RESEARCH REPORT ON TRANS+ INDIVIDUALS' ACCESS TO HEALTH CARE SERVICES

August 2021

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RESEARCH REPORT ON TRANS+ INDIVIDUALS' ACCESS TO HEALTH CARE SERVICES

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Who Are We?

University Queer Research and LGBTI+ Solidarity Association (shortly UniKuir NGO) was founded in February 2020 by a university-based LGBTI+ activist group and is the only university-based LGBTI+ organization in Turkey. UniKuir NGO aims to create a safe and inclusive space for LGBTI+ university students, to prevent hate speech and hate crimes on campus, to produce anti-discrimination policies and measures, and to defend the rights of LGBTI+s at both national and international levels. Activities for the right of LGBTI+ university students to access basic needs such as education, housing, scholarship, and health, psycho-social support services, LGBTI+ rights advocacy, and activities to combat hate crimes are among the main fields of activity of the organization. It fights against discrimination based on sexual orientation, gender identity and gender, transphobia, homophobia, biphobia and LGBTI+ phobia, cissexism, cisnormativity, discrimination against sex workers, hate speech wherever there are LGBTI+s and especially in universities. UniKuir NGO calls for solidarity to prevent stigma and social isolation and to build a society where equality and human rights are respected as fundamental values against the erasure of psychological, economic, physical and sexual violence against LGBTI+s.

Abbreviations

LGBTI+: Lesbian Gay Bi+sexual Trans Intersex Plus
ECHR: European Convention on Human Rights
ECtHR: European Court of Human Rights
SOGI: Sexual Orientation, Gender Identity
UN: United Nations
UNESCO: United Nations Educational, Scientific and Cultural Organization
WHO: World Health Organization
EIGE: European Institute for Gender Equality
ICD: International Classification of Diseases
SSI: Social Security Institution (Health Insurance)
ŞÖNİM: Violence Prevention and Monitoring Center
TTB: Turkish Medical Association
UCEP: National Core Education Program for Medicine Student

Dictionary

Sexual Orientation: It is a concept that expresses the person's sexual attraction towards whom.

Gender Indentity: It is the gender identity that the person feels themselves to be, defines themselves.

Trans+: It is an umbrella term that refers to the identification of one's own gender identity in a gender other than the one assigned at birth.

Non-binary: It is gender identity that refers to people who do not define their gender within the binary gender system. Non-binary people may express their gender identity in other terms such as genderfluid or agender.

Cisgender: It is the definition of one's gender identity in the same way as the gender assigned at birth.

Plus (+): It is a symbol that refers to people who are trans and/or non-heterosexual, and who define themselves with other sexualities.

Gender Affirming Surgery: As part of transition is the general name of the different surgical operations that trans people can undergo for genital changes. Trans people may not prefer such operations or may lack the financial means to afford them, so it is not correct to emphasize the importance of operations in the context of the integration process as a necessity beyond one's desire.

Transphobia: It is a concept that expresses negative feelings, thoughts, attitudes and behaviors towards trans+ indivuduals.

Cissexism: It is the ideology that accepts and imposes that gender consists of only "female" and "male" genders, that "biological factors" determine these genders and that this is "essential" and "fixed".

Cis Normative: It is used to describe the structural and everyday expressions imposed by seeing cissexism as a normal and single sexual identity, such as the imposition of roles determined by the binary gender system and the construction of social structures by accepting everyone as cisgendered.

Heterosexism: It is an ideology that asserts that heterosexuality is the only "natural" sexual orientation, ignoring and suppressing other sexual orientations.

Heteronormative: It defines aspects of heterosexism that are reflected in structural and everyday practices. Such as, seeing and imposing heterosexuality as the normal and only sexual orientation, constructing social values by accepting that everyone is heterosexual.

INTRODUCTION

1.1. Purpose of Research

Since the mid-20th century, psychologists and psychiatrists have contended that homosexuality is not a disease, mental disorder, or emotional problem, and they, under the influence of the ongoing rights struggle, have accomplished significant steps in the field of medicine. In 1973, the American Psychiatric Association (APA) eliminated homosexuality from the Diagnostic and Statistical Manual of Mental Disorders and excluded it from the disorder classification [1]. On January 1, 1993, the World Health Organization (WHO) removed homosexuality from the International Classification of Diseases (ICD-10) [2].

On June 18, 2018, WHO announced that trans identity, which includes "Individuals with a gender identity different from their gender determined at birth and individuals who want to reflect their gender differently from their gender determined at birth", cannot be classed as a "mental disorder," and issued restrictions in the forthcoming ICD-11 update to reflect this. Hence, the issues regarding trans+ individuals have been reclassified from the ICD's mental disorders classification to the sexual health classification.

Because of their sexual orientation, gender identity, and gender characteristics (SOGI), LGBTI+s are subjected to human rights violations all around the world. Violations cross with several components such as "nationality, race, ethnicity, indigenousness, language, age, religion, belief, political opinion, thought, disability, health, economic and social status, being a defender of immigration/refugee or human rights" and grow in multiple layers [3]. LGBTI+ violations are, hence, required to be addressed from the perspective of intersectionalism.

Data on the experiences and issues of LGBTI+ individuals in the domains of employment, housing, and health care were acquired based on the outcomes of publications periodically published by LGBTI+ organizations and research conducted [4]:

[1] Drescher J. (2015). Out of DSM: Depathologizing Homosexuality. Behavioral sciences (Basel, Switzerland), 5(4), 565-75. doi:10.3390/bs5040565

[2] WHO. (1993). Classification of Mental and Behavioural Disorders.

[3] Global Campus of Human Rights (2019) Moinitoring the Human Rights of LGBTI Persons. Online course. Course dates: 25 February - 7 April 2019 https://edx.eiuc.org/courses/course-v1:global-campus+lgbti+2019/about

[4] (Turkish Texts) KAOS-GL ve Almanya Federal Büyükelçiliği. (2009) Lezbiyen, Gey, Biseksüel Çalışanların İş Yaşamı Raporu, Ankara.; Kaos GL Derneği, LGBTI News Turkey ve IGLHRC. (2015) Türkiye'de LGBT Yurttaşlara Yönelik İnsan Hakları İhlalleri.

The main areas are obstacles to the freedom to work without masking their sexual orientation and gender identity, a lack of legal regulations to protect them from discrimination in the labor market, discrimination in the workplace, limited job opportunities, and income hardship; lack of accommodation options, discrimination in wages, constantly being forced to relocate; barriers to participation in social life; problems with the family due to sexual orientation and gender identity; barriers to accessing health care, avoiding seeking health care due to negative experiences while seeking health care, institutional heterosexism of the health system, refusal of health personnel to serve LGBTI+s, social insecurity; concerns that they will not feel safe in old age, and impossibilities in accessing to law and justice.

The report, titled " Trans+ Individuals' Access to Health Care Services," aims to monitor the challenges trans+ people are facing in accessing health services, as well as the transphobia and discrimination they confront in hospitals and during examinations, to announce their demands and needs, and to develop solutions and reparative measures that will make healthcare services inclusive of trans+ people.

1.2. Summary of Research

A total of 38 people participated in the online research conducted in April-May 2021. Four of the obtained data were excluded from the research sample because the participants stated that they were not trans+, and one of them did not accept the consent form, and the data obtained from 33 participants were analyzed. The study consists of 16 (47.1%) non-binary; 7 trans women (20.6%); 7 trans men (20.6%); 2 (5.9%) agender; 1 (2.9%) gender-fluid; 1 (2.9%) intersex participant.

Sample; mainly consists of young people (25) aged 18–25. Considering the educational background of the participants; 24 (72.7%) are undergraduates; 7 (21.2%) of them are postgraduates; and 2 (9%) of them are high school graduates.

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[4] (Turkish Texts): Türkiye Cumhuriyeti Birleşmiş Milletler Kaos GL. Evrensel Periyodik İnceleme Sunumu. Erişim Tarihi: 01.04.2019; Kaos GL. (2017a) Chronology of LGBTI+ bans in Turkey. December 6, 2017. Erişim: http://kaosgl.org/page.php?id=25052; Kaos GL. (2017b) 12. Uluslararası Homofobi Karşıtı Buluşma-Emeğin Queer Politikası. 13 Mayıs 2017. Erişim Tarihi: 20 Mayıs 2017. https://www.youtube.com/watch?v=KzWK-cRs13U; Kaos GL. (2019) 2018 Yılında Türkiye'de Gerçekleşen Homofobi Ve Transfobi Temelli Nefret Suçları Raporu. Birinci Baskı: Nisan 2019, Ankara.; Yılmaz, V., Göçmen, İ. (2015). Türkiye'de lezbiyen, gey, biseksüel ve trans bireylerin sosyal ve ekonomik sorunları araştırmasının özet sonuçları. Cilt IV, (6), 94-101.; Göçmen, İ., Yılmaz, V. (2017). Exploring perceived discrimination among LGBT individuals in Turkey in education, employment, and health care: Results of an online survey. Journal of homosexuality, 64(8), 1052-1068.

While 23 (69.7%) of the participants mostly live in metropolitan cities; 8 (24.2%) were in the city; 1 (3%) live in the district and 1 (3%) lived in the village. The employment status of the participants in the research is as follows: 18 (54.5%) students; 9 (27.3%) are private sector employees; 1 (3%) public employee; 1 (3%) stated that they work on their own; 2 (6.1%) of them are unemployed and looking for a job; 2 (6.1%) stated that they are unemployed and not looking for a job. In terms of balance of income and expenses, fifteen (45.5%) of the participants stated that the income is equal to their expenses; 10 (30.3%) stated that their income is less than their expenses; 8 (24.2%) stated that their income is more than their expenses. While 15 (45.5%) participants stated that they had SSI; 13 (30.4%) participants benefited from their parents' insurance; 3 (9.1%) participants had private health insurance; 2 (6.1%) participants stated that they do not have insurance. 18 (54.5%) of the participants stated that they did not belong to any other minority group other than being trans+; 9 (27.3%) are religious minorities; 8 (24.2%) are ethnic minorities; 3 (9.1%) refugees/immigrants; 2 (6.1%) stated that they were disabled.

When the participants were asked how healthy they felt, based on the WHO definition of being healthy during the survey, 16 (48.5%) of the participants were not so good; 11 (33.3%) were good; 5 (15.2%) were bad; 1 participant described it as very good. There were no participants who described their health status as excellent.

While 21 (63.6%) of the participants stated that they had psychiatric diagnoses; 13 (39.4%) stated that they had no psychiatric diagnosis. Among the 21 participants who stated that they had a psychiatric diagnosis, 12 participants have been diagnosed with Anxiety; 8 participants have been diagnosed with Attention Deficit Hyperactivity Disorder; 3 participants have been diagnosed with Gender Dysphoria; 3 participants have been diagnosed with Major Depression; 3 participants have been diagnosed with Chronic Depression; 2 participants have been diagnosed with Bipolar Disorder; 2 participants have been diagnosed with Panic Attack; 1 participant has been diagnosed with Borderline Personality Disorder; 1 participant has been diagnosed with Post Traumatic Stress Disorder; 1 participant has been diagnosed with Obsessive Compulsive Disorder; 1 participant has been diagnosed with Trichotillomania; 1 participant stated that they have been diagnosed with Neurodiversity. While 17 participants stated that they did not use psychiatric drugs, 16 participants stated that they did.

While the number of participants who prefer to go to state hospitals when they have a health problem is 22; 20 participants are preferring private hospitals; 13 of them are preferring private practice; 12 of them

are preferring family physicians; 11 participants are preferring university hospitals; the number of participants who prefer private polyclinics is 9. 12 of the participants applied for a general health check within the last year; 12 never applied; 6 of them in the last two years; 3 applied within the last five years. 16 of the participants stated that they felt very rarely prepared for extraordinary situations related to the disease; 9 never felt prepared; 4 often felt prepared; 3 occasionally felt prepared; 1 stated that they always felt prepared.

23 of the participants applied for mental support in the last year; 5 never applied; 4 in the last two years; 1 applied within the last five years. In questions about their mental well-being, 11 participants lead very rarely; 11 participants have very rarely lead a purposeful and meaningful life, whereas 11 of them often, 4 of them lead always; 1 occasionally leads a purposeful and meaningful life; the number of participants who have never felt that they are living a purposeful and meaningful life is 7. 12 of the participants described their mood as good and positive occasionally; 10 very rarely; 5 never; 5 often; 1 stated that they are always in a good and positive mood. 12 participants stated that they are occasionally optimistic about their future ; 10 very rarely; 6 never; 3 of them stated that they are often; and 2 of them are always optimistic about their future.

22 of the participants in the questions regarding access to health services think that trans+ people in Turkey always experience discrimination while receiving health care services; 9 often, 1 occasionally; 1 of them stated that they think they face discrimination very rarely. There are not any participants stated "never" as an answer to this question. While 31 of the 33 participants stated that they did not think that the health services provided would meet the needs of trans+ people, 2 stated that they considered the health services provided sufficient. 32 participants stated that they felt uneasy about the reactions they would receive before applying to health services; the number of participants who stated that they did not feel such uneasiness is only 1.

In the question about which medical personnel group participants observed discriminatory and stigmatizing behavior the most, 26 of the participants pointed out doctors; 25 of them pointed out nurses; 11 of them stated administrative units; 11 of them pointed out other auxiliary personnel such as pay desk, security, cleaning personnel; 10 of them pointed to their consulting staff. 2 of the participants stated that they had no such experience; a participant stated that they observed discriminatory and stigmatizing behavior mostly in primary care physician.

