difficulty	With difficulty	With great difficulty
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

77. Can you please tell us who is living with you (all or most of the time)? Please select all that apply to you.

- no one
- partner(s)
- child(ren)
- parent(s)
- other family member(s)
- friend(s)
- Other (please specify)

78. Below are some terms that describe different sexual orientations and sexualities.
Please select all that apply to you.

- Bisexual
- Gay
- Lesbian
- Asexual
- Pansexual
- Queer
- Straight or heterosexual
- Don't define
- Not sure or questioning
- Other (please specify)

79. Do you feel you belong to one of the following minority groups, and can you tell us how important it is to you to belong to this group?

	No, I don't belong to this group	Yes, but it is not important to me	Yes, but it's only slightly important to me	Yes, and it's very important to me
Ethnic minority	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Religious minority	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual minority (gay, bisexual, lesbian, queer, asexual, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gender identity minority due to being trans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Minority due to ability status	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Another minority	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

You have reached the end of the questionnaire. Thank you very much for your participation.

80. If you still have a pressing question to ask, or if you think that an important aspect has been overlooked, please describe below.

Annex 4: Questionnaire Healthcare Providers

Dear healthcare providers!

Transgender Europe, TGEU, a European human rights organization, is conducting European research on healthcare for trans people in 5 countries: Georgia, Poland, Serbia, Spain, and Sweden. The goal of this study is to increase knowledge on the healthcare situation of trans people.

If you are a healthcare provider in Georgia, Poland, Serbia, Spain, or Sweden, regardless of whether you have experience with providing healthcare for trans people, we want to hear from you. We want to learn from your experiences and views on how healthcare for trans people is organized in your country, what needs for education you see, and your thoughts on trans healthcare.

By healthcare providers we mean, for example, doctors, nurses, social workers, psychologists, counsellors, receptionists, and any other providers who have direct contact with clients/patients, regardless of whether they work in the public, private, and/or civil sector.

This topic needs a multi-disciplinary approach, and that's why your participation is so important!

I will only take you about 15 minutes to complete this anonymous questionnaire. While you are completing the questionnaire, the progress bar will allow you to see how much you have completed. Please note you cannot stop the survey and continue at a later time, so please allow enough time to complete it in one section.

We realize answering this questionnaire takes your valuable time. We thank you in advance for helping us to increase knowledge on this subject, and we look forward to hearing about your experiences as a healthcare provider.

***For the purpose of this survey, we use “trans people” as an umbrella term to refer to people whose gender identity and/or expression differs from the sex they were assigned at birth, including, but not limited to, non-binary, genderqueer, and gender non-conforming people.**

***1. I have read the above information and agree to participate in this anonymous study.**

- Yes
- No

<<> indicates that every respondent needs to respond to this question in order to go on with the rest of the survey*

Identity

*2. In what year were you born?

*3. In which of the following countries is your service as a healthcare provider based?

- Georgia
- Poland
- Serbia
- Spain
- Sweden
- Another country

By “gender identity” we mean every person’s deeply felt internal and individual experience of gender. By “gender expression” we mean the manifestation of a person’s gender identity, which is perceived by others, for example through dress, mannerisms, speech.

*4. What sex were you assigned at birth, meaning on your original birth certificate?

- Female
- Male

*5. How do you describe your gender identity at the current moment? Please select the option that fits you best.

- Female
- Male
- Transfeminine/Trans Woman/Male-to-female (MTF)
- Transmasculine/Trans Man/Female-to-male (FTM)
- Non-binary/genderqueer/gender non-conforming
- Other (please specify)

6. Do you feel you belong to one of the following minority groups, and can you tell us how important it is to you to belong to this group?

	No, I don't belong to this group	Yes, but it is not important at all to me	Yes, but it's only slightly important to me	Yes, and it's very important to me
Ethnic minority	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Religious minority	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual minority (gay, bisexual, lesbian, queer, asexual, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gender minority due to being trans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Minority due to ability status	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Another minority	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Education

*7. What is the highest level of education you have achieved?

