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Looking at Resilience among Transgender and Gender Diverse People in Portugal: Gender Affirmation Paths and Parenting Aspirations

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Abstract: The transgender and gender diverse (TGGD) population is highly diverse. To date, research on the association of the various family–parenthood aspirations of TGGD people with distinct affirming paths and identities remains scarce. A survey was conducted aiming to characterize the TGGD population's diversity and socio-demographic profile. A community-based convenience sample of 115 self-identified TGGD adults living in Portugal was collected. Most of the participants (69%) did not have any children, 10% had children of their own, and about 20% did not have children in the present but reported their intensions to have children in the future. The results were discussed, highlighting the heterogeneity found in terms of sociodemographic characteristics, gender identification, and gender affirmation pathways (social, legal, and medical), with a focus on the participants' parenthood aspirations. The under- or non-representation of transgender individuals in population surveys, such as demographic and health surveys, is a barrier to understanding the social determinants and health disparities faced by this population.

Keywords: transgender and gender diverse (TGGD) people; resilience; mental health; sexual and reproductive health (SRH); parenthood aspirations

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1. Introduction

In recent years, the Transgender and Gender Diverse (TGGD) population has been the focus of an increasing volume of studies. Recognizing that TGGD people are a highly stigmatized population, the minority stress model has been vastly used to investigate and understand the significant repercussions of the experience of stigma and discrimination on mental health (Chodzen et al. 2019; Inderbinen et al. 2021; Scandurra et al. 2018). A recent systematic review of the literature (Pinna et al. 2022) examined 165 studies on the mental health of TGGD people, signaling a significantly higher prevalence of mental health disorders amongst these individuals than the general population or cis-gender peers. Depression and anxiety, trauma and stress-related disorders, eating disorders, self-harming behaviors, substance use problems, personality disorders, and autism spectrum disorders have all been documented at higher rates (see Pinna et al. 2022). Experiences of interpersonal violence (such as intimate partner violence and sexual violence), physical and verbal abuse, exposure to discrimination, social isolation, poor peer relations, low self-esteem, and body dissatisfaction, to name a few, have all been identified as risk factors (Peitzmeier et al. 2020; Tankersley et al. 2021).

Fewer studies, however, have addressed the extraordinary resilience of TGGD people in the face of such adverse conditions and the way that they are disproportionately affected by discrimination and violence. Protective factors have been identified by some authors. For instance, for adolescents, these factors have included self-esteem, parent connectedness, peer/social support, school safety and belonging, gay–straight alliances, and the ability to use one's chosen name (Johns et al. 2018; Russell et al. 2018; Tankersley et al. 2021). Gender affirmation (social, legal, medical) has also been found to be a powerful promoter of mental health (Fontanari et al. 2020; Reardon 2019), as engaging in gender affirmation processes has been found to help youth and young adults in developing a sense of pride and positivity about their identities. Robust evidence has been found for the role of social connectedness, peer support (Puckett et al. 2019) and trans community connection (Inderbinen et al. 2021; Sherman et al. 2020) in well-being and its predictors (Puckett et al. 2019).

In sum, the literature on the TGGD population has been growing and is extensive in documenting the adverse conditions, at the individual, group/social, and community/systemic/structural levels, that people face, and the negative consequences of stigma, prejudice, and discrimination on health and well-being. This perspective may be associated with the historical pathologization of the experiences of transgender individuals (Alcaire 2015), and a focus on trauma and distress. However, the literature on resilience, coping, self-determination, and positive adjustment, is more scarce; this includes studies on valued life goals, such as family and parenthood, i.e., relational and parenting aspirations. The recent literature has started to unveil the construct of transgender positive identity (Riggle and Mohr 2015; Riggle et al. 2011; Taube and Mussap 2020). These authors have identified the authenticity and congruency of self, intimacy, and personal growth and resilience as some of the factors that contribute to a positive transgender identity.

