



Article

Abuse in Chilean Trans and Non-Binary Health Care: Results from a Nationwide Survey

Miguel Roselló-Peñaloza *, Lukas Julio, Izaskun Álvarez-Aguado  and Maryam Farhang

Facultad de Salud y Ciencias Sociales, Universidad de Las Américas, Santiago 7500975, Chile

* Correspondence: mrosello@udla.cl

Abstract: Abuse in health care (AHC) is an emerging concept used to describe healthcare practices and conduct that health services users find belittling and degrading. Such experiences, whose causes are not always voluntary but systematic and structural, have been described as one of the main barriers to the trans and non-binary population's access to health care. To study this problem in Chile, the country's first trans and non-binary health survey was conducted between January 2021 and June 2022 with the participation of 1116 people. Univariate statistical analyses were performed to calculate the frequencies (f) and percentages (%) of the different forms of AHC reported. Chi-squared tests ($p < 0.01$) and the Pearson correlation coefficients ($r > 0.10$) were used to identify statistically significant correlations between experiences of AHC, the health personnel reportedly involved, and participants' responses to these experiences. About 84% of the participants who replied to questions on this subject said that they had experienced some form of AHC. The most frequently reported were inappropriate use of pronouns (65.9%) and stereotypical comments about genders (48.3%). These events occurred mostly in encounters with secretaries and receptionists, followed by psychologists and nurses. The most frequent response of participants to these situations was to change the medical staff responsible for their care, followed by ceasing to seek professional attention. A mainstreamed relational gender perspective is required to address the complexity of this problem.

Keywords: abuse in health care; discrimination; relational gender theory; social erasure; trans and non-binary people



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1. Introduction

In the encounter of trans and non-binary people (TNB) with health systems, negative experiences are more common than we would like to think (Ansara and Hegarty 2012; Ayhan et al. 2020; González and Bernalles 2022; Grant et al. 2011; Hostetter et al. 2022; Markovic et al. 2021; Riggs et al. 2014; Rodríguez et al. 2018; Zapata Pizarro et al. 2019). Refusal of services, professional staff with little or no knowledge of the subject, improper verbal treatment, and discrediting the health services user's experience and knowledge, among other reports, indicate that an important segment of the TNB population receives inappropriate treatment and attention (Balzer and Hutta 2013; García-Acosta et al. 2019; Hoyos et al. 2023; Medina-Martínez et al. 2021; Smith et al. 2018; Vupputuri et al. 2021). This not only affects their needs for trans-specific services such as cross-hormonal therapy or genital modification surgeries, but also general healthcare requirements like early cancer diagnoses and promotion of sexual health (García-Vega et al. 2018; Lerri et al. 2017; Marshall et al. 2016).

Experiences of unfavorable treatment in medical and healthcare settings may constitute a serious public health problem due to their harmful consequences for people's physical, emotional and psychological wellbeing (Miltenburg et al. 2018). Indeed, fear of discrimination—or anticipated discrimination (Kcomt et al. 2020)—has been documented as one of the main barriers of access to health care for the TNB population (Seelman et al. 2017;

González and Bernalés 2022). International reports, like the National Transgender Discrimination Survey (Grant et al. 2011), describe a series of discriminations recounted by trans people in interactions with North American health facilities, such as refusal of services (19%), verbal harassment (18%), and physical assault (2%). The U.S Transgender Survey (James et al. 2016) also highlights experiences of refusal of services by healthcare providers (25%), intrusive or unnecessary questions about gender identity unrelated to the reason for the visit (15%), physical violence (2%), and even sexual violence (1%), among others.

There are few studies in Chile regarding this problem. The Identity Survey (MOVILH 2018), in which 326 trans people participated, found that 9.8% of the sample interviewed reported discrimination by medical staff, while only 7.8% of them made a complaint. Again, the T Survey (Linker et al. 2017), in which 315 trans and persons of “non-conforming gender” participated, showed that 95% had had their gender identity questioned in health services, 27% had been ignored in their request for attention, and 25% had received taunts in these contexts. Lastly, a study carried out in the north of the country (Zapata Pizarro et al. 2021) showed that 14% of the health staff surveyed did not respect use of the social name and that 4.3% even “expressed rejection or hatred at attending transgender people” (p. 64).

One of the most frequently cited explanations for the disadvantaged treatment (or discrimination) experienced by TNB people in health systems is “stigmatization” (Catalán 2018; Hudson 2018; Brookfield et al. 2019), a process of “othering, blaming, and shaming that leads to status loss and discrimination” (Poteat et al. 2013, p. 22), and when associated with a social identity, disqualifies individuals or groups from full social acceptance (Goffman 1963). This undesired difference or invalidation is produced and reproduced in the oppressive framework of the gender regime, understood as a multidimensional system of relationships that—surpassing the fixed categories of “man” and “woman”—binds bodies and identities to social norms and exclusionary institutional practices (Connell 2012). Such stigmatization takes shape and unfolds at the heart of gender dynamics, which, while molding subjects and their ways of life, also create, order, and reinforce the inequalities that subjects experience in society—inequalities that are expressed with particular violence and efficacy in the field of health (Roselló-Peñaloza 2018).