- No formal education
- Primary education
- Secondary education
- Post-secondary education other than college/university
- College/university/higher academic education

*8. What is your profession and how long have you been working in this field? Please select all answers that apply.

	Fewer than 5 years	Between 5-10 years	Between 10-15 years	More than 15 years	Not now, but I have worked in this field in the past	Not ever in this field
General practitioner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychologist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychiatrist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychotherapist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Counsellor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexologist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Endocrinologist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Surgeon	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Plastic surgeon	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Urologist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gynecologist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other medical specialist (cardiologist, internist, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nurse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Social worker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical therapist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reproductive health specialist/assisted reproduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pregnancy and post-natal care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pediatrician	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Geriatric care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
STI testing personnel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dentist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Administrative or clerical staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*9. With which age groups do you work? Please select all answers that apply to you.

- Pre-pubertal children
- Adolescents (in puberty)
- Adults
- Other (please specify)

10. In what kind of setting do you work? Please select all answers that apply.

- I work alone
- I work in a group practice
- I work in a group practice specializing in trans healthcare
- I work in a clinic
- I work in a clinic specializing in trans healthcare
- I work in a primary healthcare center
- Other (please specify)

11. Do you work within your country's state/public or private healthcare system? Please select all answers that apply.

- Work within the state/public healthcare system
- Private healthcare system
- Other (please specify)

12. Where do you currently work?

- City, the suburbs, or outskirts of a city
- Town, village, or countryside

*13. Have you ever had training about trans people/transsexualism/gender dysphoria?
(The term “transsexualism” is one of the diagnoses in the ICD-10 for trans people. The term “gender dysphoria” is the term for the diagnosis in the DSM-5.)

- Yes
- No

If Q13 <<No>> is selected: straight to Q17, otherwise Q14

14. Can you tell us more about how this training was provided? Please select all answers that apply.

- As part of my mandatory formal education program
- As part of my mandatory professional development
- Voluntarily on my own initiative
- Other (please specify)

15. Who provided this training? Please select all answers that apply.

- A professional healthcare provider from outside the university
- A trans- or LGBTI organization
- An instructor through the university
- City/county/government or administration
- An employer
- Other (please specify)

16. In what format did you receive this training? Please select all answers that apply.

- As a topic in a course book
- As a subject of a lecture or a topic within a course I attended
- As a topic of a workshop, seminar, or conference
- Online or web-based course
- Other (please specify)

17. How do you rate your level of confidence in working with trans users/clients/patients?

Very high	High	Average	Low	Very low	I don't know
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*18. In your opinion, would your level of competence in working with trans users/clients/patients increase by training?

- Yes
- No

19. What type of training would you find helpful to increase your level of competence in working with trans users/clients/patients? Please select all answers that apply.

- Training as part of my mandatory formal education program
- Training as part of my mandatory professional development
- Non-compulsory training opportunities
- Other (please specify)

20. By whom would you like to receive this training? Please select all answers that apply.

- A professional healthcare provider from outside the university
- A trans- or LGBTI organization
- An instructor through the university
- City/county/government or administration
- An employer
- Other (please specify)

21. In what format would you prefer to receive training? Please select all answers that apply.

- In the form of course books
- In the form of testimonies by trans people
- Online or web-based course
- As a course organized by a healthcare provider specialized in trans-specific healthcare
- As a workshop or seminar organized by a trans organization
- Other (please specify)

Organization of care

Not all answer options may be relevant to the situation in your country. Please answer to the best of your knowledge based on your country, but please continue if some of the terms are unfamiliar to you or not part of your own experience.

“Trans-specific healthcare” means everything related to social or medical transition. This could mean taking hormones like estrogen or testosterone, or having physical procedures or surgery related to gender identity or expression.