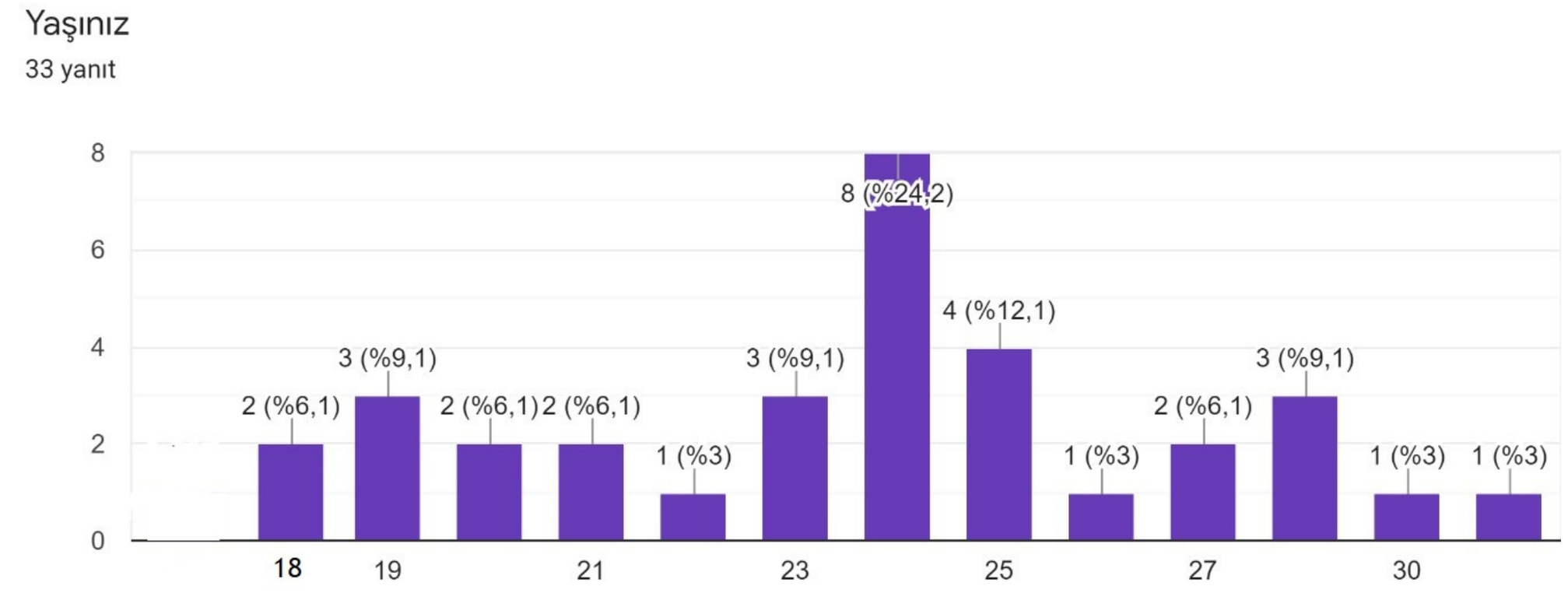
While 29 participants (87.9%) stated that the positive or negative reactions of the medical personnels affect their way of utilization of health services; 4 participants (12.1%) stated that it did not affect them.

In the questions directed to the participants who have been in transition, 20 of the participants answered the statement "Doctors have sufficient knowledge of trans+ identity and transition"; 9 participants stated never; 6 participants stated very rarely; 5 participants responded occasionally. There are not any participants who selected the option often and always. Physicians not providing enough information about the process, difficulty in getting an appointment for the transition and gender affirming surgery, access to hormones; the cisnormative nature of the psychiatric evaluation which is necessary for the transition, are the most problematic issues.

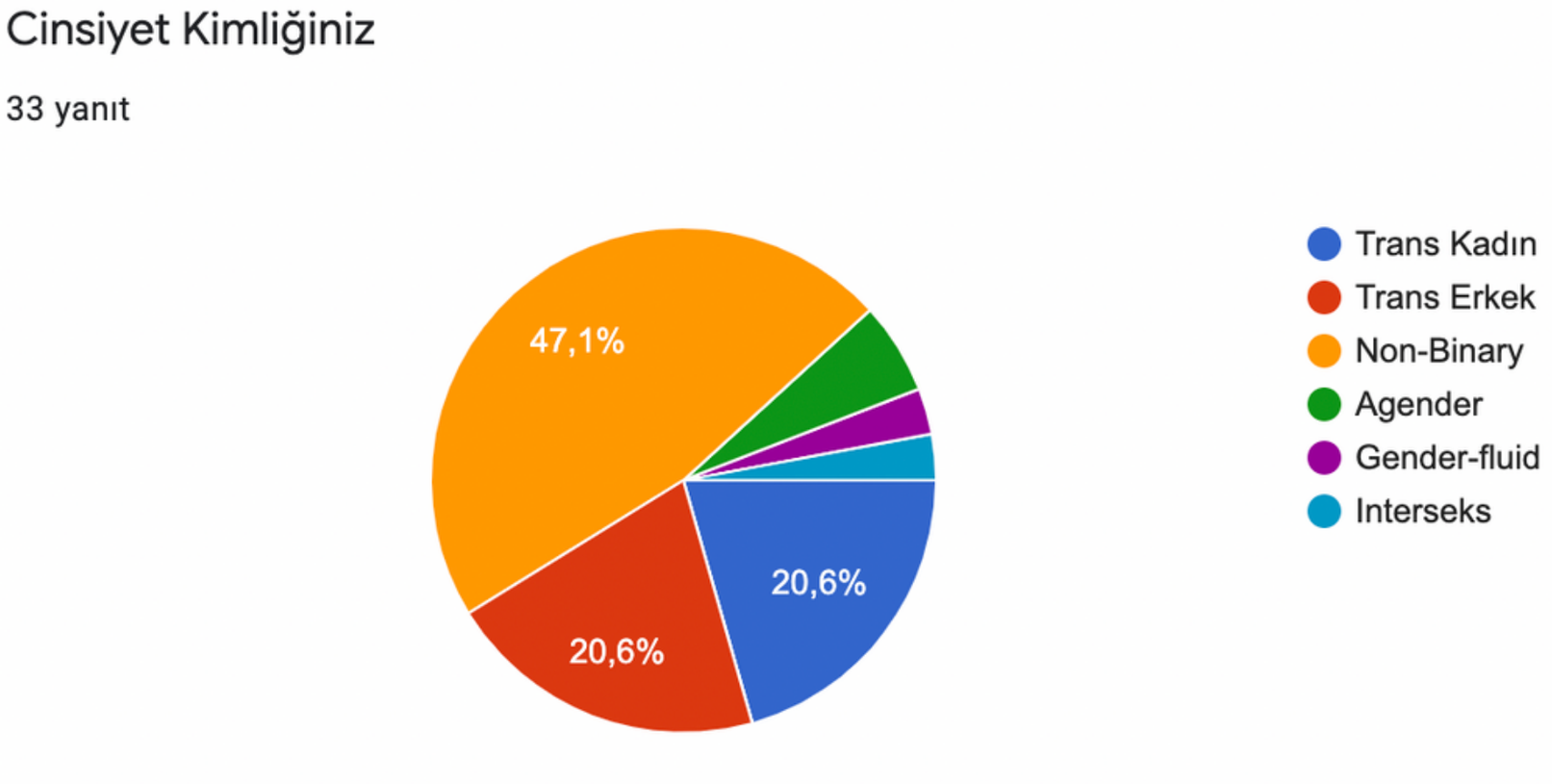
In the questions of discrimination in health services; 12 respondents stated that they are always discriminated against and insulted because they are trans+; 9 are occasionally; 6 are often; 3 are very rarely. There are 3 participants who stated that they have never been discriminated against or insulted based on their trans+ identity. While 24 participants think that the applications in the places where they received health services and the forms they were asked to fill, never covered trans+s; 4 participant think always; 3 participant think very rarely; 2 of them stated that they think they are occasionally inclusive. 18 participants were very rarely satisfied with the information they received from medical personnel and found it sufficient; 6 of them stated occasionally; 8 of them stated never; 1 parcitipant stated that they were alywas satisfied and found it sufficient. As a response to "I completely trust/satisfied with the recommendations, decisions and diagnoses of the medical personnel" statement, 13 of the participants answered very rarely; 12 of them stated never; 6 of them stated occasionally; 1 of them stated often; 1 of them stated always.

2. DEMOGRAPHIC INFORMATION

The demographic characteristics of the 33 participants in the study are as follows:



The majority of the participants in the study are young people (25) between the ages of 18-25.



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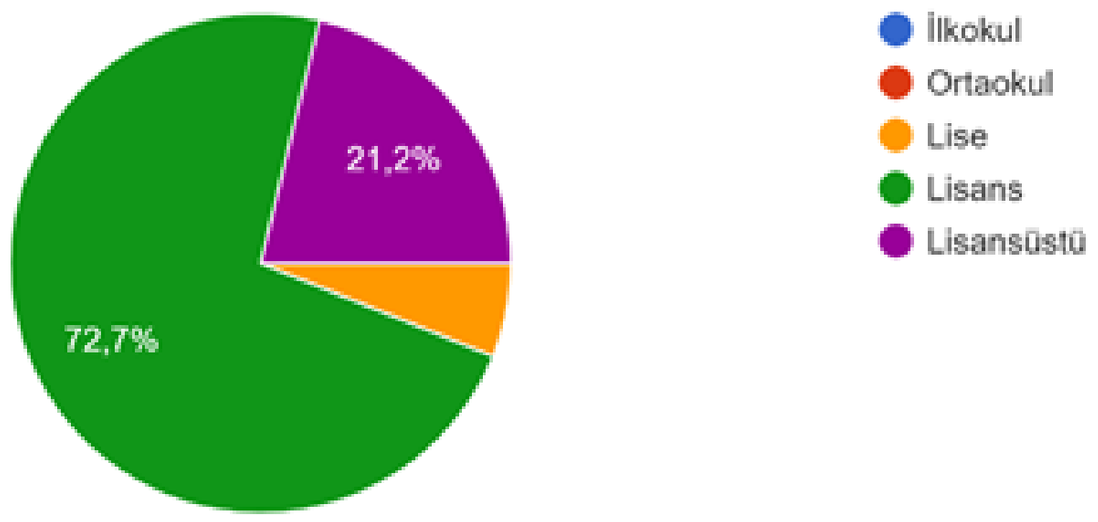
Eğitim durumunuz (Öğreniminize devam ediyorsanız onu işaretleyiniz, etmiyorsanız son mezun olduğunuz dereceyi işaretleyiniz.)

33 yanıt



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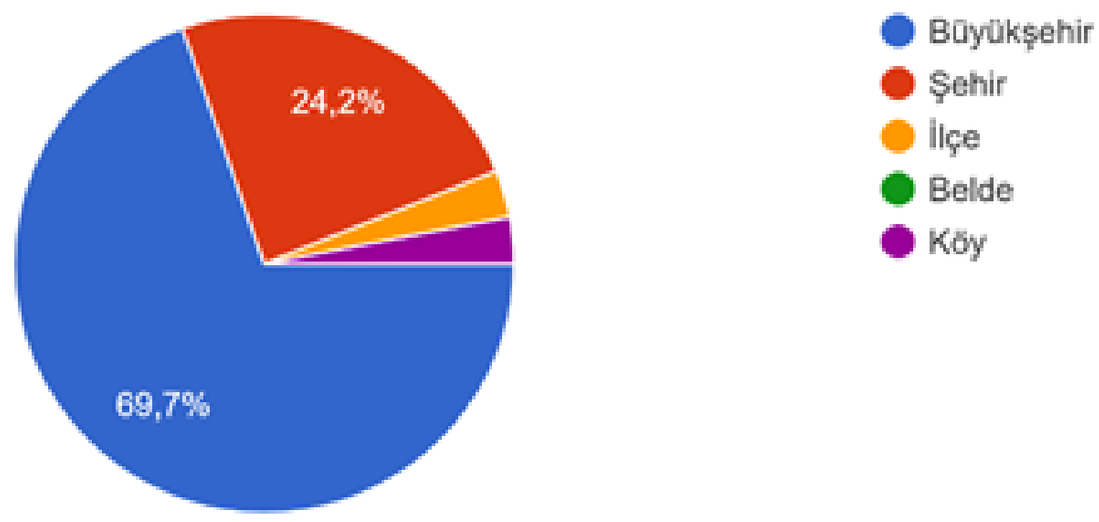
Çoğunlukla yaşadığınız yerleşim birimini nasıl tanımlarsınız?

33 yanıt



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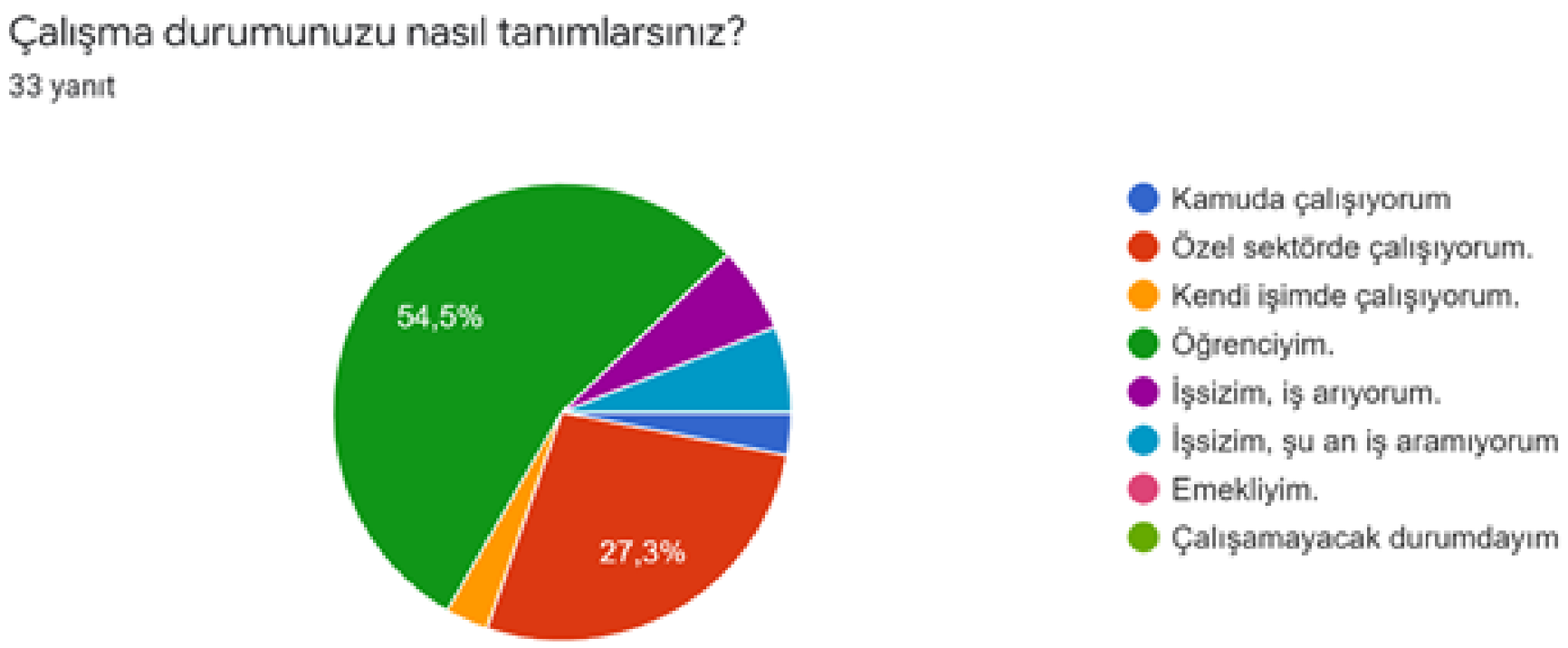