This perspective, also known as “relational gender theory” (Connell 2009), allows us to understand the interdependence that exists between the norms and inequalities of gender and the knowledge and clinical practices of scientific disciplines, a powerful assemblage that Keller (1985) called a “gender-science system”, and that lies at the root of the experiences of discrimination that TNB people face in health services. It works by reproducing, and legitimizing, two of the most oppressive hegemonic pillars of our social organization: “heteronormativity”, understood as the political-cultural privilege of heterosexuality and the traditional ways in which it structures and prescribes social relations (Berlant and Warner 1998), and “cisgenderism”, an “ideology that invalidates or pathologizes self-designated genders that contrast with external designations” (Ansara and Hegarty 2012, p. 137).

This relational and structural approach to gender connects with the academic and transgender activist Viviane Namaste’s critical analysis of this population’s encounter with health services, when she points out that “transsexuals and transgendered people are erased from the institutional world as a function of specific policies and administrative practices in health care and social services” (Namaste 2000, p. 189), an “erasure” that usually occurs in two different healthcare contexts: information systems and institutional practices and policies (Bauer et al. 2009). Informational erasure is manifested by a lack of knowledge about TNB persons, involving, *inter alia*, the assumption that all people are always cisgender (a term describing a person whose gender identity aligns with the sex they were assigned at birth); a lack of research into topics related to the health of TNB persons; and the inclusion of scarce information (if any) into academic texts, educational curricula or health protocols (Winter et al. 2016; Austin and Revital 2018; Shires et al. 2018). For its part, institutional erasure refers to the absence of policies that are appropriate for

TNB identities and bodies and includes unawareness even of the need for such policies. It can be found, for example, in the exclusion of their identities from administrative forms and documents, in the lack of health coverage for medical interventions considered to be exclusive to one gender or another (such as pregnancy in trans men or prostate cancer in trans women), or in the absence of inclusive spaces for TNB people (for example, hospital units segregated by sex).

Rather than individualizing these practices and experiences, the conceptualization of gender as a dynamic social process invites us to problematize the systematic, structural, and not always voluntary nature of these events, emphasizing their roots and legitimation in heteronormative and cisnormative cultural and institutional discourses and actions. By following this approach, we can understand this phenomenon as potentially harmful also to health personnel, who may participate unwillingly in practices that can be detrimental to what they seek: the wellbeing of the people they care for. This is why, for this study, we use the term “abuse in health care” (AHC) to address these experiences, an emerging concept that describes the medical and health “procedures or interactions that patients experience as neglecting or dehumanizing” (Brüggemann et al. 2019, p. 52), “most often unintentional and nurtured and legitimized by the structural and cultural contexts in which the encounter takes place” (Brüggemann et al. 2012, p. 130).

It should be noted that AHC is a specific concept, where “in health care” not only refers to the setting in which the abusive experiences occur but also underscores the part that discourses, practices, roles, and institutional rules play in the problem. In referring to abuse in health care, therefore, we must consider contextual and temporal aspects that are specific to healthcare settings, such as the traditional hierarchical relationships between medical professionals and users, gender biases in scientific knowledge, and the institutional limitations on quality attention like waiting times, lack of resources or specialists, etc. In the case of TNB people, AHC may include a broad range of experiences (whether the result of voluntary or involuntary actions), including rejection (for example, verbal harassment or refusal of services), active transphobia (for example, sexual violence or physical assault) and micro-aggressions (for example, signs of discomfort and refusal to respect users’ social names) (Truszczynski et al. 2020). By conceptualizing these experiences as AHC, we are able to highlight not only the responsibilities of professionals but also of institutions and even of the state in excluding and marginalizing TNB people from the health system, a problem that needs to be urgently addressed.

In this article, we present the results of the National Survey of Trans and Non-binary Health in Chile, the most extensive yet carried out in the country, in which we explore the most common experiences of *abuse in trans and non-binary health care*.

Brief Contextualization

The Chilean health system is mixed in its funding sources, combining a public insurance scheme, the National Health Fund (FONASA), with a private one, consisting of Institutions of Health Insurance (ISAPRES), as they are known. Seventy-eight percent of the country’s population are affiliated with FONASA (División de Desarrollo Institucional. Gobierno de Chile 2020), as were 68.5% of all participants in this study. In this context, the specialized health services that serve the TNB population are dissimilar in their characteristics, costs and coverage. There is also significant geographical inequality: Chile is a highly centralized country with a shortage of health facilities and specialized doctors in remoter areas of the country.

In this context, gender-specific healthcare services are heterogeneous, contributing to notable territorial disparities. Within the public healthcare sector, *gender identity units*—which offer services at no charge for people affiliated with FONASA—mostly operate on a self-administered basis, with fluctuating levels of support and institutionalization, insufficient budgets, long waiting lists, and a diversified array of services. On the other hand, the private healthcare sector charges substantial fees for required procedures, rendering them financially unattainable for a significant portion of the population.

In 2019, Law 21.120 was approved, which recognizes and protects the right to one's gender identity. This law guarantees changes to the civil register without requiring a clinical diagnosis or medical intervention but does not address the lack of provision for trans-specific health issues. For its part, the Chilean health ministry has issued some technical guidelines addressing health attention for this population aimed at regulating use of the social name in clinical records and health attention, as well as the training of gender health teams. However, these guidelines are often not complied with or are unknown to health personnel (Zapata Pizarro et al. 2021).