Studies on transgender-parent families and parenting aspirations have revealed their motivations and parental intentions as a part of personal growth, but have also revealed the diverse impacts of systemic discrimination contexts (see Downing 2013). Indeed, the sexual and reproductive health (SRH) of people or groups who are socially and economically marginalized, because of systemic and interpersonal discrimination, has received little attention and has been understudied (Agénor et al. 2021). Importantly, this is the case for TGGD individuals, who face multidimensional barriers to reproductive health and rights (Rodriguez-Wallberg et al. 2022), and may have less access to quality SRH care and specialized services (Lunde et al. 2021; Pezaro et al. 2023). Hormonal treatments and surgical interventions may take place in the medical gender-affirming processes of TGGD adults and impact their ability to have children and be involved in family planning options (Rodriguez-Wallberg et al. 2022). International guidelines (such as the American Psychological Association 2015; and the World Professional Association for Transgender Health; WPATH; Coleman et al. 2022) indicate that practitioners are required to discuss the potential risks of infertility in gender-affirming treatments and to present fertility preservation options to TGGD and their families prior to initiating any of these treatments. Research evidence (review by Agénor et al. 2021) has indicated, however, that TGGD people experience "notable barriers to achieving their fertility intentions and desires, due to a lack of access to reproductive health services, including fertility preservation, reproduction assistance, pregnancy-related care, and contraception, that addressed their unique and specific needs" (pp. 7–8). Nonetheless, in different countries, many TGGD people express their desire to be parents (Auer et al. 2018; Germany), or have shared their experiences of pregnancy and parenthood (Charter et al. 2018; Australia). Both aspirations for parenthood, and the challenges experienced in infertility preservation and treatments, have been documented in the Portuguese context (Capela et al. 2021).

In Portugal, where the present study was conducted, legislation on legal gender recognition was non-existent before 2011. Transgender people wishing to change their official documents had to sue the State in a judicial process, which resulted in a long process. Furthermore, several requirements were imposed in court, including proof of sterilization and childlessness, proof of "completed" hormonal and surgical procedures,

including genital surgery, and divorce, among others. A study explored the experiences of the transition process in the context of health care services at that time in Portugal, and identified some positive aspects, negative experiences and challenges, and some diverse paradoxes (Carvalho 2010). As this process violated Yogyakarta Principles and the Recommendations of the Commissioner for Human Rights of the Council of Europe (see Costa-Santos and Madeira 1996), in 2011 a new administrative process was established for TGGD individuals who are 18 years old or older. Legal gender recognition was granted in 8 days and (only) required the presentation of a document attesting to a clinical diagnosis of "gender identity disorder" in a Civil Registry, supported by a sexology team of clinicians comprising at least one physician and one clinical psychologist. Finally, after a 5-year-long study of the implementation and impact of the 7/2011 law (Moleiro and Pinto 2020), and there being many critics of the implicit pathologization of identities and the law's gatekeeping practices (Hilario 2018), in 2018, a new law (38/2018) entered into force, recognizing the right to self-determination of TGGD people over 16 years old, granting legal protection to gender identity and expression, permitting social transition among children and youth, and establishing the right to bodily integrity for intersex babies and children. This paradigm shift has allowed the practitioners to increase their endorsement of a social model and has opened "space for trans people to be treated as experts of their bodies and identities" (Hilário 2019, p. 463). The current legal and contextual situation in Portugal, given its recent changes, provides a unique opportunity within Southern European countries—which have been understudied contexts— in order to investigate the experiences and aspirations of diverse TGGD individuals. Notably, a recent systematic research and narrative review (Moleiro et al. 2022), which mapped transgender studies in Portugal, identified the main thematic areas investigated in the last 20 years, namely, gender trajectories and identities, clinical diagnosis and classification systems, stigma and discrimination, social and legal frameworks, HIV-related risk factor and STDs, and gender affirmation surgeries. While most papers focused on distress and treatment aspects, the perspective of well-being and development was present in a couple of studies in the thematic category of gender trajectories and identities. These included qualitative studies on the experiences of trans youth (Hilario and Marques 2020), gender diversity in infancy and in the school context (Saleiro 2017), trajectories of recognition and coming to terms with gender identity/ies (Pinto and Moleiro 2015), and the parenthood intentions of trans and non-binary people (Marinho et al. 2021). The latter work is in line with a critical turn in discussing sex and gender, as well as in relationship diversity; this is consistent with the paradigm of queer relationship diversity and intimacies proposed by Hammack et al. (2019), and relational citizenship by Santos (2019).