With “general healthcare” we mean going to a medical professional like a general practitioner or a family doctor for everything that is not related to being trans. This can include primary care situations like getting a flu shot, being treated for an ear infection, or having a general examination. It could also include going to the dentist, or seeing a specialist, like a cardiologist.

With “service user/client/patient” we mean the people you serve in your work.

22. To your knowledge, within your field of work, have you ever encountered a trans service user/client/patient?

- Yes
- No
- I don't know

23. Out of the total number of service users/clients/patients you see on a monthly basis, how many do you estimate are trans people?

0%	100%
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24. If one of your service users/clients/patients wishes to access a type of trans-specific healthcare which you do not offer, do you know where to refer them?

- Yes
- No
- No, but I know where I could get the information

25. If a trans user/client/patient wishes to contact a trans support group, do you know where to refer them?

- Yes
- No
- No, but I know where I could get the information

26. To your knowledge, is there a protocol in place (are there guidelines) for trans-specific care in your country on a national or regional level?

- Yes
- No
- I don't know if there is a protocol on a national or regional level

27. In your professional work, do you use any of the following guidelines or manuals? You may not be familiar with all the terms listed. Please select all answers that apply.

- Standards of Care 5 from WPATH
- Standards of Care 6 from WPATH
- Standards of Care 7 from WPATH
- ICD 10
- DSM 4
- DSM 5
- None of the above
- Other (please specify)

28. All things considered, how would you describe the provision of trans-specific healthcare in your country?

	Very good	Good	Fair	Bad	Very bad	I don't know	Not offered
In general	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hormone blockers/puberty blockers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cross-sex hormone treatment (such as estrogen or testosterone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chest surgery: reducing or removing breasts (mastectomy)/making breasts larger (breast augmentation)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Removal of uterus/ovaries or testes (hysterectomy/ovariectomy or orchidectomy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genital surgery (vaginoplasty/metoidioplasty/phalloplasty)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Facial feminizing surgeries	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Voice surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Removal of hair using laser/electrolysis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reshaping or removal of adam's apple (tracheal shave or removal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

29. In your opinion, have any of the following circumstances had a positive effect on the organization of general or trans-specific healthcare for trans people in your country? Please select all answers that apply.

- Pressure from the EU or the Council of Europe on your government to be more supportive of trans people
- National legislation to support human rights for trans people
- Civil society organizations or trans groups working with or addressing national or regional governments
- Trans groups training practitioners or being invited to participate in training
- Certified doctors/specialists who offer LGBTI-inclusive healthcare
- Doctors and specialists informing trans people about rights regarding healthcare
- Medical professional groups which are supportive of trans people's needs
- Having more visible trans people in the public sphere (politicians, media,...)
- Having a national protocol for trans-specific healthcare
- I don't know
- Other (please specify)

30. Please consider this situation: A person comes to your workplace and says he is a trans person and that his name is John. On his insurance card you see the name Mary for the person and a female gender marker. How would you address the person?

- I would address the person as John/he
- I would address the person as Mary/she
- I would not know how to address the person
- Other (please specify)

31. Are there any guidelines at your workplace to regulate the name and pronoun use of your service users/clients/patients?

- Yes, there are existing guidelines
- Guidelines are currently being developed
- No, there are no guidelines
- I don't know

32. What do the guidelines recommend?

- To use the legal name and legal gender
- To use the name and gender that the service user/client/patient asks us to use
- Other

33. Would you like to tell us more about these guidelines?

34. In your workplace, are measures taken to provide people of all genders with any of the following?

	Yes	No	I don't know
Gender-neutral toilets	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Privacy at the reception desk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alternatives to calling the legal name in the waiting room	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alternatives to listing legal names in the computer system	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

35. Would you like to tell us more about these or other measures?

Opinions

In this section we'd like to hear your thoughts and views on different aspects related to trans-specific healthcare. Please answer to your best knowledge. If you have no opinion on the matter, please choose "I don't know/I have no opinion".

