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Dissident Genders: Intersectionality and Assistance in Healthcare Networks

Genres dissidents : intersectionnalité et assistance dans les réseaux de la santé

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Keywords

gender identity; sexuality; gender diversity; intersectional framework

Abstract

Introduction: The persistence of a cisgender binary structure continues to marginalize individuals whose identities fall outside normative gender categories. Understanding the perspectives of gender-dissident individuals is necessary for creating health environments that uphold respect and dignity in care for people of all genders. **Objectives**: To analyze the perspectives of dissident genders on care and to understand their perception of the professional approach in healthcare networks. **Method**: This cross-sectional qualitative study employed a subject-partner methodological approach, grounded in the theoretical frameworks of Akotirene, Butler and Preciado. Data were collected through 2 virtual focus groups with gender-dissident participants and through field diaries involving the subject-partner. The data were analyzed using Minayo's content analysis methodology. **Results**: Three thematic dimensions of meaning emerged: 1) Being-itself, capturing experiences of identity, recognition, and the challenges of existing in a cisnormative world; 2) Care structuring from-in the Unified Health System, highlighting how professional beliefs and institutional norms restrict access, humanization, and continuity of care; and 3) Strategies for advancement, emphasizing inclusive practices, representativeness, and the need for structural and educational change. **Discussion and Conclusion**: Experiencing care within healthcare networks remains marked by inconsistent recognition of gender identity. Inclusive care requires subverting cisnormative values, strengthening professional education, and promoting active participation of gender-dissident people. The subject-partner framework underscores their role as co-constructors of knowledge and care.

Mots-clés

identité de genre; sexualité; diversité des genres; cadre intersectionnel

Résumé

Introduction : La structure binaire cisgenre ne permet pas la reconnaissance de sujets aux genres dissidents. Mieux comprendre les perspectives de ces personnes est indispensable afin de créer des environnements de santé garantissant le respect et la dignité de tous les genres dans les soins. **Objectifs** : Analyser la perspective des personnes aux genres dissidents sur les soins et comprendre leur perception de l'approche professionnelle dans les réseaux de santé. **Méthode** : Il s'agit d'une étude transversale qualitative, adoptant une approche méthodologique du sujet-partenaire, fondée sur les cadres théoriques de Akotirene, Butler et Preciado. Les données ont été recueillies à travers 2 groupes focalisés virtuels avec des personnes de genres dissidents et par des journaux de terrain impliquant le sujet-partenaire. Les données produites ont été analysées selon la méthodologie d'analyse de contenu de Minayo. **Résultats** : Trois catégories thématiques ont émergé : 1) l'Être-soi; 2) la structuration des soins au sein du système (public) de santé unifié brésilien et les 3) stratégies d'avancement. Dans une perspective intersectionnelle, l'existence et l'usage du nom social (choisi par la personne) ont un impact direct sur l'assistance et l'accès aux soins : les données ont indiqué l'existence d'archétypes violents et de préjugés. **Discussion et conclusion** : Cette étude fait ressortir des expériences de soins vécues par les personnes aux genres dissidents, en reconnaissant que l'irrespect demeure un défi sociétal également présent dans le champ de la santé. Des recherches supplémentaires sont nécessaires pour promouvoir la reconnaissance des individus comme sujet à part entière, en particulier ceux aux genres dissidents.

INTRODUCTION

Discussions on gender have recently gained prominence and visibility in both social and academic spheres. These debates are deeply informed by the evolution of human rights and have been driven primarily by studies and movements concerning women's rights and those of social minorities (Green et al., 2018; Preciado, 2022). In this context, the pursuit of guaranteed rights and a sense of belonging underscore the importance of understanding how the subjects relate to their gender identity (Brasil, 2015).

Gender identity is the way subjects recognize and position themselves in society. It is closed linked to the meanings and relationships that society ascribes to gender. This concept rests on the understanding that gender is a social construction, and that gender identity reflects the individual's intrapersonal perception and performative experience of being and existing within socially constructed relations (Butler, 1990).

Preciado conceptualizes dissident genders as individuals who identify themselves outside the cisgender binary, critiquing the model that links biological sex to gender (Preciado, 2008).

Gender diversity has undergone several transformations throughout history, including its declassification as a disease (Cano-Prais et al., 2021). This shift has ensured that gender-diverse population is included in discussions of public policies allowing them to exercise rights guaranteed by law (Preciado, 2019), such as spaces of education, healthcare, and social assistance, thereby fostering visibility and recognition for social minority groups.