This study aimed to characterize a sample of Portuguese TGGD individuals and to describe their diverse family–parenthood aspirations. Moreover, we aimed to explore the association of these aspirations with diverse affirming paths and identities. Ultimately, this study seeks to contribute to the understanding of gender in a fluid and multidimensional concept, which includes the parenthood aspirations of TGGD persons.

2. Materials and Methods

As part of the international project "Health and citizenship among trans populations", already implemented in France, Italy, Brazil, Chile and Norway, and others, the Portuguese study aimed to contribute information on the health of TGGD people in Portugal through the implementation of a nationwide survey. A mapping of the relevant stakeholders in Portugal was made, to involve them in the distinct stages of the research.

2.1. Sample

A total of 115 persons participated in the survey. Of those, 64 had been assigned female at birth and their gender identification was as follows: man (33%, n = 16); trans man (27%; n = 13); woman (0%; n = 0); trans woman (0%; n = 0); non-binary (27%; n = 13); agender, fluid or other (13%; n = 6). Sixteen did not report self-identification. Of the 45 participants

who were assigned male at birth, some identified as women (18%, n = 5); as trans women (32%; n = 9); as non-binary (25%; n = 7), and as agender, fluid or other (25%; n = 7). None identified as men or trans men, and 17 did not report self-identification. The remaining participants chose to not report sex assigned at birth and/or self-identification.

The mean age of the participants was 30.01 years old (SD = 5.97), ranging from 16 to 68 years old. Most (85.2%) were Portuguese, while some had been born in other countries but spoke Portuguese (namely, from Brazil; 14.8%). With regards to educational attainment, 11.3% had completed basic education, 50.4% had completed high school and/or professional training, and 38.3% were in higher education or had completed their degree. Considering their occupation, 37.8% were active, 34.8% were students, and 13.1% were inactive.

Regarding sexual orientation, most participants identified as heterosexual (39%) or bisexual/pansexual (39%), while only 12% identified as gay or lesbian. As for relationship status, 48.7% were living alone at the time of the survey, 31.3% were in a relationship with a significant other, and 14.8% were married or cohabiting with a partner; in total, 2.6% indicated they were in a relationship with more than one person, 1% were separated or divorced, and other situations were reported by some. Globally, this was a community-based sample, and not a clinical sample, as the recruitment was marginal in health settings.

2.2. Instrument

The researchers developed a self-administered survey written in Portuguese, based on the original study in France by the project-coordinating team (Giami et al. 2011), and already replicated in other countries and languages (e.g., in Spanish by the team in Chile; see Barrientos Delgado et al. 2021). It aimed to characterize the TGGD population in each of these countries, developmental and social experiences, medical and psychological transition processes, and health and well-being (e.g., global health, chronic illnesses, mental health, sexual health, HIV status). The translation in Brazilian Portuguese was made available to the team, for information and possible adaptation (Carrara et al. 2019). Language adequacy and survey questions were revised by the team but also by a small group of stakeholders, including trans people, who provided feedback. Cultural adjustments were also made, given the legal framework and other contextual variables. Finally, the survey was introduced in Qualtrics, for online administration, and printed for paper-and-pencil administration.

Several sections may be identified in the survey, such as sociodemographic variables, and gender affirmation pathways in terms of social transition (e.g., different contexts where the person presents and uses names according to gender identity), legal transition (e.g., access to change of legal name and sex in the civil registry), and medical affirmation (i.e., choices regarding desired treatments and interventions, and the degree to which participants felt their affirmation process was complete for them). Health status was also assessed, including self-perceived health quality, chronic illnesses, mental health, sexual and reproductive health, and health and developmental history. Importantly, participants were asked about their gender identification using an open-ended question (Giami and Beaubatie 2014). Participants were asked: "How would you describe your gender identity in your own words?" Answers were provided in an open space and they were later analyzed and coded using a content analysis.