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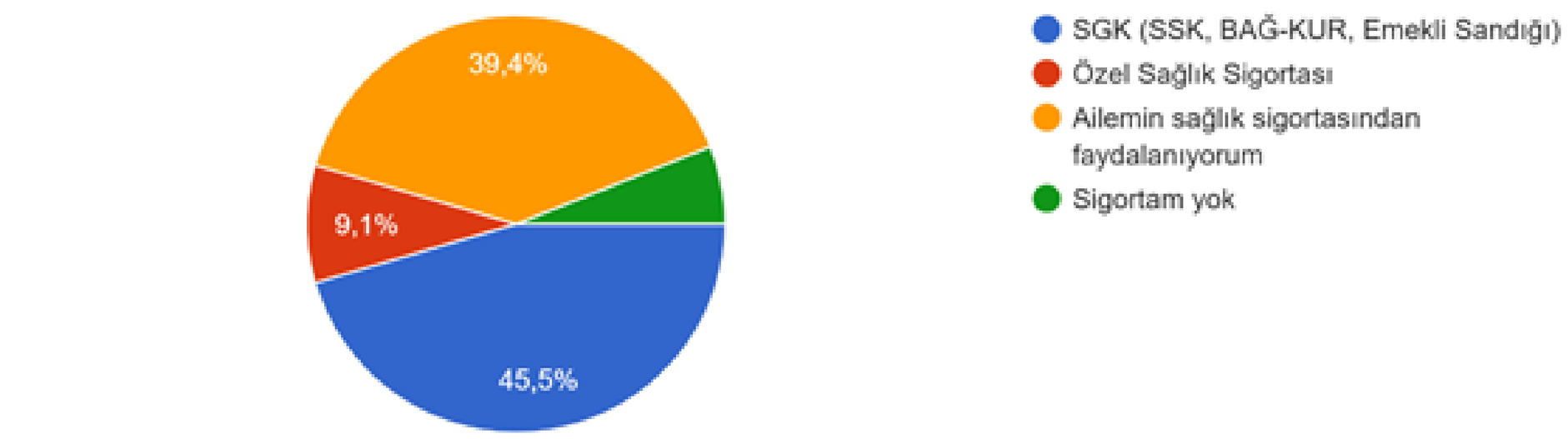

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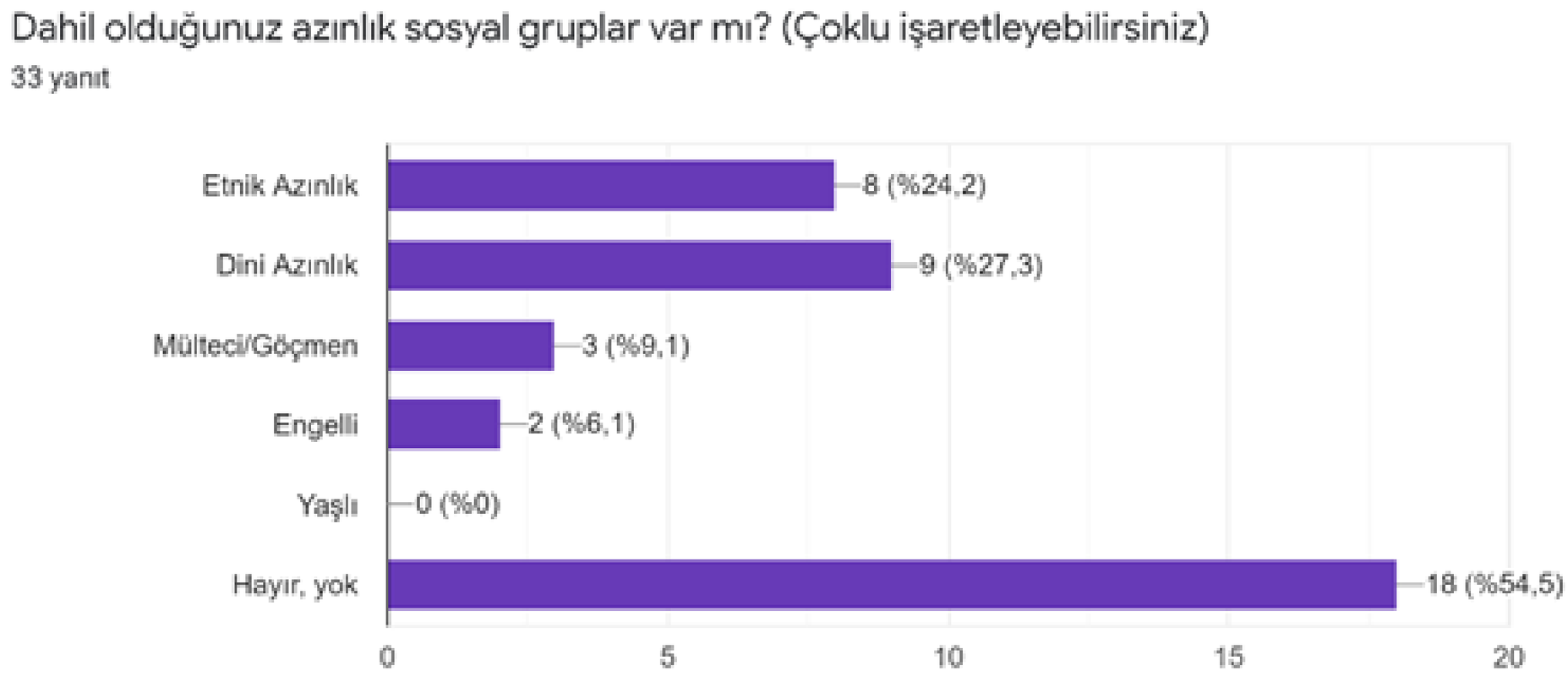

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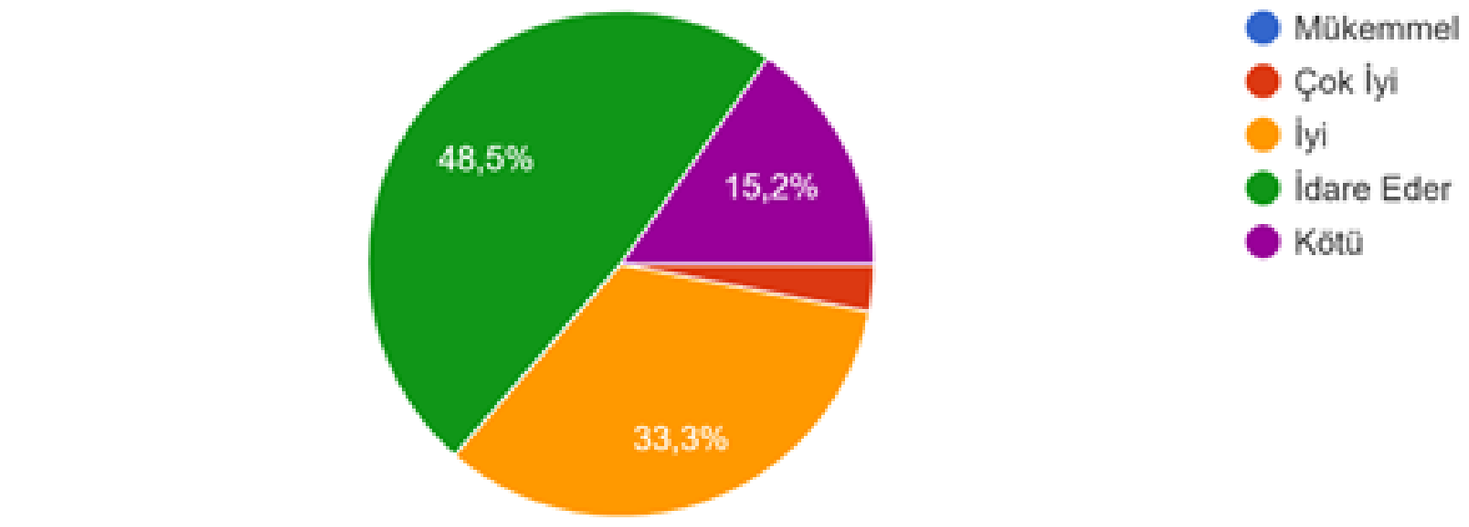
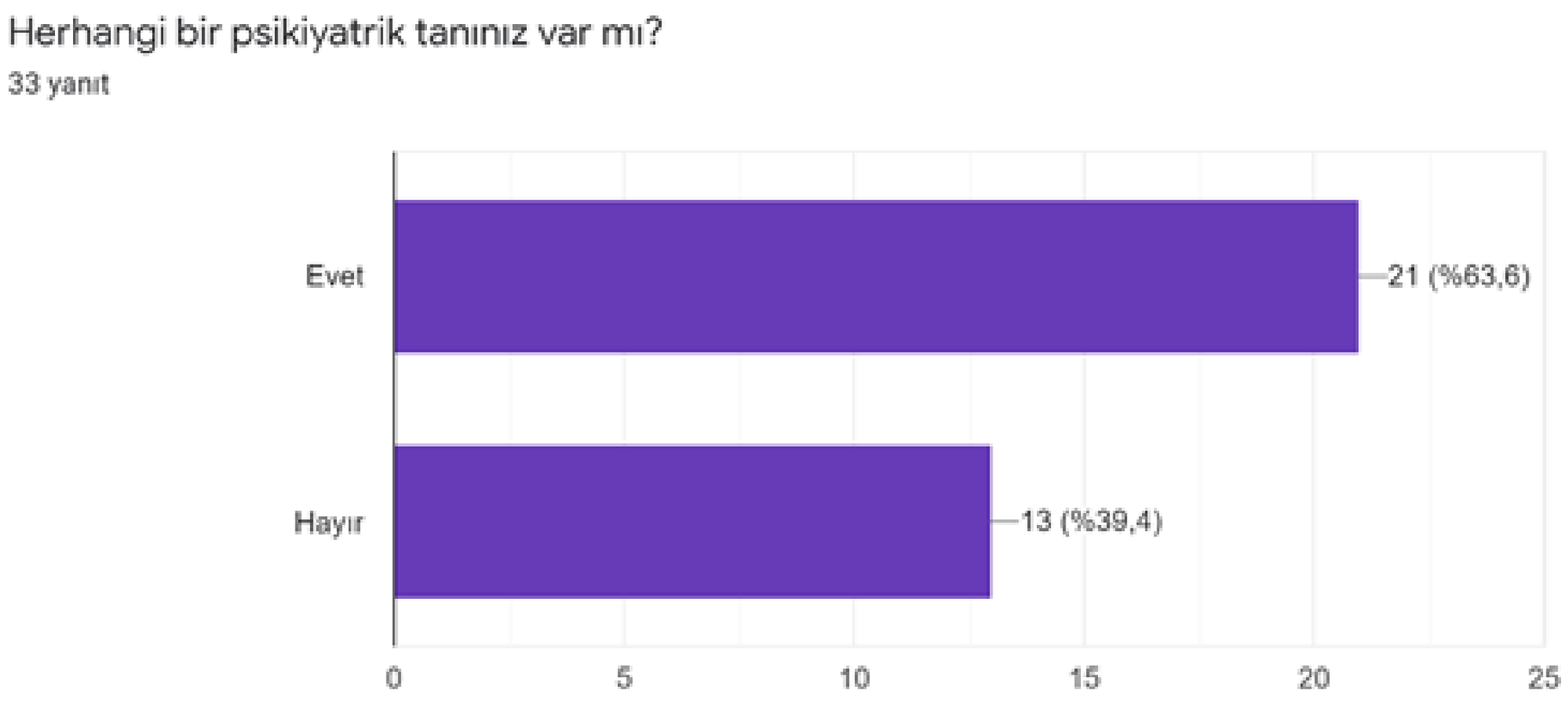
3. GENERAL INFORMATION ON HEALTH STATUS



When the participants were asked how healthy they felt, based on the WHO definition of being healthy during the survey, 16 (48.5%) of the participants were not so good; 11 (33.3%) were good; 5 (15.2%) were bad; 1 participant described it as very good. There were no participants who described their health status as excellent.



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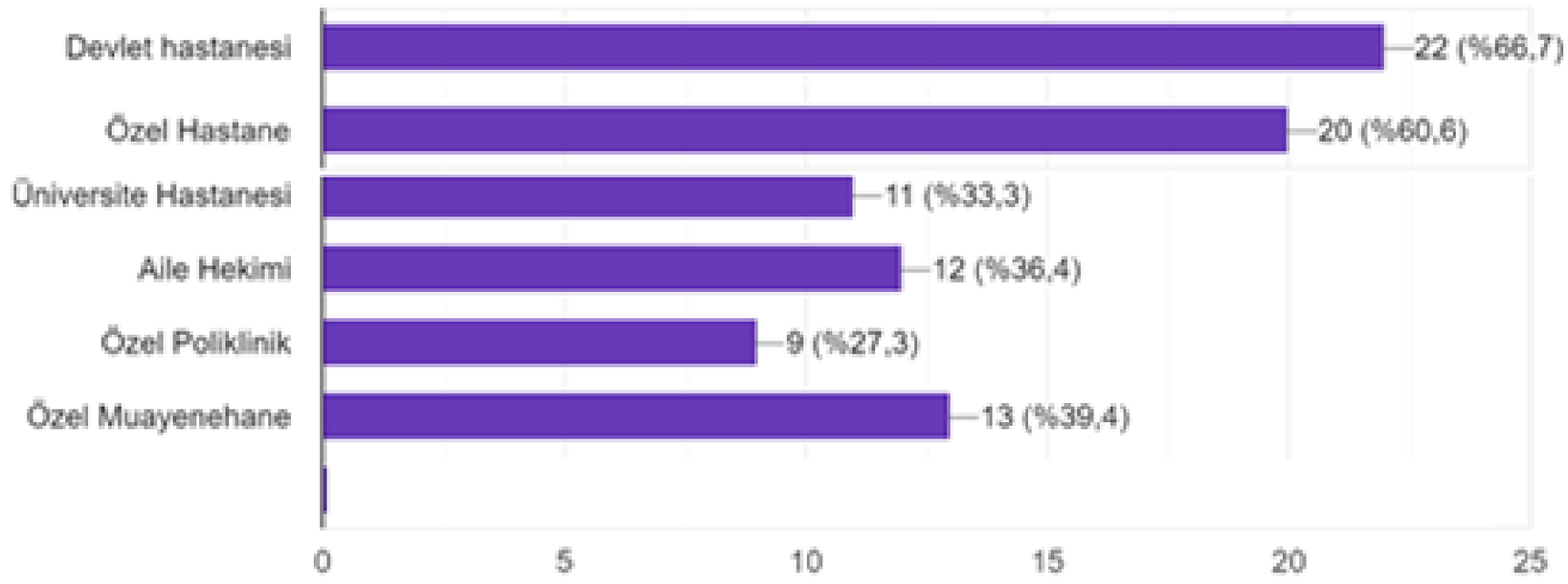
While 17 participants stated that they did not use psychiatric drugs, 16 participants stated that they did.