The reduction of gender to biological sex remains pervasive, and many spaces continue to be structured according to a dualistic-gender model. This is evident in environments and initiatives such as gender-segregated toilets, gynecology offices, vaccinations targeted specifically at girls, "Pink October, Blue November", and women's healthcare programs (Preciado, 2019; Rocon et al., 2016). These are only a few illustrative examples that expose how the trivialization of gender diversity persists, rendering invisible the care needs of individuals who do not identify within the man/woman or boy/girl binary scheme.

In 2011, Brazil established the National Comprehensive Health Policy for Lesbians, Gays, Bisexuals, Transvestites and Transsexuals, which outlines a series of strategies and guidelines aimed at assuring care for lesbians, gays, bisexuals, transvestites and transsexuals, queer, intersex, asexual, pansexual, non-binary and other gender identities or sexual orientations (LGBTQIAPN+) (Brasil, 2013). This policy is integrated into the broader framework of the Brazilian healthcare networks (HCN).

The HCNs constitute organizational models within the structure of the Brazilian public Unified Health System (SUS), designed to promote the decentralization of care and to strengthen coordination among services with varying technological complexities. Within this model, health services are conceived as complementary, encompassing a continuum from primary care to specialized and high complexity hospital care (Brasil, 2010). However, the persistence of fragmented lines of care and the disarticulation between this policy and other health initiatives continue to pose challenges for its effective integration into the daily work process of health professionals and services (Costa-Val et al., 2022).

The fragmentation of care and the limited integration of policies underscore the need for analytical frameworks that account for how structural inequalities intersect within healthcare systems. For this confrontation with health inequity, the intersectionality, as a theoretical and methodological framework, offers a valuable approach for fostering critical and nuanced analysis of populations experiencing social marginalization and/or deprivation of guaranteed rights (Akotirene, 2022; Andrade, 2023; Bolissian et al., 2023).

Within the healthcare field, an intersectional perspective enables the implementation of care practices responsive to the specific needs of people with dissident gender identities, by promoting an understanding and provision of care that is sensitive to their lived experiences. Furthermore, intersectionality supports political advancement in the development of legislation,

programs and public policies aimed at safeguarding these rights (Nogueira et al., 2021).

From this perspective, it becomes pertinent to examine how individuals who self-identify as dissident genders perceive and experience healthcare within Brazil's integrated health networks, as well as the facilitators and barriers influencing their access to these services. This issue is embedded in the broader debate on the persistence of dualistic, cisnormative healthcare practices that continue to render dissident gender identities invisible, despite the existence of public policies aimed at guaranteeing their rights. By situating the study within this tension, this study aims to contribute to the visibility of these populations and to highlight structural and relational barriers that hinder equitable access to healthcare.

Thus, the central research question of this study is: "How do individuals of dissident genders perceive healthcare provision within healthcare networks, and how do they interpret the professional approaches they encounter during care?"

Objectives

The objectives of this study are to analyze the perspectives of dissident genders on care and to understand their perception of the professional approach in healthcare networks.

Method

Design

This cross-sectional, exploratory study adopts a qualitative approach and is structured according to the assumptions of the patient-partner methodological framework (Karazivan et al. 2015; Pomey et al., 2015), here adapted as a "subject-partner" framework. The theoretical foundations guiding the study's conceptualization draw on the works of Carla Akotirene, Judith Butler, and Paul B. Preciado.

The use of the subject-partner emphasizes the participant's active role. As such, protagonism means that the subject partner or participant is active and has a central position within the study, shifting from a passive role to one of a subject within scientific research; thus, acknowledging their lived experiences, including (self)care practices. This semantics aligns the notion of "partner" more closely with the subject situated within their social and existential context – an individual experiencing the phenomenon under study (Smith et al., 2019). Within the Brazilian context of the SUS and its integrative perspective of health, understood as extending beyond the absence of the disease, this adaptation is particularly pertinent for individuals who self-identify with dissident gender identities, as it fosters a more inclusive and situated approach.

Furthermore, the notion of "subject-partner" is inspired by the concepts of intersectionality (Akotirene, 2022), recognizing the need to move beyond conceiving gender identity as a mere health determinant and toward understanding it as a social and relational determination, shaped by socio-anthropological processes. The experiential orientation of the subject-partner approach also draws on participatory research methodologies, aiming to position the subject as an active agent in the research process.