2. Materials and Methods

2.1. The National Trans and Non-Binary Health Survey (Chile)

The questionnaire prepared by the research team for use in the survey was submitted for prior evaluation by experts, including academic researchers and TNB people, who commented on the appropriateness and wording of the questions, indicators and response choices. The final result was a 53-item questionnaire covering the survey's three dimensions: the demand for health care and services, barriers to access, and experiences of AHC. The present article presents the results obtained on this last dimension, which includes 17 forms of *abuse in trans and non-binary health care* identified in the specialized literature and recognized by TNB people collaborating in the study (see Table 1).

Table 1. Experiences of AHC included in the National Trans and Non-Binary Health Survey (Chile) *.

Question: Have you had any of these experiences when seeking attention in the health system? You may tick more than one option.
• Inappropriate use of pronouns
• Refusal to respect your social name
• Attempts at dissuasion, or suggestion that you abandon your gender transition processes
• Signs of discomfort (such as avoiding eye contact)
• Refusal of services (including transition-related medical treatment)
• Inadequate or superficial care (for example, superficial physical examinations)
• Omission or lack of information about medical procedures and their possible adverse effects
• Enforced care or care without consent (for example, forced visits to a psychiatrist or unnecessary medical exams)
• Sterilization without consent
• Ignoring your own knowledge of your body and gender identity
• Abrupt or reluctant attention
• Physical assault on receiving attention
• Sarcastic or ironic replies to your questions
• Stereotypical comments on gender (for example, instructions to be "more feminine" or "more masculine")
• Derogatory comments about your gender identity or expression
• Sexual assaults (for example, obscene come-ons, inappropriate touching, etc.)
• Excessive requests for procedures or documents (with respect to gender identity) as a condition for attention

* Apart from these 17 experiences, a free response option was included as "Other, please specify". All of the responses obtained in this category were recoded and counted in the available response options. In the tables and figures of this article, the different experiences of AHC were synthesized due to format constraints.

In addition, a list of possible responses to these experiences of AHC was included. Only those strategies related directly to the health system were considered in making the list. For this reason, instruments designed for other purposes—such as the Ways of Coping measure (Folkman et al. 1986), which includes dimensions associated with religion, or self-destructive behaviors in response to stressful or unexpected situations—were not used. Instead, an ad hoc set of responses was compiled for the health context, some of them solely applicable to the TNB population (Table 2).

Table 2. Response options included in the National Trans and Non-Binary Health Survey (Chile) * to the question “If you suffered one or more of the experiences mentioned previously, what did you do about it?”.

Question: If you suffered one or more of the experiences mentioned previously, what did you do about it? You may tick more than one option.	
•	I stopped seeking attention
•	I changed my healthcare professional
•	I changed my medical center
•	I abandoned the treatment
•	I have postponed or I have tried to avoid checkups or attending other preventive medical appointments
•	I had to teach the person who attended me about trans or non-binary people in order to get proper attention
•	I have decided to stop presenting myself as a trans or non-binary person in these spaces
•	I filed a complaint
•	I did nothing

* Apart from these nine response options, a free option was included as “Other, please specify”. It was possible to recode all of the responses obtained in this category and count them in the available response options.

The questionnaire was available in digital form on a web platform (SurveyMonkey) and self-applied by participants online. Lesbian, Gay, Bisexual, Trans, Intersex and Queer (LGBTIQ+) organizations and activists helped disseminate the questionnaire on various other platforms on the internet. Participants were given four gender options to identify their gender, as well as an open category (“other”) for those wishing to describe their gender themselves. The four gender options were: female, male, non-binary (persons who do not identify with or dissent from binary male/female genders), and gender-fluid (a form of identification in which people flow between two or more gender identities, whether these are binary or not).

2.2. The Sample

Responses to the National Trans and Non-Binary Health Survey were received from 1116 individuals between January 2021 and June 2022. However, the study allowed for the possibility of respondents not answering all of the questions, given the length of the questionnaire and its self-applied nature. For the present analysis, only responses completed for each item were considered, each of which was analyzed independently. This report gives the number of respondents (n) for each specific statistical analysis.

The survey’s AHC dimension, reported in the present article, received responses from 69.8% of the sample (778 persons), all of whom complied with the study’s three criteria for inclusion: self-identification as a trans or non-binary person, residence in Chile and age of at least 18.

2.3. Statistical Analysis

The information collected was processed and analyzed using SPSS version 28.0 software. A univariate statistical analysis was conducted, whose results are given in frequencies (f) and percentages (%). Information provided on the main prevalences is based on the distribution of the responses of the general sample (N) and the distribution between groups (n) according to the variables of interest. In addition, bi-variate statistical analyses were performed to identify the presence of statistically significant differences, for which the chi-squared test at a 99% confidence level ($p < 0.01$) was performed. In interpreting the results, of particular interest were relationships between variables that presented high values ($r > 0.10$) when the intensity of their statistical relationship was measured using the Pearson correlation coefficient.