Sağlığınız ile ilgili bir sorun çıktığında hangi kurumları tercih ediyorsunuz? (Çoklu işaretleyebilirsiniz)

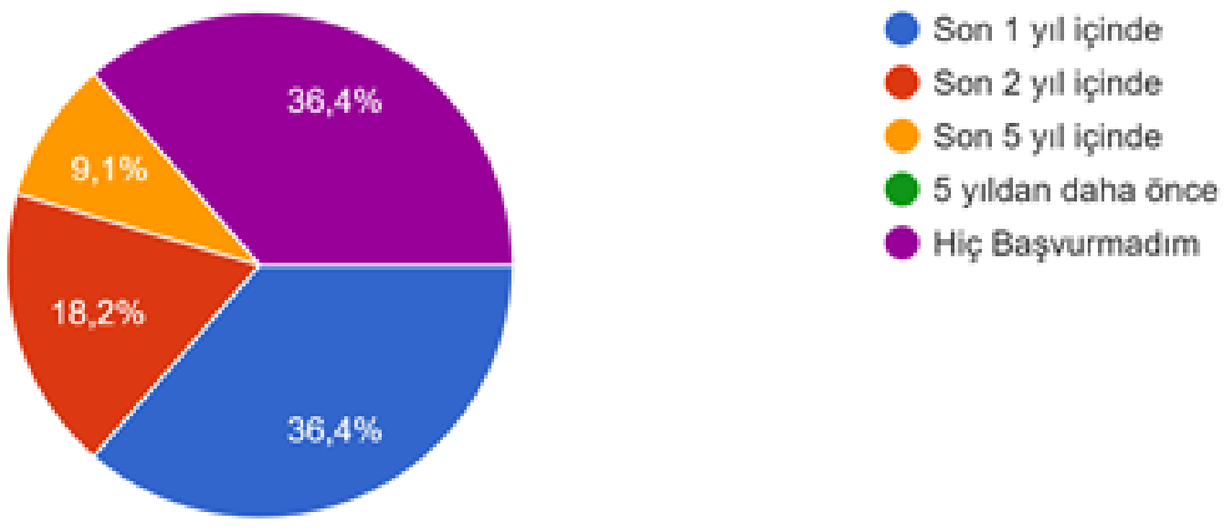
33 yanıt



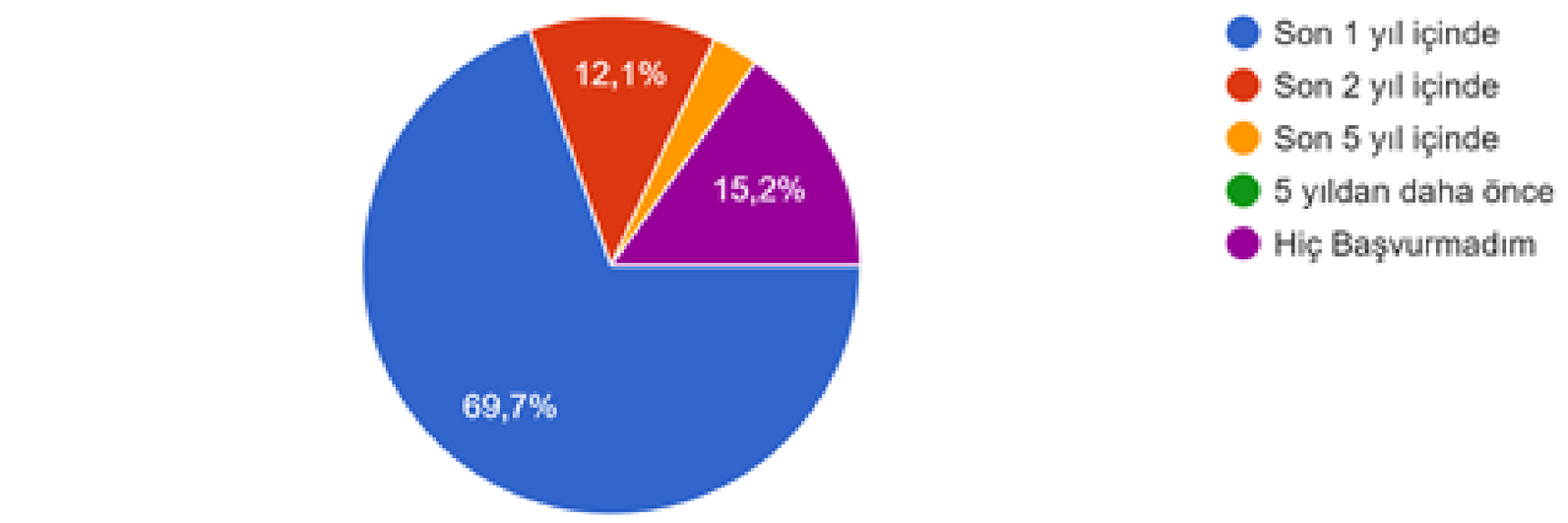
While the number of participants who prefer to go to state hospitals when they have a health problem is 22; 20 participants are preferring private hospitals; 13 of them are preferring private practice; 12 of them are preferring family physicians; 11 participants are preferring university hospitals; the number of participants who prefer private polyclinics is 9.

En son ne zaman genel sağlık kontrolü için hekime başvurdunuz?

33 yanıt

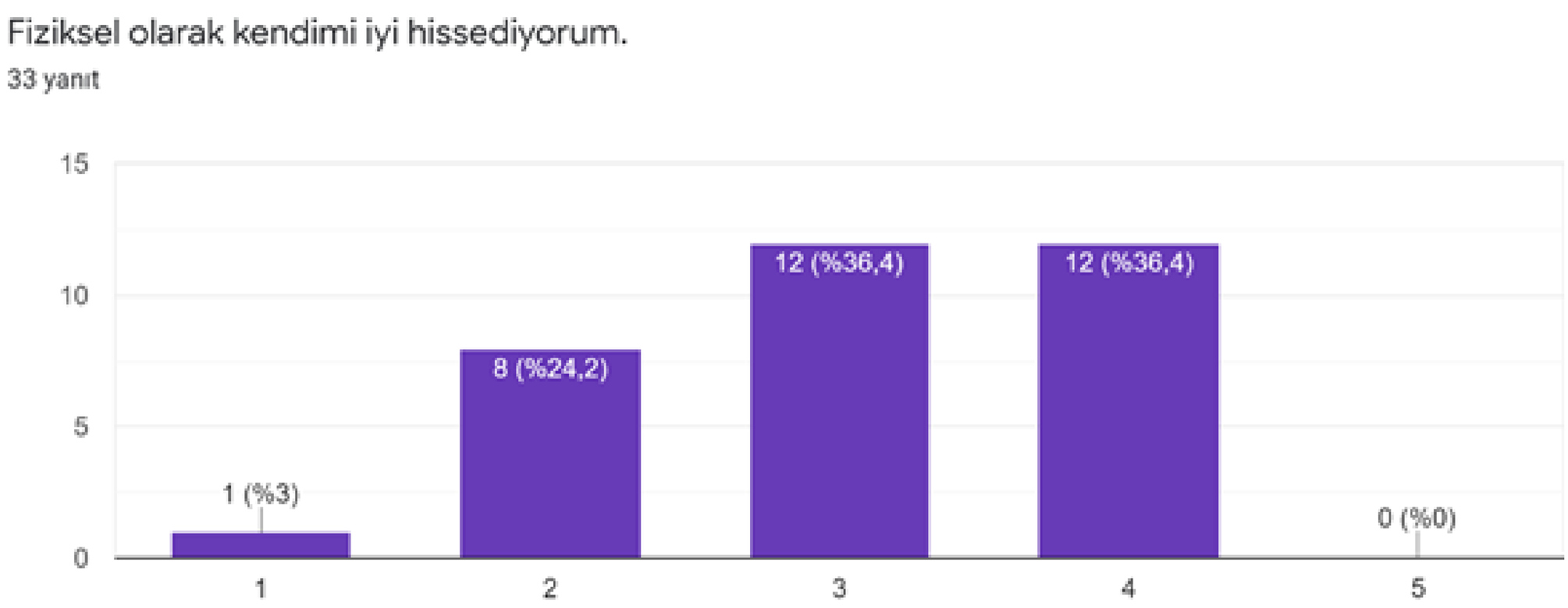


12 of the participants applied for a general health check within the last year; 12 never applied; 6 of them in the last two years; 3 applied within the last five years.



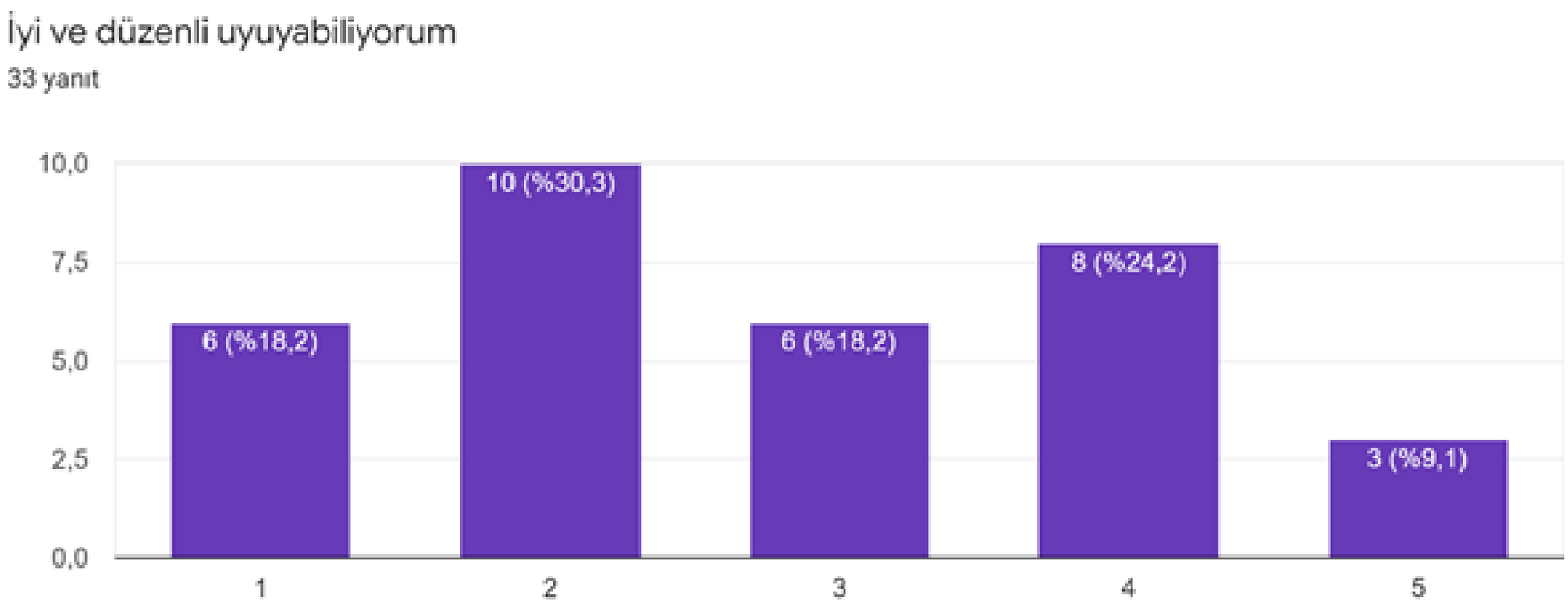
23 of the participants applied for mental support in the last year; 5 never applied; 4 in the last two years; 1 applied within the last five years.

4. PHYSICAL AND MENTAL WELL-BEING



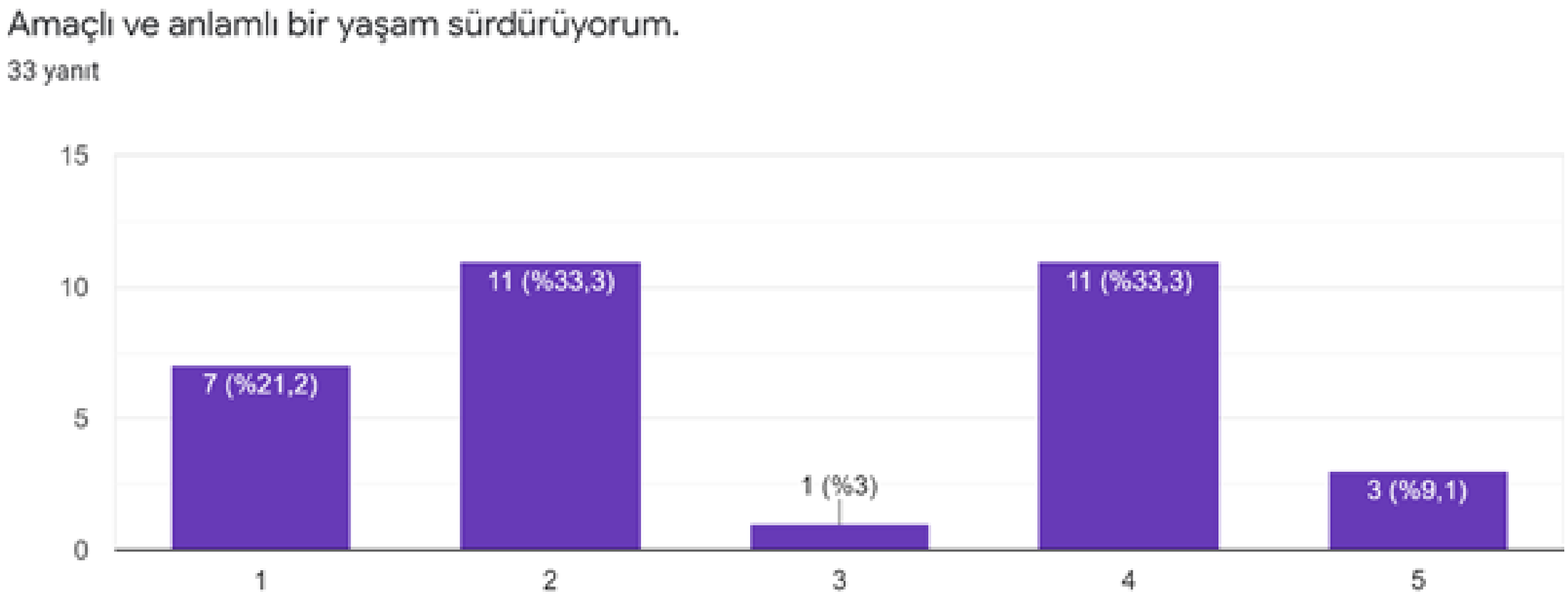
While the number of participants who often feel well physically is 12; 12 of them feel occasionally well; 8 of them feel very rarely well. The number of participants who have never felt physically well is 1. No participant stated that they always feel physically good.