Participants

Individuals who met the inclusion criteria – identifying as dissident genders and being at least 14 years old at the time of recruitment – were included in the study. The inclusion of adolescents was justified by the need to foster dialogue on gender and sexuality during adolescence, acknowledging that these topics are often met with resistance or stigmatization at this stage of life (Baams & Kaufman, 2023).

Participants were recruited using the snowball technique (Kirchherr & Charles, 2018), initiated through two seeds selected from the principal researcher's network.

Procedure

The meeting with the subject-partner (pseudonym Uirapuru) was conducted virtually via Google Meet. Uirapuru self-identifies as a 17-year-old trans man. During the meeting, he was introduced to the study's objectives and contributed significantly by formulating the focus group's trigger question, advising on care and

sensitivity in facilitating discussions and assisting in participant recruitment. Detailed notes from this meeting were recorded in a field diary. A second meeting was attempted with a second subject-partner, who subsequently declined participation after the initial contact.

The contributions of the subject-partner to this study included the adaptation of language to effectively facilitate focus groups; the practice of attentive and empathetic listening, ensuring that the focus groups function within a framework of care and support in addition to data collection; and the grounding of the focus group's facilitation in a sensitive, person-centered approach toward individuals with dissident gender identities, acknowledging the recurrent experiences of violence faced by this population in society. The subject-partner did not actively participate in the subsequent phases of the study, such as data analysis and discussion, due to challenges in maintaining consistent communication between the researcher and Uirapuru.

The focus groups were conducted following the group strategies proposed by Bauer and Gaskell (2002). Sessions were held virtually via Google Meet, according to the participants' preferences and availabilities. The discussions began with the following trigger question: "What do you think of your healthcare at the units?" Based on this initial prompt, the conversation evolved through the participants' own responses and reflections. The researcher assumed the role of mediator, fostering dialogue and strengthening the relational dynamics among participants around the central question.

After the discussion of the first guiding question was completed, two additional questions were posed sequentially, following the same format as the initial one: "What care do you think is fundamental when you arrive at the health service for care?" "What question do you consider fundamental when receiving care in a health service?"

The focus groups were audio-recorded with the participants' consent, and a field diary was used to document the researcher's observations and reflections during the discussions.

DATA ANALYSIS

All recordings were fully transcribed, and participants' confidentiality was strictly maintained. The data obtained was analyzed using the content analysis framework proposed by Minayo (2012).

The analysis was conducted through a comprehensive reading of the full focus group transcripts, followed by the identification and extraction of singular subjective elements referred to as units of meaning (UM). These UM were directly related to the study's objectives and were identified through participants' statements during the sessions. The UM were then organized and examined in dept to explore their relationships, similarities and divergences. This process of categorical organization led to interpretative and analytical synthesis, culminating in the development of three thematic categories (Minayo, 2012).

Data collection took place between November 2022 and April 2023, encompassing the meeting with the subject-partner and the focus groups. Data analysis occurred concurrently and extended until December 2023.

ETHICAL CONSIDERATIONS

The project adhered to the ethical principles and standards established by Resolutions 466 of 2012 and 510 of 2016 as well as the recommendations of Circular Letter No.001 of 2021 issued by the Brazilian National Research Ethics Committee. The study was approved by the Research Ethics Committee of Federal University of State of Rio de Janeiro (Opinion No. 5.736.848), and an amendment was subsequently approved (Opinion No. 6.016.242). Before taking part in the study, each participant provided informed consent electronically via a digital platform hosted on Google Forms platform. To ensure confidentiality, the procedure used for the subject-partner was extended to all participants, with pseudonyms drawn from Brazilian folklore. This choice reflects an effort to honor national cultural traditions while recognizing gender and sexuality identifications as socially and regionally situated constructs.

RESULTS

CHARACTERISTICS OF THE PARTICIPANTS

The participants were four trans men, one trans woman, and one non-binary person. In terms of gender and sexual identity, two identified as heterosexual, one as bisexual, one as pansexual, one as polysexual, and one as attracted to men. Their ages ranged from 28 to 37 years, and all resided in the state of São Paulo, Brazil.