2.3. Procedures

After the translation, adaptation, and revision of the survey, researchers submitted it to the Ethics Committee and received approval (26/2018). The survey was then implemented online and disseminated through diverse stakeholders and community centers. A project Facebook page was developed, and social media were used to disseminate the call for participation. In addition, the main NGOs in the country were reached by email and invited to participate in and disseminate the survey amongst community members. Paper-and-pencil surveys were also collected in health care services and NGOs in the capital, especially

aiming to target the most excluded TGGD persons (who would not otherwise have access to the online survey). Participants started by reading and signing a free and informed consent before filling out the survey. Anonymity and confidentiality were guaranteed, and participants were able to stop participation at any time. Assistance was offered to answer the paper-and-pencil survey, particularly those in health community clinics and NGOs with low educational status and/or more severe social vulnerability conditions.

2.4. Statistical Analyses

Since this was an exploratory quantitative study, no hypotheses were posited, and only descriptive analyses were conducted to summarize data in a meaningful way. Therefore, descriptive statistics [frequency (percent) or mean and standard deviation (SD)] were calculated for sociodemographic variables, gender identification variables, and gender affirmation pathways variables, stratified by parenthood aspirations. The data were analyzed using IBM SPSS Statistics version 28.

3. Results

This paper focuses on participants' current and desired parenthood aspirations. The majority (n = 80; 69%) do not have any children, only 10% (n = 11) have children of their own, and about 20% (n = 23) do not have children but intend to have them in the future (Figure 1).

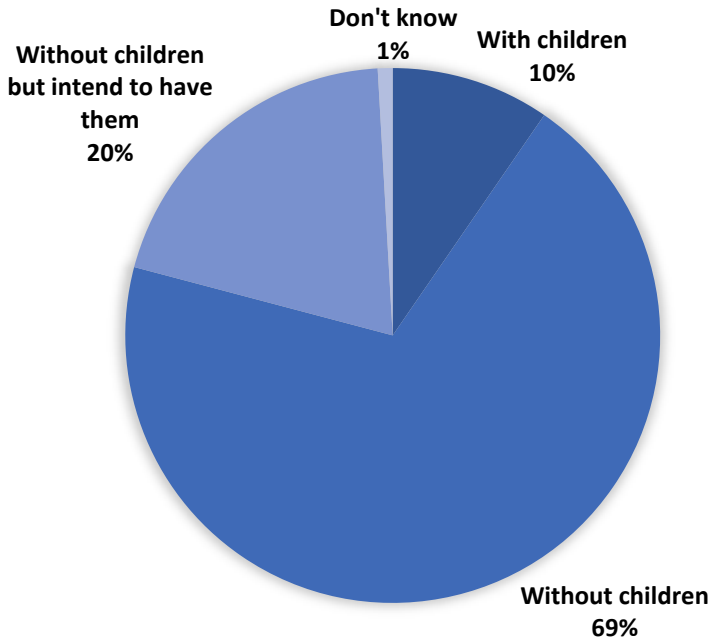

Figure 1. Current and desired parenthood.

3.1. Parentood Aspirations by Sociodemographic Characteristics

The characteristics of the study population by current and desired parenthood are displayed in Table 1. Participants with children had an average age of 43 years, most had a higher educational level, and, considering their occupational status, had a declared profession. Most participants without children and especially those intending to have children were still students. Considering the current partnership status, many of the participants without children in the present moment, but intending to have children in the future, were in a relationship, with 30% of them living with partner.

Table 1. Sample characterization by current and desired parenthood.

	Participants with Children n (%) 11 (9.6)	**Participants without Children n (%) 80 (69.6)**	**Particiants without Children But Intending to Have Them n (%) 23 (20.0)**
Age (years), mean	42.55 (±3.730)	29.90 (±1.168)	24.41 (±1.042)
Age group (years), %			
16–24 years	1 (9.1)	38 (47.5)	13 (59.1)
25–44 years	6 (54.5)	28 (35.0)	9 (40.9)
45+ years	4 (36.4)	14 (17.5)	0 (0)
Educational level, %			
Primary education	3 (27.3)	6 (7.5)	4 (17.4)
Secondary education	1 (9.1)	47 (58.8)	10 (43.5)
Higher education (1st, 2nd, 3rd cycles)	7 (63.6)	27 (33.8)	9 (39.1)
Occupation status, %			
Declared profession	9 (81.8)	29 (36.3)	5 (21.7)
Undeclared profession	1 (9.1)	9 (11.3)	1 (4.3)
Unemployed	0 (0)	7 (8.8)	4 (17.4)
People on sick leave	0 (0)	4 (7.0)	0 (0)
Student	0 (0)	28 (35.0)	12 (52.2)
I do not want to answer	1 (9.1)	3 (3.8)	1 (4.3)
Current partnership status, %			
Alone	5 (45.5)	43 (53.8)	7 (30.4)
In a relationship with one person	4 (36.4)	25 (31.3)	11 (47.8)
In relationship with more than one person	1 (9.1)	2 (2.5)	1 (4.3)
In a marriage/union	1 (9.1)	9 (11.3)	4 (17.4)
Another situation	0 (0)	1 (1.3)	0 (0)
Living with partner, %	6 (54.5)	19 (23.8)	7 (30.4)