16 of the participants stated that they felt very rarely prepared for extraordinary situations related to a disease; 9 never felt prepared; 4 often felt prepared; 3 occasionally felt prepared; 1 stated that they always felt prepared.

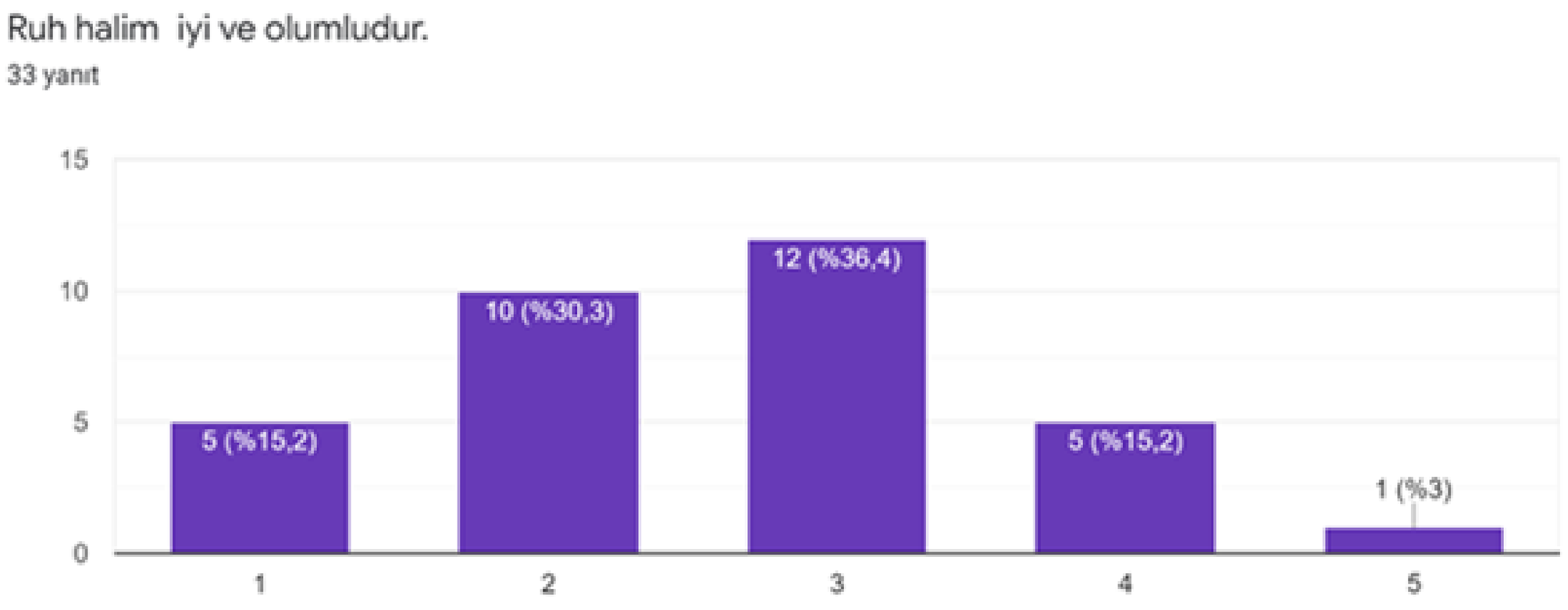


While 10 of the participants stated that they could sleep well and regularly; 8 of them stated often; 6 of them occasionally; 6 of them never; 3 of them stated that they could always sleep well and regularly.

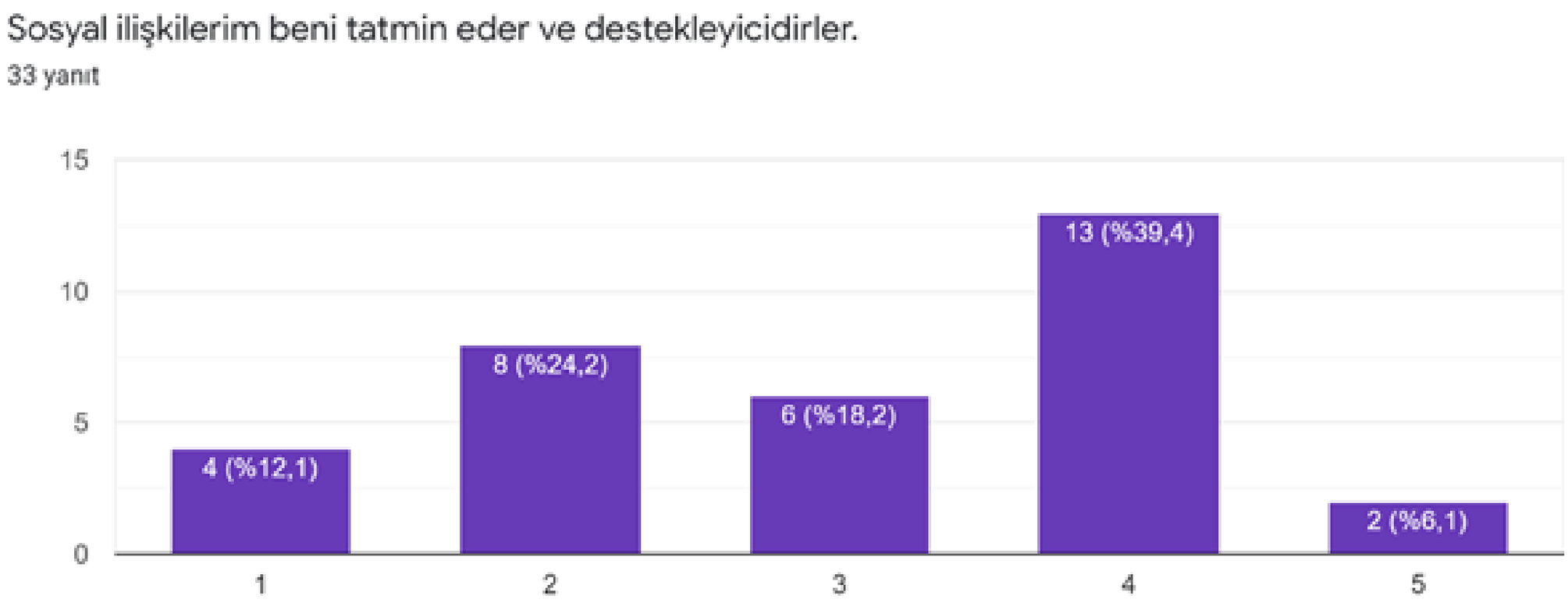
The number of participants who stated that they could never perform their daily activities because of having deficiency in focusing was 14; 12 can perform their daily activities without having; 4 of them stated often; 3 of them stated occasionally. There are no participants who can always perform their daily activities without having difficulty focusing.



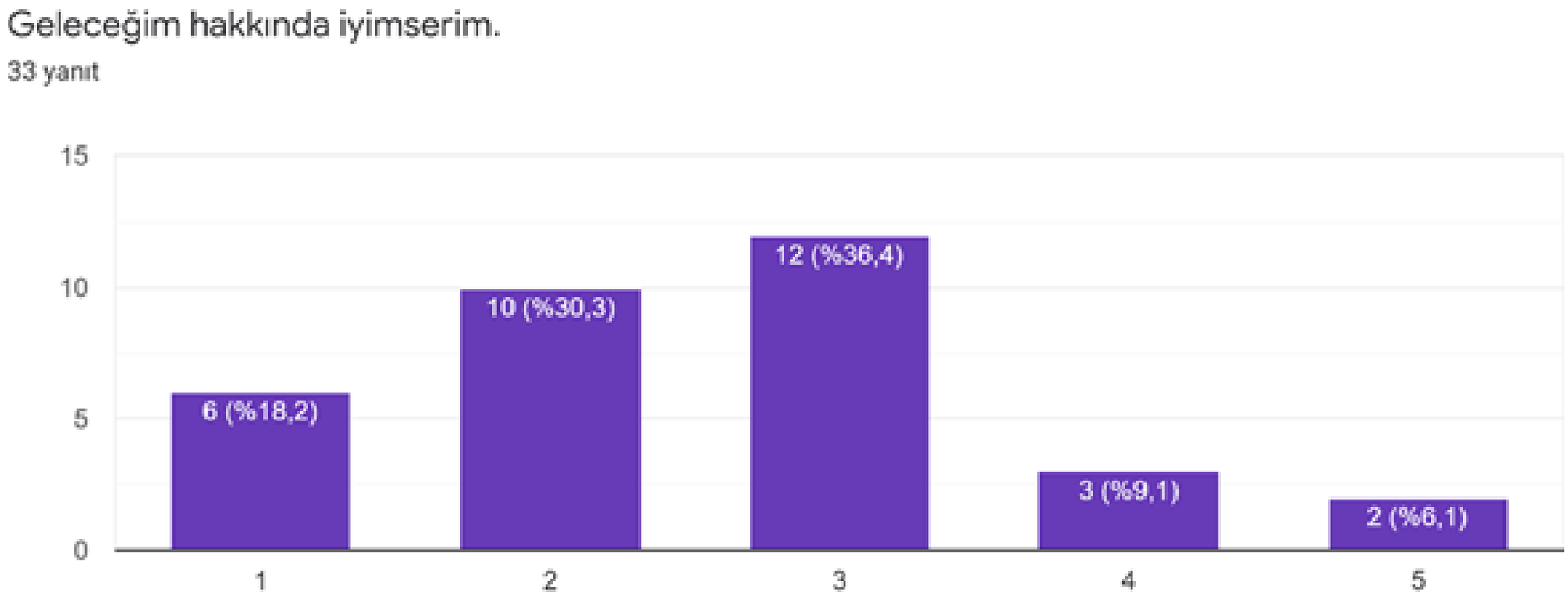
In questions about their mental well-being, 11 participants lead very rarely; 11 participants have very rarely lead a purposeful and meaningful life, whereas 11 of them often, 4 of them lead always; 1 occasionally leads a purposeful and meaningful life; the number of participants who have never felt that they are living a purposeful and meaningful life is 7.



12 of the participants described their mood as good and positive occasionally; 10 very rarely; 5 never; 5 often; 1 stated that they are always in a good and positive mood.

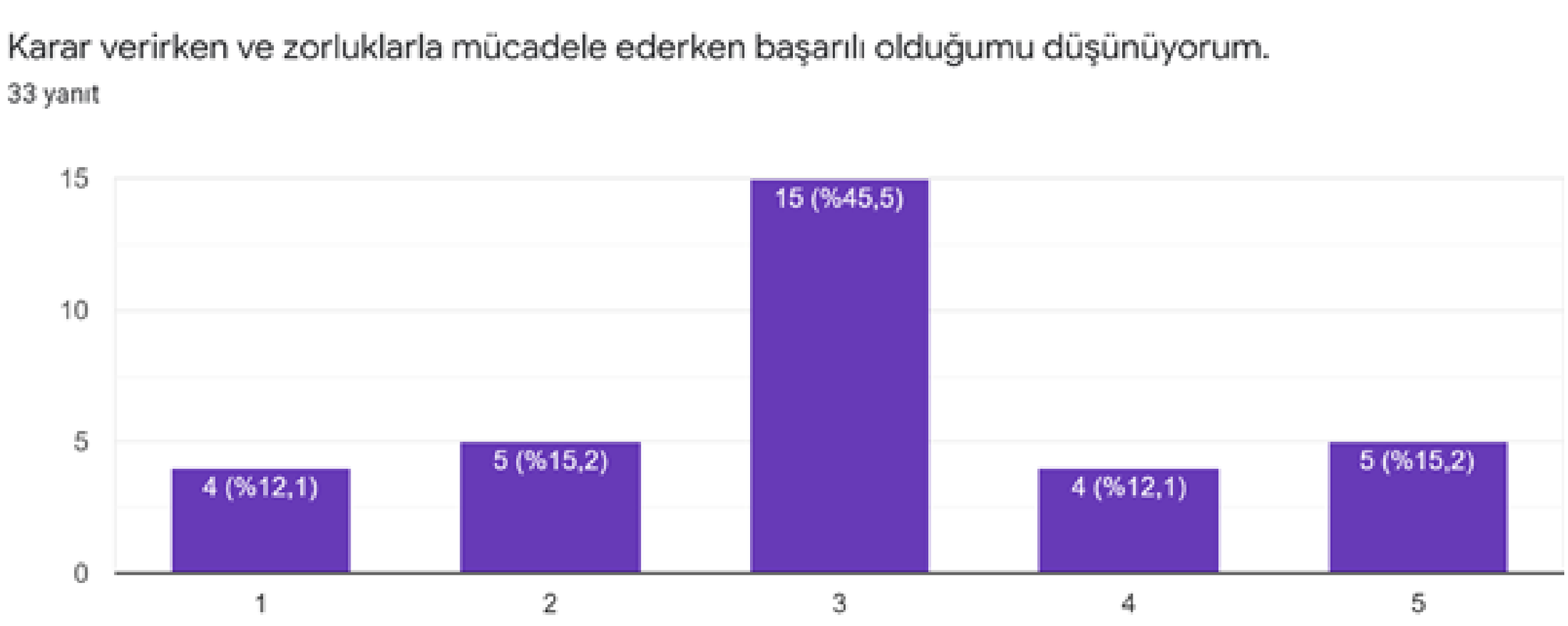


While 13 participants stated that their social relations were often satisfactory and supportive; 8 very rarely; 6 of them occasionally; 4 of them stated never; 2 of them always had satisfactory and supportive social relationships.



12 participants stated that they are occasionally optimistic about their future ; 10 very rarely; 6 never; 3 of them stated that they are often; and 2 of them are always optimistic about their future.

11 participants often; 7 of them occasionally; 7 very rarely; 6 of them stated that they always feel that people in their lives love and respect them; 2 of them stated that they never felt this.