3. Results

3.1. Demographic Data

The participants were aged between 18 and 67 years (Mode = 23 years; $X = 25.9$ years), with 68.2% of the sample between 19 and 32 years of age. Of the total, 41.1% ($n = 320$) identified as male gender, 34.2% ($n = 266$) as non-binary gender, 16.6% ($n = 129$) as female gender, and 5.5% ($n = 43$) as gender-fluid. Another 2.5% ($n = 20$) did not identify with any of these four categories. The following results focus on the four gender identities explicitly included (male, female, non-binary and gender fluid), due to their greater presence in the sample as a whole.

3.2. Experiences of Abuse in Trans and Non-Binary Health Care

More than one-fifth of the sample (22.2%, $n = 173$) reported having never attended a health service for reasons related to their gender identity or expression. Among the main reasons given were having known about situations of violence in healthcare settings (37.6%) or having experienced them directly (13.9%). Those who had consulted for reasons related to their gender identity or expression (77.8%; $n = 605$) were likely ($p < 0.01$) to have experienced a refusal to respect their social name ($r = 0.174$); excessive requests for procedures or documents in order to receive attention ($r = 0.172$); inappropriate use of pronouns ($r = 0.137$); refusal of services ($r = 0.133$); attempts to dissuade them from continuing with their gender transition processes ($r = 0.122$), and omission or lack of information about medical procedures and their possible adverse effects ($r = 0.108$).

Considering the total sample ($n = 778$) and of all the possible reasons for consultation (not only those related to gender identity or expression), 83.9% ($n = 653$) of the participants said that they had experienced some form of AHC. Among the experiences most reported were inappropriate use of pronouns (65.9%), stereotypical comments about genders (48.3%), abrupt or reluctant attention (44%) and signs of discomfort (44%). Table 3 shows the frequencies and percentages with which these experiences were reported, distributed by gender identity.

It should be noted that non-binary and fluid-gender participants reported more stereotypical comments concerning genders (54.1% and 60.5%, respectively) than their male and female gender peers (45.6% and 37.2% respectively), even surpassing the total sample (48.3%). A similar difference, although by smaller percentages, could be seen for having their own knowledge about their body or gender identity ignored, receiving derogatory comments about their gender identity or expression and sarcastic or ironic responses to their questions.

On the other hand, the binary-gender population (male or female) reported more frequently than their non-binary or gender-fluid peers receiving excessive requests for procedures or documents (with respect to their gender identity) in order to receive attention (30% of men and 24.8% of women, compared to 14.3% of non-binary people and 7% of gender-fluid people). Binary-gender participants also experienced a refusal of services proportionately more often than other identities, although the percentage difference was smaller in this case.

Table 3. Experiences of abuse in trans and non-binary health care.

Experiences of Abuse in Trans and Non-Binary Health Care	Total Sample (N = 778)		Male Gender (N = 320)		Female Gender (N = 129)		Non-Binary Gender (N = 266)		Fluid Gender (N = 43)	
	%	n	%	n	%	n	%	n	%	n
Inappropriate use of pronouns	65.9	513	67.5	216	58.9	76	68.8	183	60.5	26
Stereotypical comments about genders	48.3	376	45.6	146	37.2	48	54.1	144	60.5	26
Abrupt or reluctant attention	44.0	342	43.4	139	39.5	51	45.5	121	44.2	19
Signs of discomfort	44.0	342	45.9	147	39.5	51	45.5	121	34.9	15
Refusal to respect the person's social name	43.3	337	46.3	148	43.4	56	41.7	111	34.9	15
Ignoring the person's own knowledge of their body and gender identity	35.2	274	33.1	106	24.0	31	39.8	106	44.2	19
Sarcastic or ironic replies to the person's questions	35.2	274	33.8	108	27.9	36	39.5	105	37.2	16
Omission or lack of information about medical procedures and their possible adverse effects	29.4	229	30.9	99	27.9	36	27.1	72	32.6	14
Derogatory comments about the person's gender identity or expression	28.9	225	26.9	86	23.3	30	33.1	88	32.6	14
Inadequate or superficial care	26.0	202	26.6	85	21.7	28	27.4	73	27.9	12
Excessive requests for procedures or documents	22.0	171	30.0	96	24.8	32	14.3	38	7.0	3
Forced care, or care without consent	16.5	128	18.4	59	18.6	24	12.0	32	23.3	10
Attempts at dissuasion, or suggestions that gender transition processes be abandoned	15.8	123	19.7	63	14.7	19	11.7	31	14.0	6
Refusal of services	15.3	119	18.1	58	21.7	28	10.5	28	7	3
Sexual aggression	7.8	61	5.6	18	7.8	10	9.8	26	11.6	5
Physical assault on receiving attention	4.0	31	3.4	11	4.7	6	4.1	11	4.7	2
Sterilization without consent	1.9	15	2.5	8	2.3	3	1.1	3	0.0	0

Although they were among the least commonly reported, experiences such as refusal of services (15.3%), sexual aggression (7.8%), and physical assault on receiving attention (4%) require special attention due to their seriousness. The same applies to sterilization without consent (1.9%; $n = 15$), a practice considered “a violation of the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment” (U.N. Human Rights Council 2013, p. 11), but until recently considered “an inevitable consequence of treatment” (Rowlands and Jean-Jacques 2018, p. 1); an example is the removal of healthy ovaries and uteruses in people with the biological capacity to gestate.