***36. (*The Beliefs about Gender Scale*):** Can you tell us to what extent you agree with the following statements? Please choose the most suitable answer.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	I don't know/I have no opinion
There are only two genders, male or female.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Only these two genders (male and female) are morally acceptable and legitimate in our society.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
All adults identify as either male or female.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you are either male or female, then you are that gender for all time.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
All males have a penis and all females have a vagina.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is just a social norm to assign babies on what their bodies are like.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anyone who is not naturally male or female is a 'freak of nature'.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If someone wants a sex reassignment, their doctor or psychologist can talk them out of it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Even a person with ambiguous genitalia is still either male or female.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Whether a person sees himself/herself as male or female is largely a matter of upbringing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The term “gender incongruence” in the question below refers to the proposed name for the diagnosis for trans people for the next version of the World Health Organization’s International classification manual of diseases, the ICD.

*37. We’d like to know your opinion on the following statements. Can you tell us to what extent you agree with the following statements.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	I don’t know/ I have no opinion
Gender incongruence among adolescents or adults is a psychiatric disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Gender incongruence among children (before puberty) is a psychiatric disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a psychiatric diagnosis in general has a stigmatizing effect on a person	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a psychiatric diagnosis of gender identity disorder or transsexualism or gender dysphoria has a stigmatizing effect on a person	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a psychiatric diagnosis is more stigmatizing for children than for adults	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Having a diagnosis which is not psychiatric but only medical would be a better option for trans people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trans people have more mental health problems than non-trans people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A mental health professional should decide if a person is ready for hormone treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A mental health professional should decide if a person is ready for surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*38. Can you tell us to what extent you agree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	I don't know/I have no opinion
Hormone blockers/puberty blockers should be available to adolescents who enter puberty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cross-sex hormones (such as estrogen or testosterone) should be available to adolescents in puberty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A real life experience/test (required living for a period of time presenting according to your gender identity) should be included in the transition process	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Non-binary or genderqueer people should have access to trans-specific healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Everyone should be able to freely choose treatment paths and options	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The way a person expresses themself should not influence their access or how they are treated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Legal gender recognition is the official procedure to change a trans person's name and gender identifier in official registries and documents, such as birth certificate, ID card, passport, driving license.

*39. Can you tell us to what extent you agree with the following statements (continued)?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	I don't know/I have no opinion
Sterilization should be removed as a	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

requirement for gender recognition						
It would be good to have a third legal gender in our country	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People under 18 years of age should be able to access legal gender recognition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Access to legal gender recognition should be possible without any medical (diagnosis/hormones/surgery) requirements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Access to legal gender recognition should be restricted to those with a diagnosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Every person should have the right to decide their own legal gender, regardless of age	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Every person should have the right to change their own name, regardless of age	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*40. Can you tell us to what extent you agree with the following statements (continued)?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	I don't know/I have no opinion
Mental health issues, such as depression, anxiety, self-harm, suicidal ideation, etc., are criteria to exclude someone to referral to an endocrinologist (for puberty blockers or cross-sex hormones such as estrogen or testosterone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A mental health professional should decide if a person is ready to be referred to a gender clinic or a specialist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It would be good to have gender-neutral personal code numbers in our country	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trans people should be able to access reproductive healthcare/assisted reproduction on the same terms and non-trans people in our country	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Intersex people should be excluded from accessing trans-specific healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Having guidelines for name and pronoun use in healthcare settings is important	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having gender-neutral toilets in waiting rooms in healthcare settings is important	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A person who would be considered homosexual after transitioning should be excluded from trans-specific healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*41. In your opinion, how widespread is discrimination of trans people in your country?

- Very rare
- Fairly rare
- Fairly widespread
- Very widespread

42. If you still have a pressing question to ask, or if you think that an important aspect has been overlooked, please describe below.