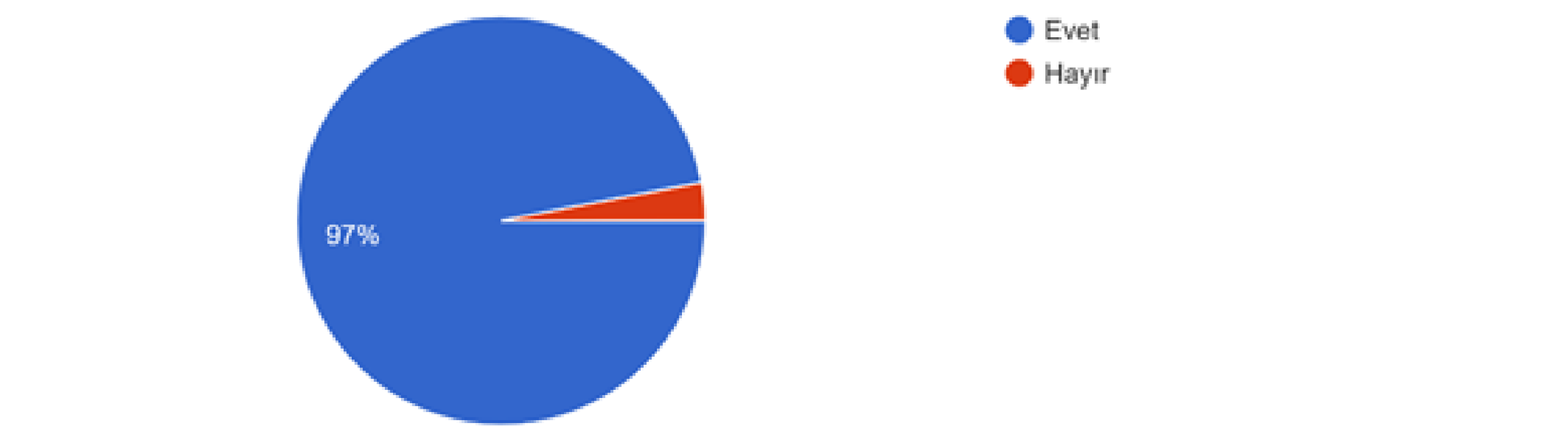


While 15 participants occasionally thought that they were successful in making decisions and coping with difficulties; 5 of them always; 5 of them very rarely; 4 of them often; 4 of them stated that they thought they could never be successful at decision-making and coping with difficulties.

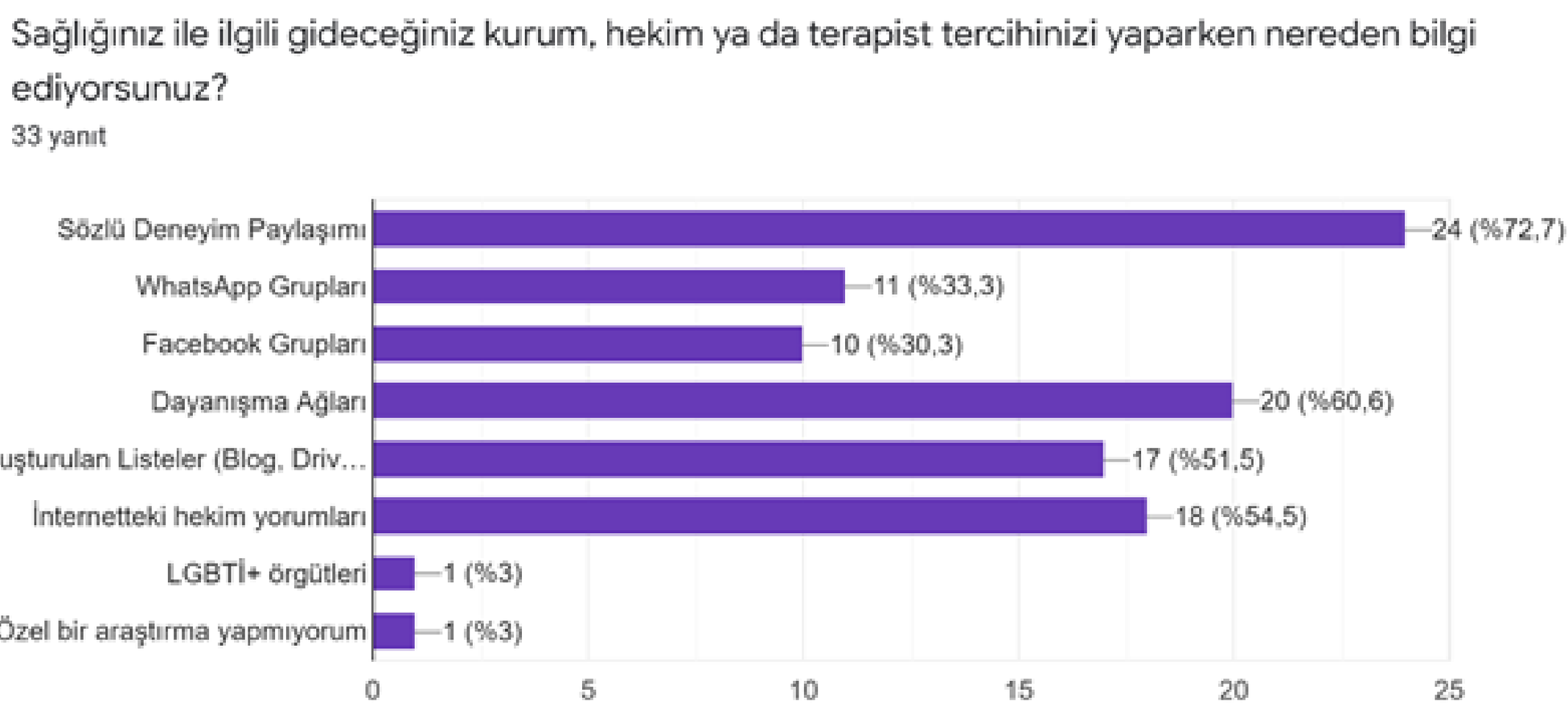
5. ACCESS TO HEALTH SERVICES.

22 of the participants think that trans+ individuals always experience discrimination while receiving health care services; 9 often, 1 occasionally; 1 of them stated that they think they face discrimination very rarely. There is no participant stated "never" as an answer to this question.

While 31 of the 33 participants stated that they did not think that the health services provided would meet the needs of trans+ people, 2 stated that they considered the health services provided sufficient.



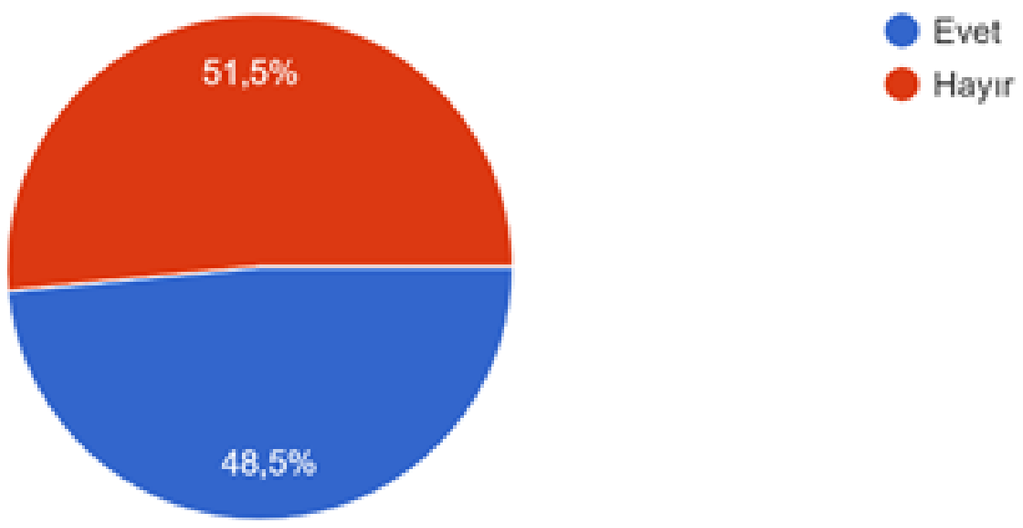
32 participants stated that they felt uneasy about the reactions they would receive before applying to health services; the number of participants who stated that they did not feel such uneasiness is only 1.



While deciding the institution, doctor or therapist they will go to for a health problem, 24 participants preferred verbal experience sharing in the question where the participants gave multiple answers about which information sources they used; 20 participant preferred solidarity networks; 18 participants considered comments about medical personnel on the internet; 17 participants considered blogs and lists created in digital tool; 11 participants preferred WhatsApp groups; 10 participants preferred Facebook groups. One of the two participants who chose the other option preferred LGBTI+ associations; the other participant stated that they did not do any special research for this.

Gerekli olduğunu düşündüğüm ya da istediğim zaman psikolojik desteğe erişebiliyorum/erişebilirim.

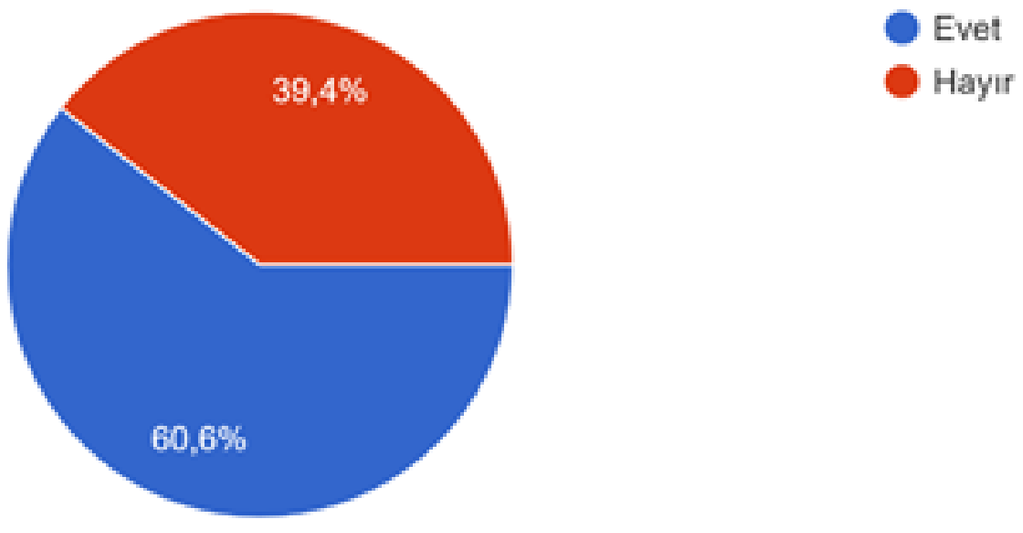
33 yanıt



While the number of participants who can access psychological support when necessary or whenever they want is 17; the number of those who cannot reach psychological support is 16.

Psikolojik Destek Hizmetlerini pahalı olmaları sebebiyle karşılayamıyorum.

33 yanıt

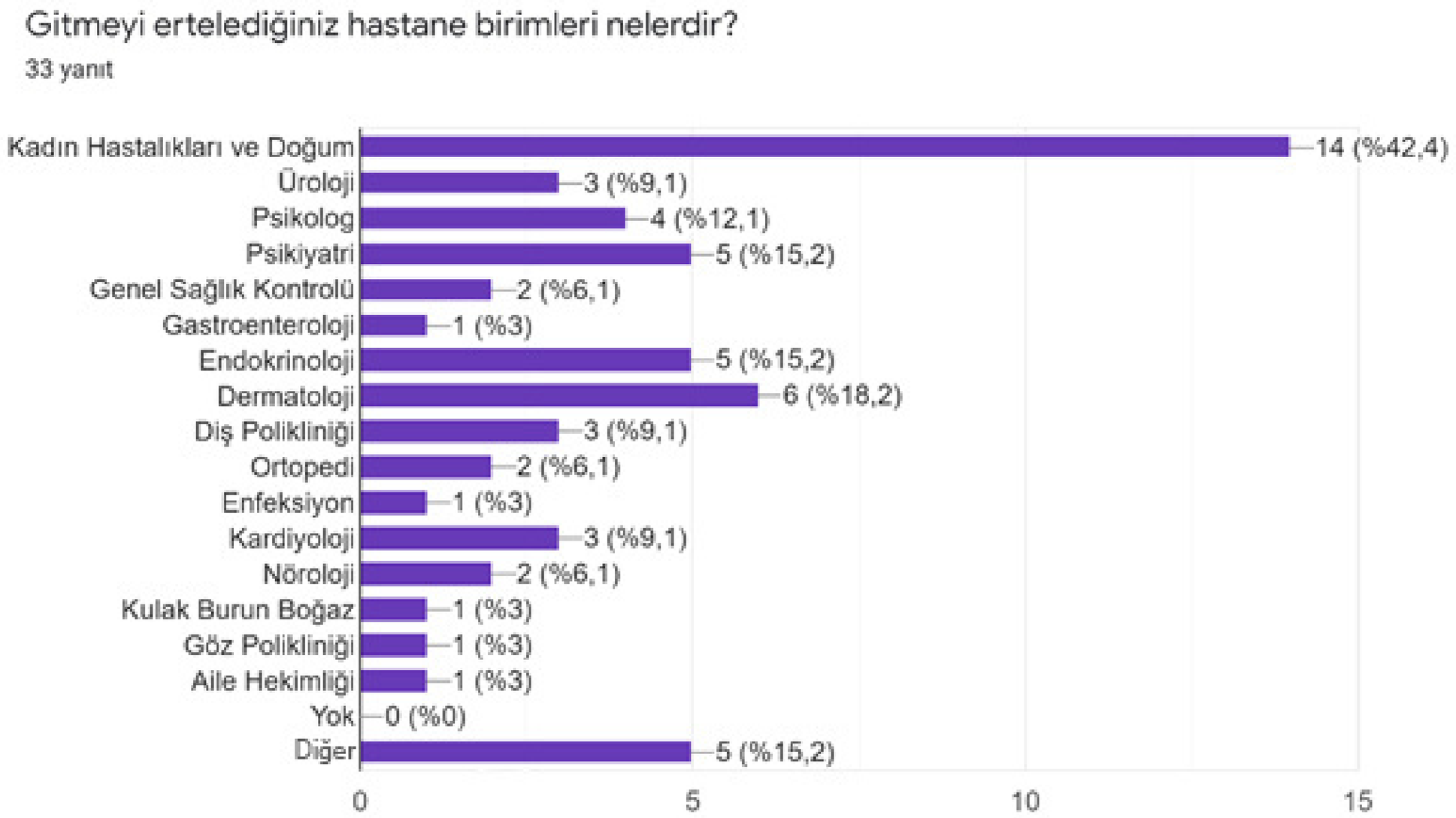


While 20 participants stated that they could not afford psychological support services because they were expensive; 13 participants stated that they did not encounter such a problem.