3.3. Health Personnel Associated with Abuse in Trans and Non-Binary Health Care

Although abuse in trans and non-binary health care must be understood in a broad cultural and structural framework, it is important to identify the health workers associated with the experiences of AHC reported, as this information will help identify the training and intervention priorities in the different services and specialisms in order to prevent new abusive incidents.

Nearly two-thirds of the sample (65.8%, $n = 512$) indicated with whom they had suffered the reported AHC experiences. Of those who gave this information, 57.6% declared having experienced some form of AHC by secretaries or receptionists, followed by psychologists (49.2%), nurses (41.4%), security personnel (35.7%), urologists or gynecologists

(37.1%), psychiatrists (35.7%), endocrinologists (35.4%), other users (31.4%), midwives (29.1%), surgeons (26.2%) and social workers (20.3%).

These percentages inform us of the experiences of AHC reported by the total sample that responded to this item ($n = 512$), which is why it is not sensitive to the different number of interactions that users had with different healthcare workers. It is, therefore, to be expected that the majority of the reported experiences were with secretaries and receptionists, as they mediate almost every visit to health facilities, unlike surgeons, for example, who are comparatively less frequently visited.

To further explore these results, a bivariate analysis was conducted in search of statistically significant ($p < 0.01$) and strong associations ($r > 0.10$) between the reported form of AHC experienced and the category of professional or health personnel identified as an agent. In Figure 1—made for illustrative purposes, based on the statistical information analyzed—the health personnel can be seen who were most likely to have engaged in the forms of AHC indicated at the origin of each arrow. For example, it is probable that when one of the participants in the sample was refused respect for their social name, it was by a psychologist or a nurse (in both cases, $p < 0.01$, $r = 0.24$), or that when a participant received gender-stereotypical comments, the health professional involved was an endocrinologist or a psychologist (in both cases, $p < 0.01$, $r = 0.29$).

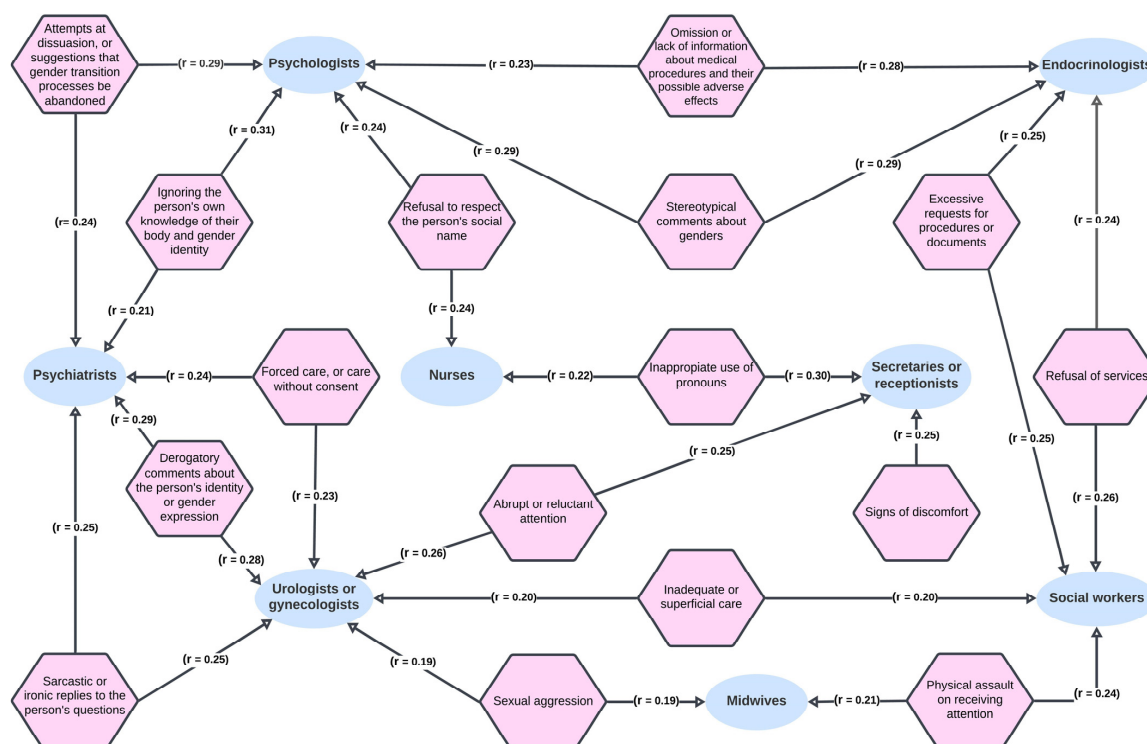


Figure 1. Illustration of statistically significant ($p < 0.01$) and strong associations ($r > 0.10$) between reported experiences of AHC and health personnel identified as probable agents. The figure does not include all of the forms of abuse in trans and non-binary health care included in the survey, or all of the health staff identified as responsible. This is because relationships that are significant in terms of the parameters used ($p < 0.1$, $r > 0.10$) were not found in every case. To identify the medical personnel who correlated significantly with each form of AHC, select a form of AHC (in pink) and look for the health personnel correlated at the end of each arrow. Conversely, to identify the forms of AHC correlated with each category of health agent, select the agent (in blue), and find the correlated form of AHC at the source of each arrow.