3.2. Gender Identity Process

Considering sex assigned at birth, most participants with children were assigned male at birth (66.7%), while most participants without children (56.6%), and especially those intending to have children (73.9%), were assigned female at birth. Participants without children, but intending to have them, self-identified mostly as "trans/non-binary", "trans men", or "men"; the participants with children described their gender identity as "trans women" or "other" self-identification (Figure 2).

Participants with children had been living according to their gender identity for 8 years or longer and most tended to consider that their gender affirmation process was concluded. The gender identity processes by current and desired parenthood, such as frequency and circumstances of self-presentation according to gender identity, and requests for a change of birth certificate, are displayed in Table 2.

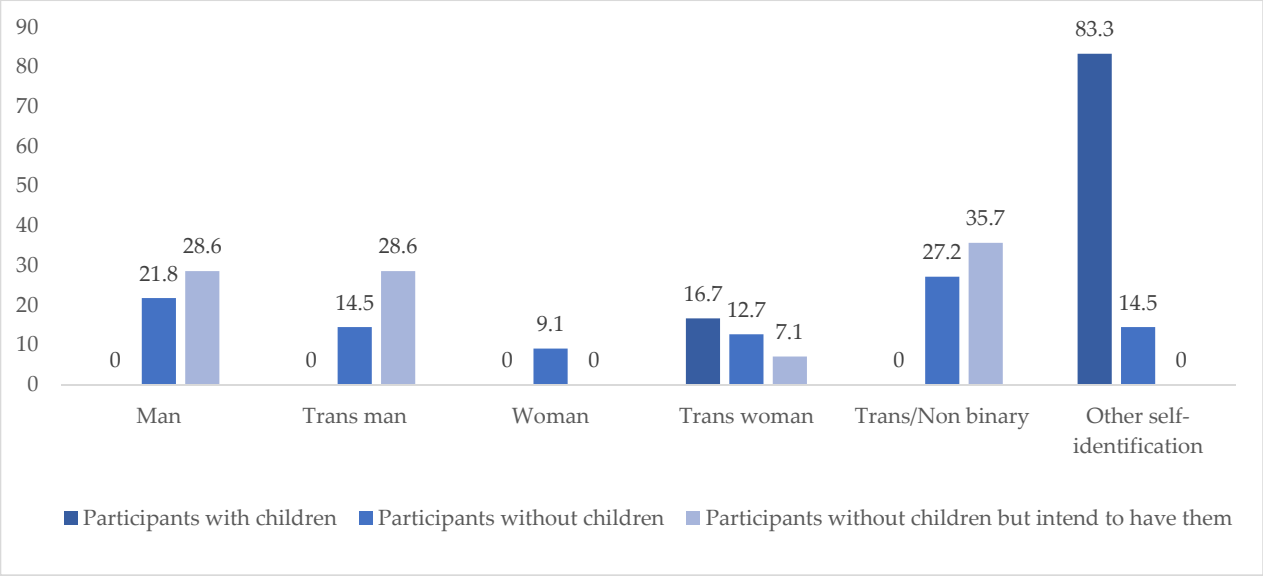

Figure 2. Self-identification by current and desired parenthood.

Table 2. Gender identity process by current and desired parenthood.