Four participants identified as white and two as brown, according to the classification used in the Brazilian national census. Regarding education, two held postgraduate degrees, one had incomplete undergraduate studies, two had completed professional technical courses, and one had completed high school. Employment status also varied: one participant was unemployed, two were self-employed, two held formal employment registered in the Brazilian labor system, and one worked under a formal contract. Income levels were classified according to the monthly minimum wage in effect at the time of data collection (R$ 1,302.00; approximately US $253). Two participants reported earning between zero and one minimum wage, two between one and two, and two more than four minimum wages. As for housing, three lived alone, two lived with family members, and one lived with her mother.

In terms of healthcare service utilization, one participant reported using services weekly, one monthly, three every two months, and one less than once a year. The services accessed included primary healthcare units, Specialized Care Services for Sexually Transmitted Infections/AIDS, Testing and Counselling Centres (TCC), emergency departments, and specialty clinics such as gynecology, endocrinology, and psychiatry. Participants also mentioned accessing psychological or mental health care, vaccination and hormone administration, and, in some cases, private or insurance-based healthcare services.

ANALYSIS AND THEMATIC FINDINGS

Anchored in the subject-partner framework, data interpretive analysis recognized participants as agents whose lived experiences articulate tensions between identity, care, and social structures. Drawing on the works of Carla Akotirene, Judith Butler, and Paul B. Preciado, three thematic categories were established to capture these dimensions of meaning: 1) Being-itself; 2) Care structuring from-in the SUS; and 3) Strategies for advancement.

1) Being-Itself

The first thematic category emerged from participants' accounts related to identity, the experience of being oneself in society, and the challenges encountered in social interactions, including forms of violence associated with self-expression. These dynamics were also reflected in participants' experiences within SUS health units and their services. The use of the "social name" appeared as a central element in this category, as it affirms and legitimizes the person's existence. As expressed by Boto, this recognition through the social name represents a fundamental dimension of visibility and respect:

> [...] because for many people the name, we know how it is, for a cis person the name is almost nothing, for us, it's everything. The first time they called you Saci, you almost fainted. I almost died when someone looked at me and said 'Boto'. I got a bit airborne.

The study participants reflected on how the subjects present themselves and perform their identities in society. "Passability", the extent to which one is recognized as their expressed gender, was described as a marker of social legitimacy, often determining whether one's existence and dignity are respected. When this recognition is uncertain or ambiguous, the risks of violence and the denial of gender identity increase. As Cuca explained:

> But, for example, if you, and I think it happens a lot with non-binary people, if you happen to express that you are of a non-binary gender or are a trans man or trans woman and your passability doesn't exist, transphobia is inevitable, it is unavoidable and convinced, it will happen.

Collective construction processes and subjective perceptions shape the social reading of gender, making it necessary for people of non-binary or gender-dissident identities to position

themselves socially. Society maintains an idealized representation of gender, and for individuals, gender technologies, such as the use of hormones or gendered expressions of appearance, can paradoxically reinforce binary markers rather than dismantle them. As Boitatá expressed:

> [...] However, when you are a non-binary person, people will often not even know you are non-binary because of how you look, you know? If you do not say it. So, they will treat you like a cis person, so you are read as cis.

According to the participants, passability can confer certain privileges within a binary gender culture, like those experienced by the cisgender population has. As Iara reflected: "[...] On the other hand, I feel that […] my privileges are a difference in treatment compared to other[s] […] waiting to be seen or asking for information [because I] hav[e] a cisgender expression."

Participants further reported feelings of erasure and invisibility experienced by those who diverge from cis-normative gender expectations. Such experiences raise serious concerns about their effects on both the will to live and the capacity to inhabit social spaces in an authentic manner. As noted in the field diary: "Uirapuru talks about the importance of the study for understanding the impact on conservative families, and that through this research, we can sensitize these families, recalling his own family, which has acted and continues to act conservatively towards him."

2) Care Structuring From-In the SUS

In this category, it was observed that care continues to be structured around a binary framework of health production. This framework operates as a structural mechanism that sustains conservative practices within health institutions and influences how professionals deliver care.