It is striking that mental health specialists (psychologist and psychiatrist) were among those professionals most likely to be mentioned when experiences of AHC were reported, with significant correlations on five of the experiences studied. They included attempts

at dissuasion, or suggestions that gender transition processes be abandoned; derogatory comments about the person's identity or gender expression, and sarcastic or ironic replies to their questions, all of which are experiences that not only may negatively affect the mental health of users but may drive them away from the health system altogether.

Urologists and gynecologists—combined in this survey to create a category relevant for all of the gender identities studied—stand out with the greatest number of significant correlations with reported experiences of AHC. They included, specifically, sarcastic or ironic replies to questions, derogatory comments about a person's identity or gender expression, forced care or care without consent, abrupt or reluctant attention, inadequate or superficial care, and sexual aggression. This last form of aggression was reported also in a statistically significant relationship with midwives, which also correlated with physical assault on receiving attention.

3.4. Responses to Experiences of Abuse in Trans and Non-Binary Health Care

In addition to identifying the AHC experienced by the TNB population and its correlations with different health agents, it is important to know how TNB people respond to these situations so that we can assess the impact that these experiences have on their access to health.

Three-quarters ($n = 576$) of the sample told us how they responded to experiences of abuse in trans and non-binary health care (see Figure 2). In percentage terms, the most frequent responses were to change healthcare professionals (33.3%), to stop seeking attention (30.2), and to change the place of medical attention (26.6%). It is noteworthy that, as a result of these experiences, almost a quarter of the respondents (24.5%) decided to stop presenting themselves as a trans or non-binary person in health facilities, 16% abandoned treatment, and only 8% filed a complaint about the situation.

In analyzing how people with different gender identities coped with experiences of AHC, we found that more than half of the gender-fluid population (51.5%)—27 percentage points above the sample as a whole, and 45 percentage points above their female gender peers—decided to start concealing their gender identity in healthcare contexts.

For the female population, the most frequent response to situations of AHC was to do nothing (29.5%), which is above the prevalence in the sample as a whole (21%). The most frequent response for the male population, as it was for the non-binary gender population, was to change healthcare professionals (31.2% and 40.8%, respectively).

When the analysis is disaggregated by health facility, for those who attend private centers, changing healthcare professionals emerges as the majority response (40.8%). To stop seeking attention, on the other hand, is the most frequent reaction to AHC among those who attended non-specialized public hospitals (34.1%) and gender-identity programs that are located in public centers in Chile (32%). It should be noted that, in these latter facilities, the tendency to abandon treatment due to experiences of AHC was lower (13.1%), comparing with 17.5% in private centers and 20.1% in public hospitals, although in these specialized facilities, it is also more common for people to respond by doing nothing (21.9%, compared to 17.1% and 19%, respectively).

The bivariate analysis showed a statistically significant relationship between having had most AHC experiences with endocrinologists or psychologists and responding to these situations by changing healthcare professionals ($p < 0.01$; $r = 232$). In contrast, for those who reported having most of these experiences with psychiatrists, the most common response was to abandon treatment ($p < 0.01$; $r = 259$).

The least usual way of responding to situations of AHC was to report them. Filing a complaint correlated significantly ($r > 0.11$) with refusal of services ($r = 0.211$), physical assault ($r = 0.144$) and excessive requests for procedures or documents ($r = 0.117$). Only 7.1% of the people who declared that they been sterilized without their consent reported it to authorities.