In the question of which the participants can give multiple answers, of which institutions they prefer for psychological support, 20 participants prefer private clinics/centers; 13 participant stated LGBTI+ associations' psycho-social support programs; 11 participants prefer state hospitals; 6 participants stated that they prefer private hospitals.

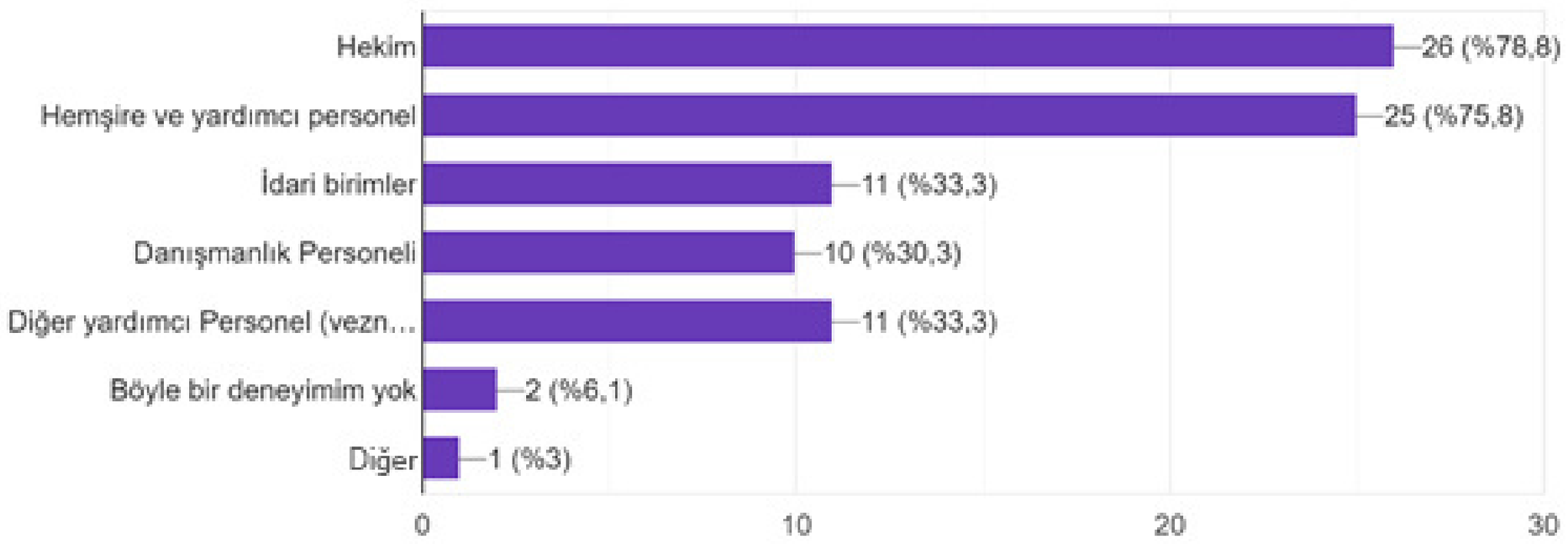
"I apply to LGBTI+ associations that provide psycho-social support. At least, I think that I will not encounter phobic comments and that it is a safer space for trans+ people."
- Participant 15

"Now that I have started working, I go to another therapist. When I was a student, I applied to therapists and networks of LGBTI+ associations. I wish they had more."
- Participant 7



When they were asked which hospital units the participants postponed going to, 14 participants stated that they postponed going to the Gynecology and Obstetrics unit; 6 of the participants stated Dermatology; 5 of them stated Endocrinology; 5 of them stated Psychiatry; 4 of them stated Psychologists; 3 of them stated Urology; 3 of them stated Cardiology; 3 participant stated Dental Clinics; 2 of them stated General Health Check; 2 of them stated Neurology; 2 of them stated that they postponed going to Orthopedics departments. There is one participant each who postponed going to Gastroenterology, Infection Unit, Ear Nose and Throat, (ENT), Eye Polyclinic, and Family Physician. 2 of the participants who marked the "other option" postponed their transition, 1 postponed the check-ups after their transition; 2 people stated that they had reservations about going to any unit, but primarily gynecology. None of the participants stated that there was no unit they postponed going to.

"I've never had a gynaecology examination before, because I don't know what is expecting for me."
-Participant 12



In the question about which medical personnel group participants observed discriminatory and stigmatizing behavior the most, 26 of the participants pointed out doctors; 25 of them pointed out nurses; 11 of them stated administrative units; 11 of them pointed out other auxiliary personnel such as pay desk, security, cleaning personnel; 10 of them pointed to their consulting staff. 2 of the participants stated that they had no such experience; a participant stated that they observed discriminatory and stigmatizing behavior mostly in primary care physician.

"The doctor attending the endocrinology clinic said, "Oh, why are you havign this, honey, are you going to get pregnant?" over a drug that I use for my breast development and also used during pregnancy, and laughed at me. There were 2 more assistants in the room besides me and everyone froze up."

- Participant 25

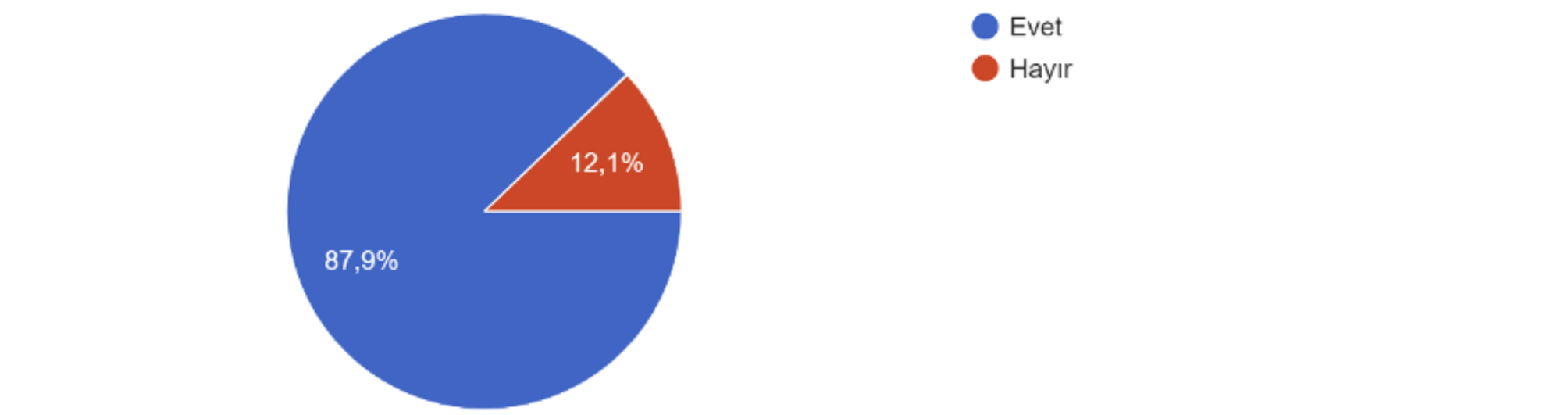
"All health care professionals should undergo general training so that LGBT+ individuals can benefit from their vital patient rights."

- Participant 17

In the question that the participants gave multiple answers about what are the reasons that prevent them from accessing health services even in case of need, 28 of the participants thought that they would be exposed to bad and discriminatory behavior by showing their sexual identity and orientation as a reason; 16 of them thought that patient privacy rights would not be protected; 4 of them stated that their health insurance was insufficient or that it does not fully cover the costs. The number of participants who do not have such hesitation is 3. 1 participant cited the lack of access to good doctors during the pandemic, and another participant cited the physicians' lack of knowledge about sexual identity and orientation as a reason of having hesitation.

"Physicians' limited knowledge of sexual orientation and gender identity worries me about the way they will guide me."
- Participant 18

"I don't have such reservations, but this is definitely not because every doctor is very conscious and woke. I go to the same doctors I trust for years for my checkups, but I am very afraid that one day I will not be able to reach one of those ally doctors."
- Participant 3

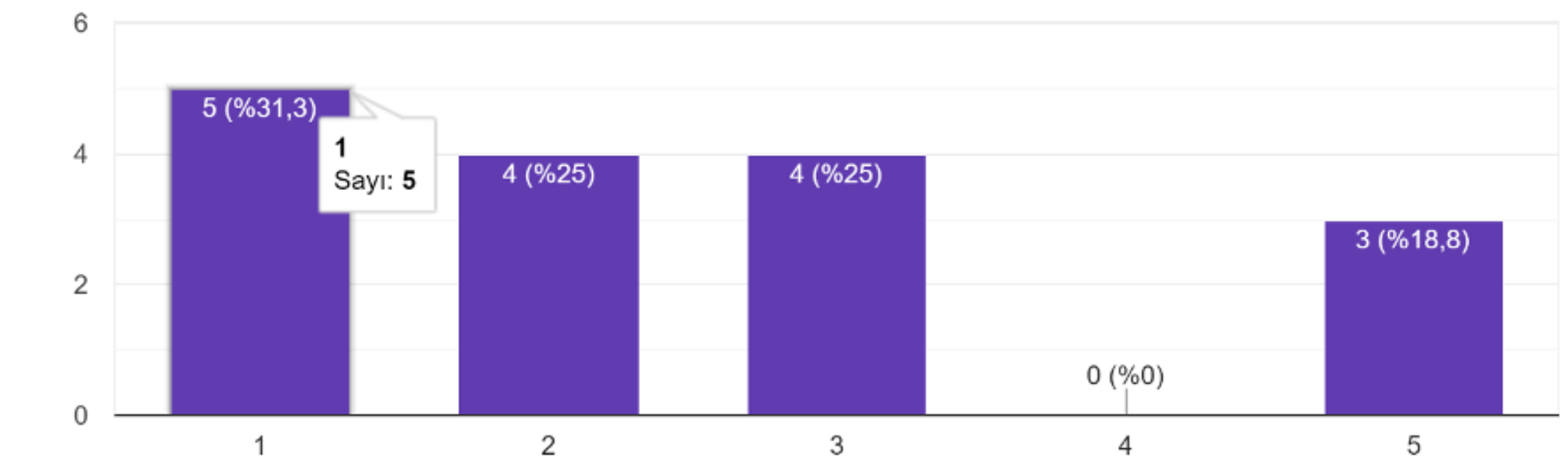


While 29 participants (87.9%) stated that the positive or negative reactions of the medical personnels affect their way of utilization of health services; 4 participants (12.1%) stated that it did not affect them.

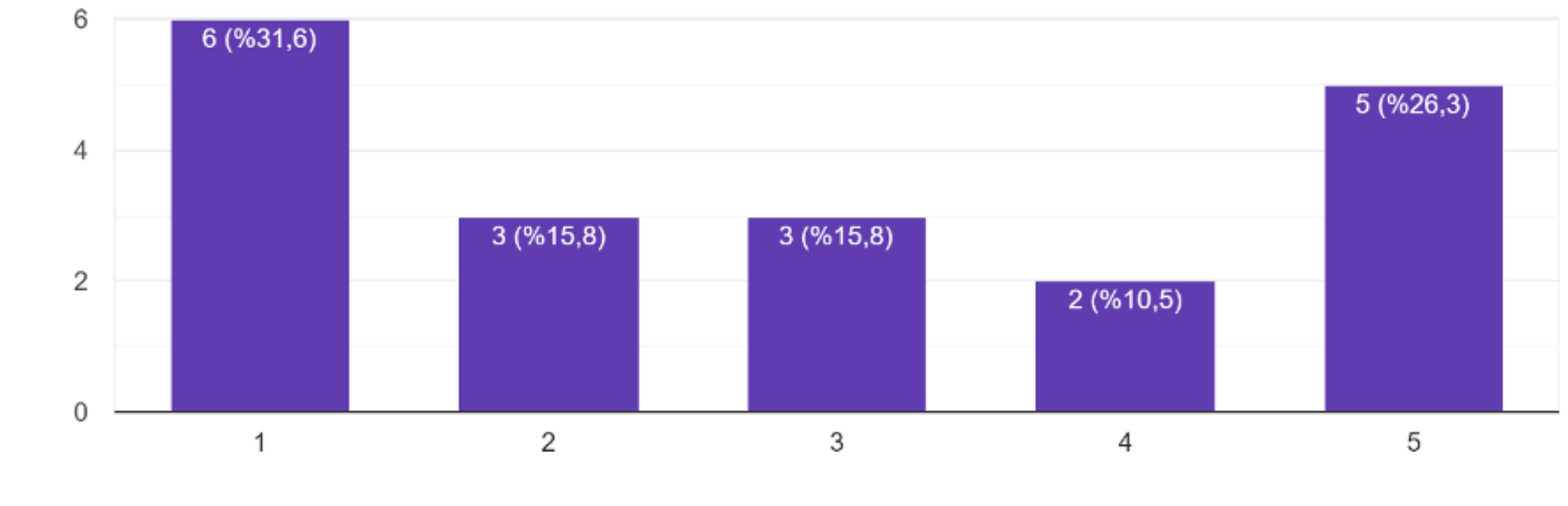
"After a phobic and discriminatory gynecologist examination I had in the past, I could not go back for an examination for nearly a year and a half. Now every time I go, I worry about what awaits me this time."
- Participant 29

Only the participants who are in transition were asked to answer the following 9 questions in this section, and it was stated that they could pass a question if they had not experienced. In the charts, 1 means never, 2 means very rarely, 3 means occasionally, 4 means often, 5 means always.