The provocative title of this category is therefore justified, as SUS policies are expected to promote equity and inclusiveness in healthcare. Participants frequently reported positive experiences of respectful and adequate care, emphasizing moments of genuine recognition and support. Within healthcare services, the transexualizing process and gender-affirming hormone therapy emerged as central elements in this category. As Saci described: "[...] The reception I received was excellent. She told me everything I had to do, gave me all the prescriptions, and brought all the medicines." However, participants also pointed to persistent barriers in accessing gender-affirming hormone therapy and the transsexualizing process, such as long delays, the need to resort to private services or illegal markets, discontinuity of care, and the trivialization of gender-related care by professionals. As Boitatá explained:

> But, for example, a person comes in [with] diabetes […] to get medicine […] and a trans woman comes in wanting gender-affirming hormone therapy... people will trivialize it because they'll think that hormone therapy is cool […] 'oh, people are dying here, and you want to take hormones', like, who cares?

Furthermore, the data revealed the need for dissident gender bodies to be both recognized and cared for within healthcare facilities. Participants also emphasized the importance of access to care specific to gender and sexual relations. Mental health emerged as a crucial dimension in ensuring comprehensive care for individuals of dissident genders, while other care specialties were also identified as essential to guarantee holistic attention for their health needs. As Saci mentioned: "[...] how the hormone acts in your body, if you can take that hormone dose. You're taking the hormone, but what about your psychological state? Is it good for you?" Similarly, Cuca highlighted the scarcity of specialized services: "I sometimes miss the services that we list within these trans issues, the endocrinologist, gynecologist, proctologist, urologist, in short, sometimes a psychiatrist, because there are people who need it."

Participants' statements highlighted the lack of professional preparation and training for engaging with gender-dissident people within the HCN, particularly the absence of humanization in care. As Iara observed: "I feel, in general, that care is precarious." Cuca added: "So, as well as being very limited, sometimes it is very inhumane." Boto emphasized the need for greater empathy among professionals: "People should be a little more sensitive because it is the health sector." Boitatá further illustrated how this lack of sensitivity

manifests from the very first point of contact: “I think the care we have already talked about, treating you with respect and in a humanized way because occasionally, you have not even entered the hospital yet, and the security guard already looks at you sideways, understand?”

3) Strategies for Advancement

This thematic category encompasses strategies for advancing towards more inclusive care. However, it also raises the question of whether these strategies are embedded within the structure of the SUS and public health policies or depend primarily on the personal initiative and sensitivity of individual professionals.

Findings indicate that empathy and attentiveness to the person are fundamental to ensuring appropriate care. For instance, asking questions directly to users during consultations fosters inclusivity, as it bases clinical judgment on users’ own perceptions and needs rather than on professional assumptions — including their identification with specific health services or equipment. Participants also suggested structural measures to support inclusivity. Saci proposed, for example, the use of a written questionnaire that allows individuals to self-identify without having to do so verbally: “So, there are certain things you must have. I think there should be a questionnaire if you’re non-binary or if you’re a man... You don’t need the person to ask you.”

Some participants emphasized that continuing education and open dialogue could help dismantle taboos rooted in conservative and prejudiced models of social interaction. As Iara explained:

> [...] while we do permanent education in the services on various topics, and this is still a topic that people debate very little. And there’s a lot of resistance, even when there are moments of debate; in short, they maintain their prejudiced positions.

Cuca also underscored the importance of institutional engagement: “And you need management to engage in this dialogue, this construction. [...] there needs to be this dialogue between the specialized service unit’s management and the unit’s coordinator.”

Participants in this study highlighted not only the responsibility of supervisors and managers but also that of policymakers in advancing inclusive and equitable practices. They pointed out that financial investments and governmental commitment are decisive factors that can either enable or hinder progress in the care of gender-dissident populations. On the other hand, participants highlighted the importance of collective engagement among gender-dissident populations, particularly through participation in management and decision-making councils. The presence of dissident gender individuals within professional teams, referred to by participants as representativeness, was also emphasized as a key means of advancing inclusive care. As Boto reflected:

> I was on the management board of the TCC for four years. [...] But I also feel that it’s not just the system itself, I think that sometimes we’re so disunited that I don’t think the users themselves go for it.

Boitatá further emphasized the significance of representation within healthcare teams: “It’s representation. If there’s a trans doctor, a trans receptionist, the whole team will think more about it, they’ll worry more about it.”

DISCUSSION

“One day / I lived the illusion that being a man would be enough / That the male world would give me everything / I wanted to have / but no / My feminine side, which until then had been kept hidden / Is the best part of me now / It’s the part that makes me live”. (Excerpt from “Super-Homem (A Canção)” by Gilberto Gil, translated from Portuguese released on the singer-songwriter’s 1979 album).