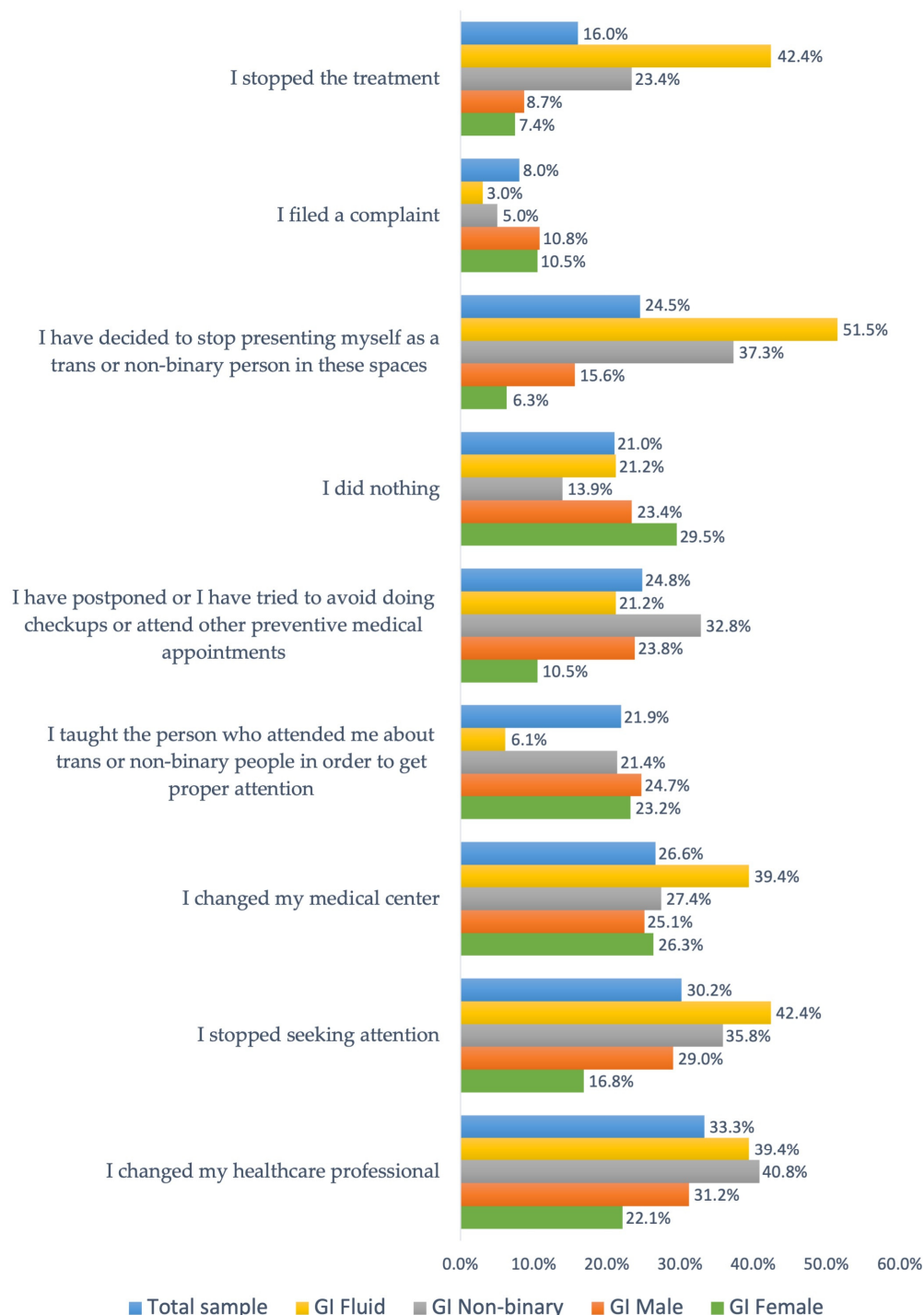


Figure 2. Responses to experiences of AHC by gender identity. GI = gender identity.

Changing healthcare professionals and changing health facilities, it should be noted, were correlated responses ($r = 0.527$), probably because a person who decides to change their healthcare professional would also decide to change the place of medical attention rather than seek attention from another member of the same institution. Moreover, it is likely ($p < 0.01$) that when individuals decide not to present themselves any longer as a trans or non-binary person, they will also decide to abandon treatment ($r = 0.313$) and postpone or avoid having medical checkups ($r = 0.302$).

4. Discussion

The results presented in this article show the main experiences of abuse in trans and non-binary health care in Chile. The study addresses attention for both general and specific health issues and includes public and private health services in the country.

First, it is striking that among the main reasons individuals gave for not seeking attention for the specific care needs related to their gender identity or expression were the experiences of violence that others, or they themselves, have had in health facilities. This finding reinforces international evidence that highlights fear of suffering abuse in healthcare spaces as a determining factor in this population's reluctance to seek medical attention (Namaste 2000; Risher et al. 2013; Seelman et al. 2017).

While international evidence estimates that perception of experiences of abuse in health care is about 8% for cisgender men and 20% for cisgender women (Brüggemann and Swahnberg 2013; Brüggemann et al. 2012), in the present research, 83.9% of the surveyed population declared that they had had some abusive experience in healthcare contexts. This shows that incidents of abuse in TNB health care in Chile are not exceptional but systematic, and that they require urgent attention.

The National Survey of Health, Sexuality and Gender (ENSSEX), carried out in Chile, reported that 5.4% of the country's total population claimed to have been sexually assaulted at some point in their lives (Ministerio de Salud Chile 2023), regardless of the public or private context in which the assault occurred. In light of this figure, it is alarming that 7.8% of the population that responded to the National Trans and Non-binary Health Survey stated that they had suffered sexual assault, solely considering their experiences in healthcare contexts. This percentage increases to 9.8% in the non-binary gender population, and 11.6% in the fluid-gender population. Although similar percentages have been previously reported by international studies (e.g., Grant et al. 2010), we now have this information for the first time in the Chilean context. This should alert our health authorities to the need for an urgent update of institutional protocols aimed at eradicating all types of sexual violence in health facilities, mainstreaming a gender perspective that explicitly incorporates the TNB population.

The same can be said about sterilization without consent, which was reported in healthcare spaces by 1.9% of the people surveyed. The unconsented loss of reproductive functions in the TNB population has been widely denounced in the international literature (e.g., Johnson and Finlayson 2016). In Chile, there is an obligation to inform the health authority of the existence of these practices, noting that "sterilization without adequate informed consent is an illegal practice (...) it is a violation of human rights, and it is the obligation of the state of Chile to prevent, punish, provide reparation, and a guarantee of non-repetition" ((Subsecretaría de Salud Pública (11/11/2022) 2022, p. 8)). However, only 7.1% of the people in the survey who alleged having suffered this type of practice reported it to authorities.