	Participants with Children n (%) 11 (9.6)	**Participants without Children n (%) 80 (69.6)**	**Participants without Children But Intend to Have Them n (%) 23 (20.0)**
Sex assigned at birth			
Female	3 (33.3)	43 (56.6)	17 (73.9)
Male	6 (66.7)	33 (43.4)	6 (26.1)
Years living according to gender identity			
Never lived	1 (20)	8 (13.1)	4 (22.2)
Less than 8 years	0 (0)	31 (50.8)	10 (55.6)
For 8 or more years	4 (80)	22 (36.1)	4 (22.2)
Frequency of self-presentation according to gender identity			
Always	4 (80)	46 (76.7)	11 (61.1)
Often	0 (0)	9 (15.0)	5 (27.8)
Sometimes	1 (20)	3 (5.0)	2 (11.1)
Rarely	0 (0)	1 (1.7)	0 (0)
Never	0 (0)	1 (1.7)	0 (0)
Circumstances of self-presentation according to gender identity			
In all circumstances	4 (80)	47 (79.7)	11 (61.1)
Everywhere, or often, but not at work	0 (0)	5 (8.5)	3 (16.7)
Only with my friends	1 (20)	3 (5.1)	2 (11.1)
Only with a sexual partner or spouse	0 (0)	1 (1.7)	0 (0)
Other circumstances	0 (0)	3 (5.1)	2 (11.1)

Table 2. *Cont.*

	Participants with Children n (%) 11 (9.6)	Participants without Children n (%) 80 (69.6)	Participants without Children But Intend to Have Them n (%) 23 (20.0)
Requested change of birth certificate			
Yes	1 (16.7)	26 (44.1)	7 (43.8)
No, but intend to change	3 (50.1)	32 (54.3)	6 (37.6)
I do not want any changes	2 (33.3)	0 (0)	2 (12.5)
I do not know	0 (0)	1 (1.7)	1 (6.3)
For me, the gender affirmation process is complete			
Yes	3 (42.9)	7 (11.9)	3 (18.8)
No	2(28.6)	47 (79.7)	12 (75.0)
I do not know	2 (28.6)	5 (8.5)	1 (6.3)

3.3. Health and Barriers to Care

Body transformations by current and desired parenthood are displayed in Table 3. Participants without children reported several body transformations, such as the use of cross-sex hormones, and breast and genital surgeries.

Table 3. Body transformations by current and desired parenthood.

	Participants with Children n (%) 11 (9.6)	Participants without Children n (%) 80 (69.6)	Participants without Children But Intend to Have Them n (%) 23 (20.0)
Use of cross-sex hormones			
Yes	1 (12.,5)	33 (50.8)	8 (40.0)
No	1 (12.5)	16 (24.6)	6 (25.0)
No, but intend to	4 (50.0)	16 (24.6)	7 (35.0)
Don't know/don't answer	2 (25.0)	0 (0)	0 (0)
Surgeries done			
Breast surgeries	1 (25.0)	20 (38.5)	4 (25.0)
Genital surgeries	1 (25.0)	5 (9.3)	0 (0)
Planned surgeries			
Breast surgeries	1 (25.0)	22 (42.3)	8 (50.0)
Genital surgeríes	0 (0)	36 (66.7)	8 (53.3)

Considering health conditions (Table 4), participants without children presented high levels of depression or other emotional disorders, and severe mental illness.

Table 4. Health conditions by current and desired parenthood.

	Participants with Children n (%) 11 (9.6)	**Participants without Children n (%) 80 (69.6)**	**Participants without Children But Intend to Have Them n (%) 23 (20.0)**
How would you define your health status?			
Very good	0 (0)	9 (15.3)	0 (0)
Good	1 (16.7)	25 (42.4)	9 (56.3)
Fair	3 (50.0)	19 (32.2)	4 (25.0)
Poor	2 (33.3)	5 (8.5)	2 (12.5)
Very poor	0 (0)	1 (1.7)	1 (6.3)
Diagnosis of chronic illness			
No	3 (50.0)	31 (52.5)	7 (43.8)
Yes	3 (50.0)	28 (47.5)	9 (56.3)
Diabetes	1 (9.1)	0 (0)	1 (4.3)
Arterial hypertension	2 (18.2)	4 (5.0)	1 (4.3)
Dyslipidemia	0 (0)	3 (3.8)	0 (0)
Heart disease	1 (9.1)	1 (1.3)	0 (0)
Respiratory disease	0 (0)	5 (6.3)	2 (8.7)
Gastric disease	0 (0)	2 (2.5)	2 (8.7)
Depression or other emotional disorder	0 (0)	16 (20.0)	4 (17.4)
Severe mental illness	0 (0)	3 (3.8)	1 (4.3)
Excessive substance use	0 (0)	2 (2.5)	0 (0)
Obesity	0 (0)	2 (2.5)	4 (17.4)
Other diseases	0 (0)	13 (16.3)	5 (21.7)