Gilberto Gil’s “Super-Homem (A Canção)” (1979) marked a symbolic rupture with the moral and civil constraints imposed by Brazil’s military dictatorship. By revisiting his own masculinity, Gil revealed the life-giving force of his feminine side, challenging the patriarchal binary that defined existence and recognition.

This same search for authenticity resonates today in the experiences of gender-dissident individuals who must continually affirm their existence within a cisnormative world (Araújo, 2018). The findings of this study, particularly within the category "Being-itself," echo Gil's reflection: the affirmation of gender identity constitutes an existential and ethical act. It expands the boundaries of binary conceptions of gender, underscoring that while gender is socially produced and regulated, its lived enactment remains deeply personal, relational, and situated (Lima et al., 2023).

Our findings confirm, however, that within the context of the SUS, this self-affirmation encounters structural and professional barriers. The transexualizing process—a form of care that should be guaranteed as a right—continues to be constrained by biomedical paradigms that pathologize gender diversity (Rocon et al., 2020). Health professionals frequently resist using social names or appropriate pronouns (Gomes et al., 2022; Rocon et al., 2022), reproducing forms of symbolic violence that restrict access to care. Moreover, our findings reaffirm that prejudice and limited training remain pervasive. As noted by Paiva et al. (2023), this situation is particularly evident in nursing—the largest professional group in the sector—while health facilities often lack preparedness to welcome gender-diverse users. Even among children and adolescents, insufficient knowledge and presumptions about sexuality persist as barriers to inclusive care (Silveira et al., 2025). A study by Thomazi et al. (2022) on the implementation of an outpatient clinic for transgender people found that experiences of discomfort and implicit violence—such as staring and prejudgment—often lead individuals to prefer remote or virtual forms of care.

These practices exemplify how biopower—defined by Foucault (1978) as the institutional regulation of bodies and identities through everyday norms and professional conduct—operates in healthcare settings, transforming them into spaces where recognition is continually negotiated or denied.

The persistence of these patterns highlights the need for epistemic and structural transformation. Although removing transphobic diagnostic categories from the ICD-11 represents meaningful progress, biomedical reform alone does not ensure that healthcare practices genuinely embrace diversity (Gomes et al., 2018). Inclusive care requires professionals capable of dialogical engagement—recognizing the subject-partner as a co-constructor of knowledge and of care itself. Strengthening professional education to include intersectional and gender-sensitive content (Negreiros et al., 2019), ensuring representativeness within health teams, and fostering the active participation of gender-dissident individuals in decision-making spaces (Bezerra et al., 2021) are central to this transformation. Such actions move beyond tolerance toward relational ethics, deconstructing the prejudiced archetypes that sustain exclusion and re-signifying care as an encounter between autonomous subjects. In this sense, the participants' desire to build inclusive spaces of care mirrors Gil's poetic insight: the part of ourselves that has long been hidden—our capacity for empathy, plurality, and relational understanding—is precisely what allows us, both as professionals and as a society, to live.

LIMITATIONS AND STRENGTHS OF THE STUDY

Although the findings accurately reflect participants' perceptions of care in the HCN, the small sample size limits the generalizability of the results. This limitation seems closely linked to the challenges of raising awareness and fostering engagement between gender-dissident populations and academic research settings. Nonetheless, the use of the "subject-partner" framework represents a key strength of this study, as it recognizes and values gender-dissident individuals as active agents in the research process, mirroring their leading role in affirming their own gender identities.

CONCLUSION

Through an analysis of how gender-dissident individuals perceive professional approaches to care, this study found that experiencing care in the HCN as a person of a dissident gender remains challenging, marked by inconsistent recognition

and respect for identity. Three key dimensions of meaning: Being-itself, Care structuring from-in the SUS, and Strategies for advancement—reveal that professional beliefs and institutional structures continue to reproduce binary norms, thereby constraining the transformative potential of care. Advancing inclusive practices therefore requires subverting cisnormative values, strengthening professional education, and ensuring the active participation of gender-dissident people in health governance. This study, which adopts the subject-partner framework, not only sheds light on the lived experiences of those challenging gender norms but also affirms their role as co-creators of knowledge and as agents of change in healthcare.

Authors' contribution: EA and ATN designed the study, supervised data collection, collected and analyzed the data, drafted the methods as well as the introduction and the literature review. All three authors revised and organized the article, prepared the first draft and approved the final version of the manuscript.

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