Coinciding with other studies in the area, the responses indicate that non-binary gender participants received more stereotypical and derogatory comments about their gender identities and expressions compared to their male and female gender peers. This finding underscores the importance of ensuring that health personnel training efforts incorporate gender variations beyond the male–female binomial. This is evident, above all, if we consider that concealing one's gender identity is the most common response to abuse among gender-fluid people (51.5%), and the second most common for non-binary gender people (37.3%), a response that could have a negative impact on preventive measures and the promotion of their general and specific health. This is especially so taking into account that concealing one's gender identity correlates significantly with two other responses that may reflect an expulsion from the health system: ceasing to go for medical checkups or even abandoning treatment.

Excessive requests for procedures or documents related to gender identity as a condition for attention stand out as a form of AHC mostly reported by those who identify with the male (30%) and female (24.8%) genders. This could be related to paternalistic

practices on the part of healthcare personnel, who often delay the start of hormone replacement therapy while waiting for sufficient tests to confirm the diagnosis of gender dysphoria (Finley 2020), a practice that contravenes the most recent WPATH Standards of Care guidelines (Coleman et al. 2022). It is essential that the flow of health care for TNB people be reviewed from a non-pathologizing perspective, incorporating the user population in the process of analysis, subsequent decision making and the permanent training of health personnel.

Associating different forms of abuse in TNB health care with the health personnel most likely to practice them provides useful information for the design of training and intervention programs in the area. The bivariate analysis showed a significant correlation ($p < 0.01$) between five of the reported AHC experiences and mental health professionals (psychologists and psychiatrists), and between 10 of the experiences studied and specialists in endocrinology, urology and gynecology. This should alert not only medical services and their linked authorities, but especially the universities that train these professionals, considering that, according to a study recently carried out in the north of the country, “84% [of doctors] never received any training on the topic in their university education, [and that] 96% were interested in receiving information about the topic” (Zapata Pizarro et al. 2021).

To abandon treatment is a decision that 16% of the survey participants reported taking in reaction to AHC events. Together with ceasing to seek attention, it was the second most common response reported by the gender-fluid population (42.4% in both cases). If we consider that the relevant literature has related this avoidance-based coping strategy with high levels of anxiety and depression (Budge et al. 2013), it is worrying that when the agents of these experiences are psychiatrists, it is even more probable that treatment will be abandoned. If we take into account the comparatively worse mental health indices reported for this population, including a high risk of suicide (Burgess et al. 2008; Barrientos 2016; Crissman et al. 2019; Fredriksen-Goldsen et al. 2014), we can see clearly why the international literature has insisted on the importance of training for all health personnel (Zwickl et al. 2019; Vupputuri et al. 2021; Hostetter et al. 2022) to halt the continued expulsion of TNB people from the health system (Reisner et al. 2015).

Turning to the intersection of these experiences with socioeconomic factors, we can see that those who have public health insurance—close to three quarters of the national population, traditionally those with lower incomes—prefer to stop seeking medical advice when faced by abuse in health care, while those with private insurance usually choose to change healthcare professionals. This is not only a stark reminder of the socioeconomic gap in access to health, but also highlights the importance of taking full account of differences in social position and axes of oppression in the analysis and construction of an equitable and violence-free health policy.

Limitations and Projections

There are some limitations to consider in this study. Regarding the sample distribution, the instrument’s online application (a methodological decision due to the mobility and physical contact restrictions associated with the COVID-19 pandemic) limited the participation of older people, many of whom are not digitally competent. Moreover, the relatively low representation in the sample of people with female gender identity could be due to a greater distribution of the questionnaire in social networks of people with male and non-binary identities, although it is not possible to know this with certainty. An important projection of the study, therefore, is to work specifically with these populations and thus obtain data that are more representative of their reality.

Another limitation of the study lies in the scope of the questionnaire and its analysis. The research team decided to design an ad hoc instrument that would allow a descriptive exploration of a reality about which the existing data were scarce and, in several aspects, non-existent in the country. To this end, we consulted the opinions of experts, including people from the TNB community, in evaluating the relevance and quality of the contents. Considering the instrument’s innovative nature—both for its subject matter and its national

coverage—future statistical tests to validate the different sections and items through a factorial analysis of their main components would be an important contribution to achieving more complex and explanatory models.

Finally, it is important to remember that the study was based exclusively on the participants' perceptions. An understanding of this problem and its impact on relevant public policies and interventions would benefit from research that also approaches the perceptions of health personnel regarding these experiences in which they find themselves involved. Furthermore, qualitative studies that deepen our knowledge of the meanings associated with these experiences, and their relationship with the health and daily life of TNB people, stand out as a priority.

5. Conclusions

The systematic experiences of AHC against the TNB population are a public health problem that must be urgently addressed. In this article, we have made use of the concept of *abuse in trans and non-binary health care* to draw attention to the dehumanizing and exclusionary nature of these experiences, and to emphasize their roots in the structural, productive and oppressive dynamics of the gender regime. Rather than personalizing or psychologizing experiences of AHC, this approach involves understanding them as part of a gender-science-culture system that potentiates and reproduces them, based on the stigmatization and social erasure of TNB people. To address the complexity of this phenomenon, a relational gender perspective must be adopted that takes into consideration the multiple agents and institutions involved. Hopefully, by considering the relationship between specific forms of AHC, the health personnel involved, and how users respond, the findings of this article may serve in the development of interventions, training and protocols that protect TNB people from further abusive events.

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