Rates of both reporting discrimination within healthcare, based on gender identity or expression, and reporting foregone care were generally high among all participants. Rates of foregone care were particularly high among participants who do not have children but intend to have children (Figure 3). Finally, participants reported history of psychological or verbal abuse, including in the home (18%), and of sexual violence or abuse (35%).

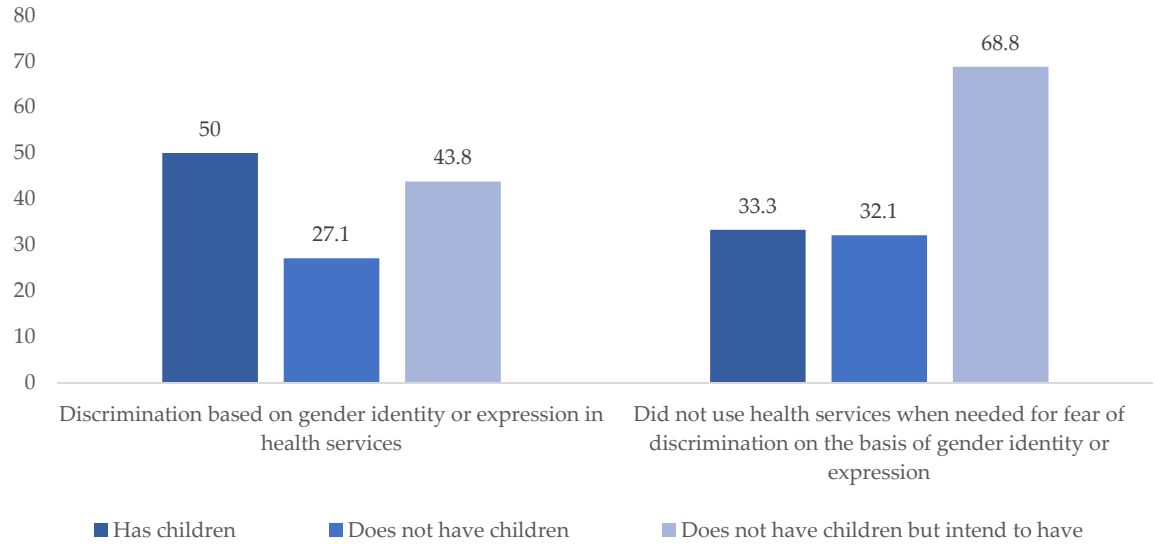

Figure 3. Experiences of discrimination by current and desired parenthood.

4. Discussion

This study had, as its main objective, characterizing the diversity of the TGGD population in Portugal, while exploring their parental status and desired parenthood in relation to the heterogeneity of their sociodemographic features and of their gender identity and gender affirmation pathways (social, legal, and physical/medical affirmation).

In our study, the sample consisted of TGGD people recruited through diverse means in a community-based approach. The analysis of the background and sociodemographic characteristics revealed that, despite reporting some history of abuse/violence and discrimination, the TGGD individuals in our sample had mostly completed high-school or college education, half had a significant relationship or lived with a partner, and a few had children (10%) or aspired to have them (20%). Most participants reported living according to gender identity in almost all circumstances or contexts of daily life (up to 8 years, or even over a period of 8 years), even though most had not changed their legal documents yet and had not completed their desired gender-affirmation medical interventions. These findings speak to the resilience of TGGD people, despite being disproportionally exposed to discrimination and violence, and the possible protective roles of social gender identity affirmation processes (Fontanari et al. 2020; Johns et al. 2018; Reardon 2019; Russell et al. 2018; Tankersley et al. 2021). In fact, these young adults seemed to be reaching valued life goals, such as education, intimate partnerships, and family aspirations (James et al. 2016).

The participants' younger age was clearer among those without children and especially among those intending to have them, which is consistent with previous studies (e.g., Auer et al. 2018; Charter et al. 2018; Marinho et al. 2021). Another result that aligned with previous studies (Carrara et al. 2019; Giami and Beaubatie 2014) is the relatively high level of educational attainment in the population, and this higher educational level was especially evident among participants with children. In addition, in our study, we found that the participants without children but intending to have them mostly reported having a partner. Furthermore, although most of the TGGD people surveyed in our study did not have children, similar to other studies, our findings are consistent with previous results that indicate that people assigned male at birth had children more often than those assigned female at birth (Lawrence 2005). Conversely, participants without children, and especially those intending to have children, were assigned female at birth, and identified as men or trans men. Importantly, participants without children but intending to have them *also* identified as "trans/non-binary". The parenthood aspirations of gender fluid and non-binary people are still scarcely investigated (e.g., Lunde et al. 2021; Rodriguez-Wallberg et al. 2022; Tornello and Bos 2017), but could significantly contribute to the understanding of queer intimacies (Hammack et al. 2019), and to parenthood beyond maternity and paternity (see McKenzie 2022).

This study contributed to demonstrating that the TGGD population in Portugal differs substantially in their sociodemographic characteristics, their gender self-identification, their gender-affirmation patterns (social, legal, and medical), and their parenting aspirations. Thus, the three groups analyzed (participants with children, participants without children, and participants without children but intending to have them) appeared to be very distinct. These findings are relevant in social- and health-policy development, as differential parenthood aspirations will follow specific reproductive health needs (Lunde et al. 2021; Rodriguez-Wallberg et al. 2022). Moreover, we conclude that the under- or non-representation of transgender individuals in population surveys, such as demographic and health surveys, is a barrier to understanding the social determinants and health disparities faced by this population.

5. Limitations, Future Directions, and Conclusions

Our study has some limitations, including convenience sampling, which could cause sample bias and limit the representativity of the overall TGGD population in Portugal. Still, the sample was diverse and the intentional recruitment of heterogeneous community settings through partnerships, and online and paper-and-pencil methodologies, were used.

Notably, this was not a clinically recruited sample, and thus results may not represent the experiences of TGGD people who face more clinically significant distress and health challenges. In addition, data are quantitative and in order to fully understand the complexity of the gender affirmation paths and parenting aspirations, qualitative studies will be needed. The study was designed to consider the diversity of the TGGD population in general and survey a vast set of domains and experiences; it was not specifically focused on the reproductive health and rights of TGGD individuals. However, the inclusion of parenthood aspirations, along with several other dimensions and contexts, allowed us to highlight the need for a gender diverse reproductive health approach to identify reproductive health care strategies to meet their multiple needs.

Future research is needed to reflect the full range of reproductive health issues that are relevant to transgender and gender-diverse people with a more inclusive and comprehensive approach. The reproductive health topics addressed should go beyond fertility intentions and include procreative options, such as information on choices and medically assisted procreation, perinatal care, pregnancy, delivery, and postpartum care, as well as family planning and contraceptive options (Agénor et al. 2021; Coleman et al. 2022). Moreover, comparative approaches among subgroups or populations (e.g., experiences of trans men, of trans women, and of non-binary or fluid individuals) might be rich in understanding how reproductive health issues are experienced and addressed/managed by the health system. Cross-cultural comparative studies may also point to relevant data, as well as key critical analyses of how parenthood and queer intimacies among TGGD individuals (Hammack et al. 2019; McKenzie 2022) are represented in diverse cultures and diverse health-care systems.

Intersectionality approaches need to be implemented to contribute to the understanding of how multiple forms of social inequality may impact the reproductive health of transgender diverse populations in terms of race/ethnicity, socioeconomic position, age, and functionality, among other social categories; promoting individualized care that is more inclusive of trans bodies and identities, and that is related to the context of each person's parenthood goals, will ensure equitable and high-quality care for all forms of family planning (Agénor et al. 2021; Pezaro et al. 2023).

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