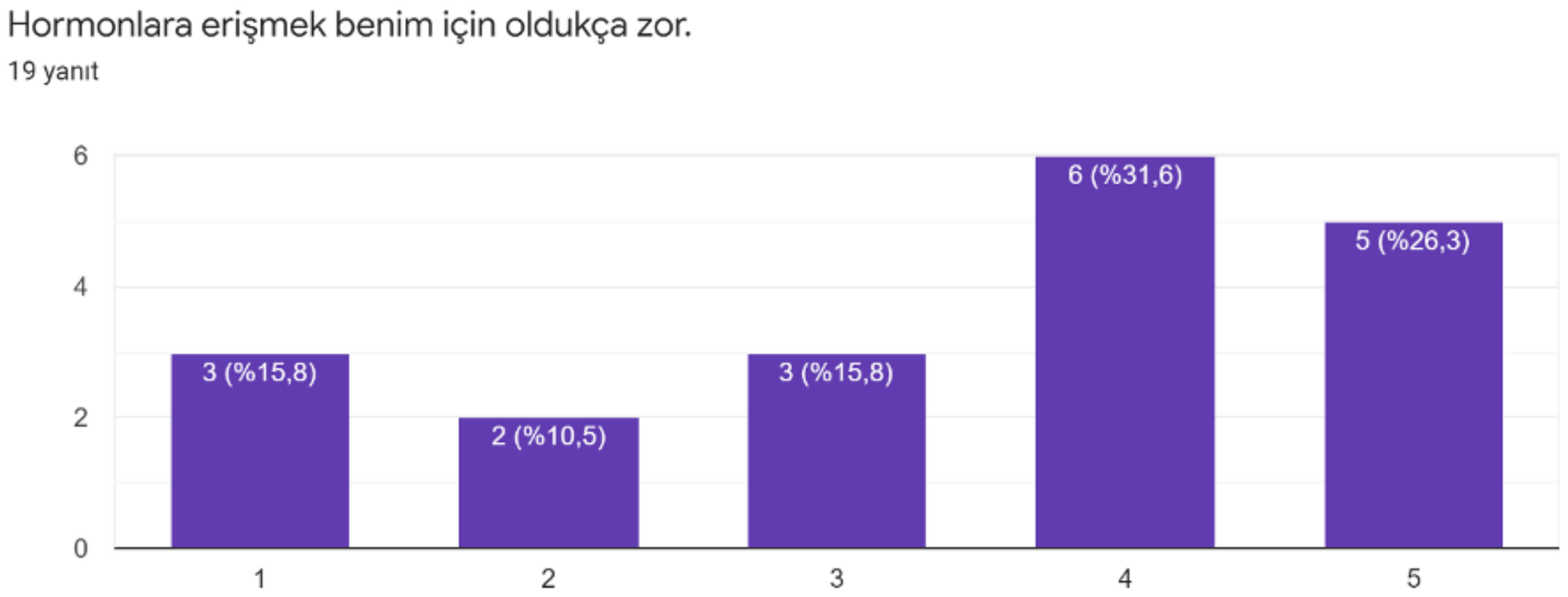
20 of the participants answered the statement "Doctors have sufficient knowledge of trans+ identity and transition"; 9 participants stated never; 6 participants stated very rarely; 5 participants responded occasionally. There are not any participants who selected the option often and always.



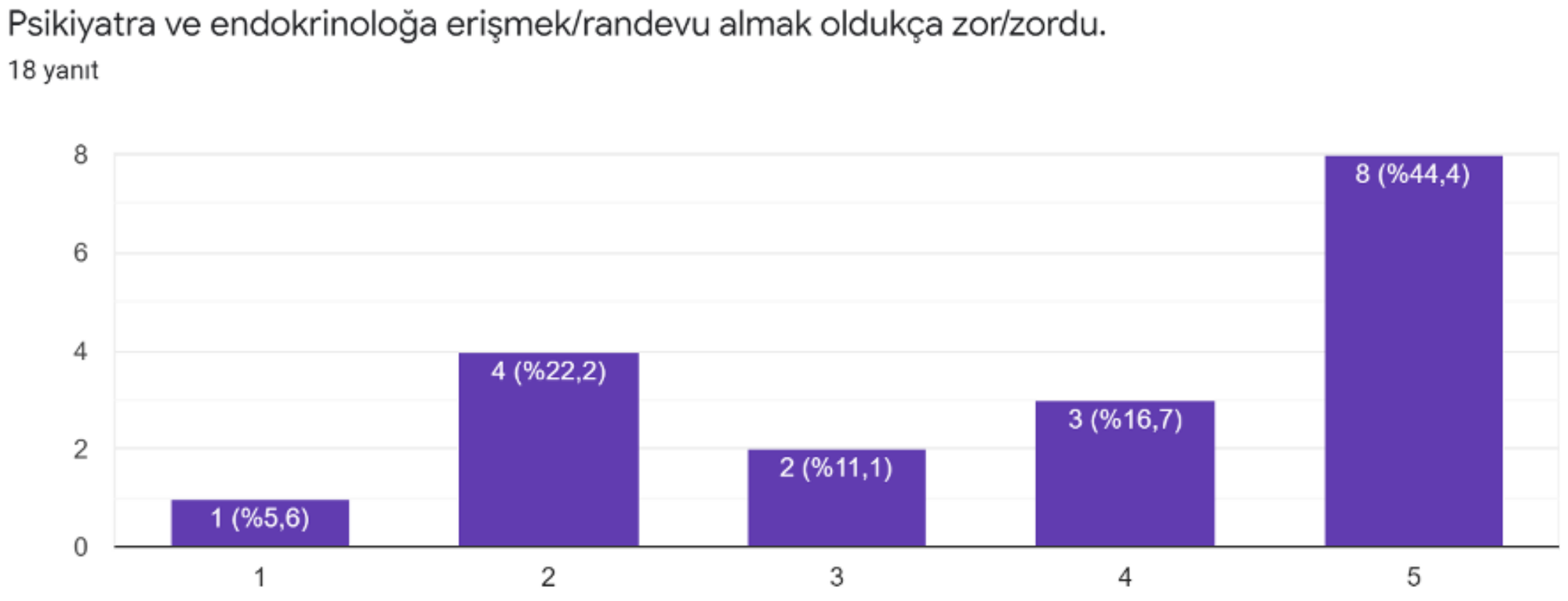
While 5 out of 16 participants stated that physicians never gave sufficient information about the transition and/or did not explain different options; 4 of them said very rarely; 4 of them stated occasionally, and 3 of them stated always. There were no participants who selected often.



6 out of 19 participants stated that they have never experienced a problem as not being able to find a suitable hospital/doctor in the city they live in; 5 of them always had this problem; 3 of them said very rarely; 3 of them said occasionally; 3 of them stated that they encountered this problem often.



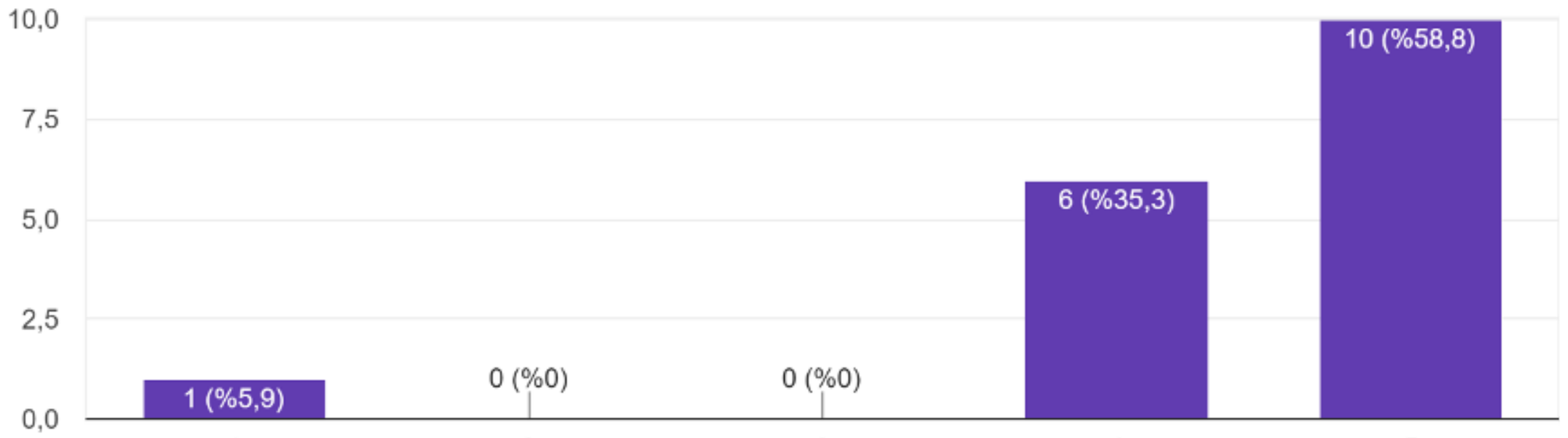
6 out of 19 participants stated they often had difficulties in accessing to hormones; 5 of them stated always; 3 of them stated occasionally; 2 of them stated that it is very rarely difficult; 3 participants stated that they have never had a problem with access to hormones.



While 8 out of 18 participants stated that they always had difficulties in accessing a psychiatrist and endocrinologist for the transition; 3 stated often; 2 stated occasionally; 3 stated very rarely; 1 of them stated that they have never experienced such a problem.

Psikiyatrik değerlendirmede benden abartılı bir kadınlık/erkeklik performansı beklendiğini düşünüyorum/düşündüm.

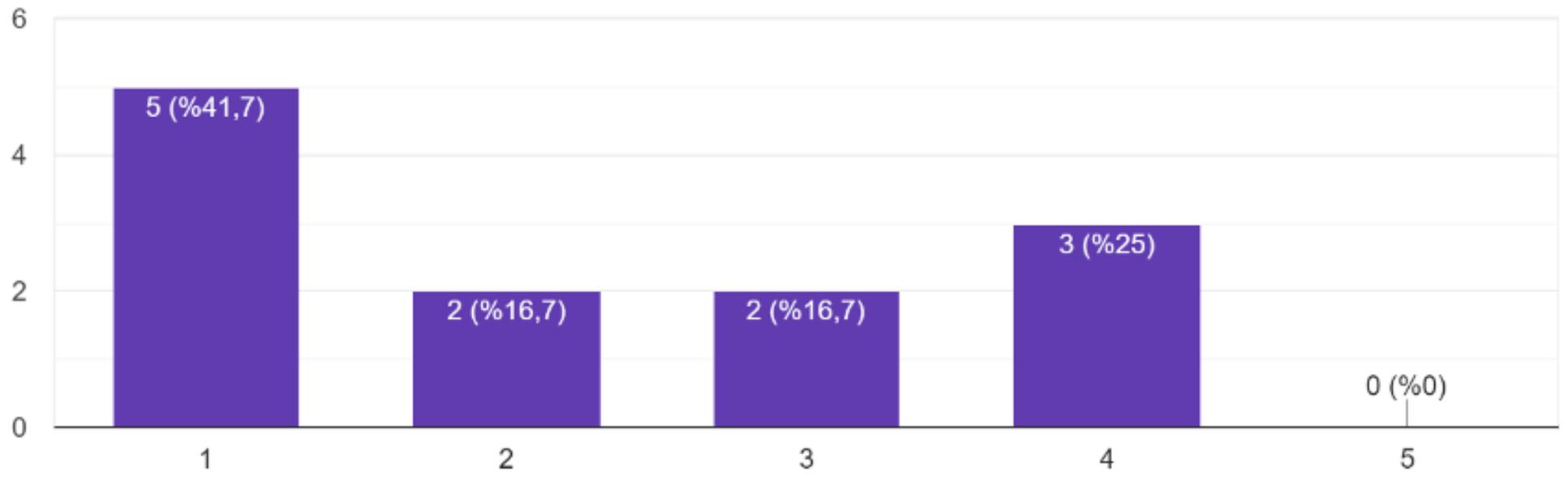
17 yanıt



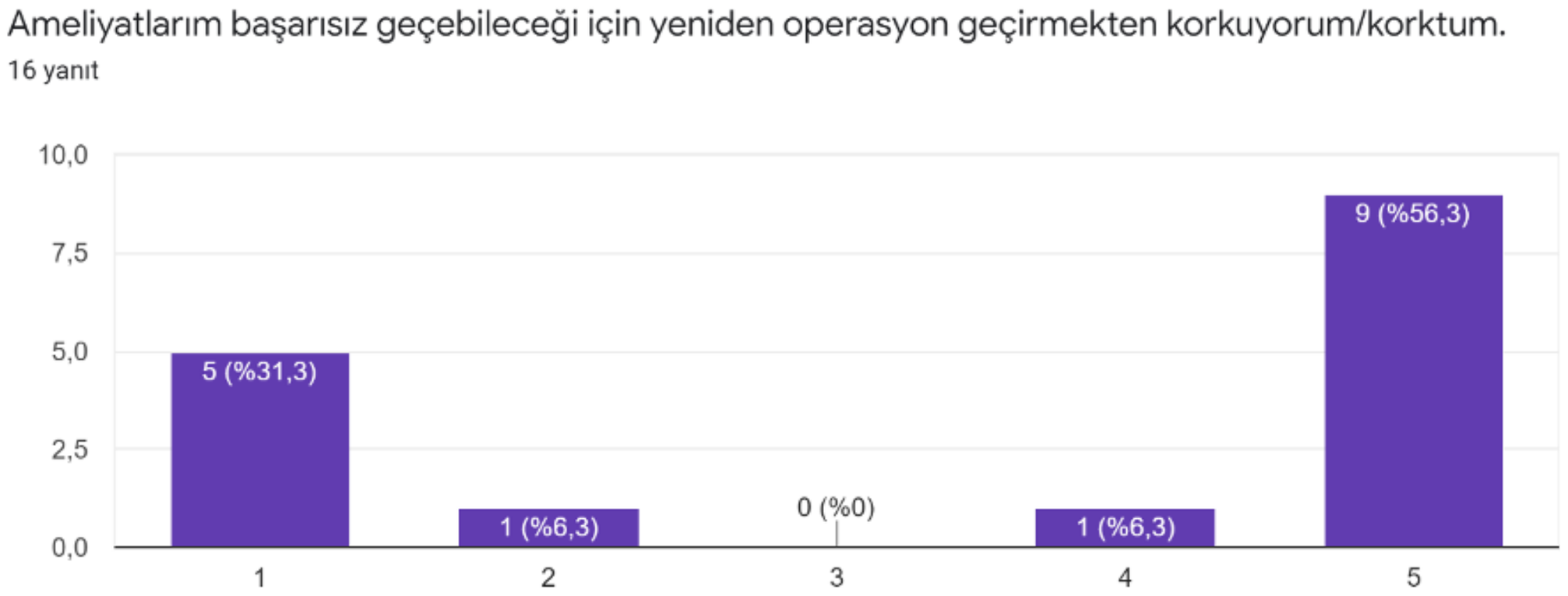
10 out of 17 participants stated that an exaggerated femininity/masculinity performance is always expected from them in the psychiatric evaluation made during the transition; 6 of them said often; 1 of them stated that they have never encountered such an expectation. There isn't any participant who selected the option very rarely and occasionally.

Geçirdiğim operasyonların ardından müdahale edilmesi gereken bir durumla karşılaştığımda talebim sağlık personelleri tarafından reddedildi/ihmal edildim.

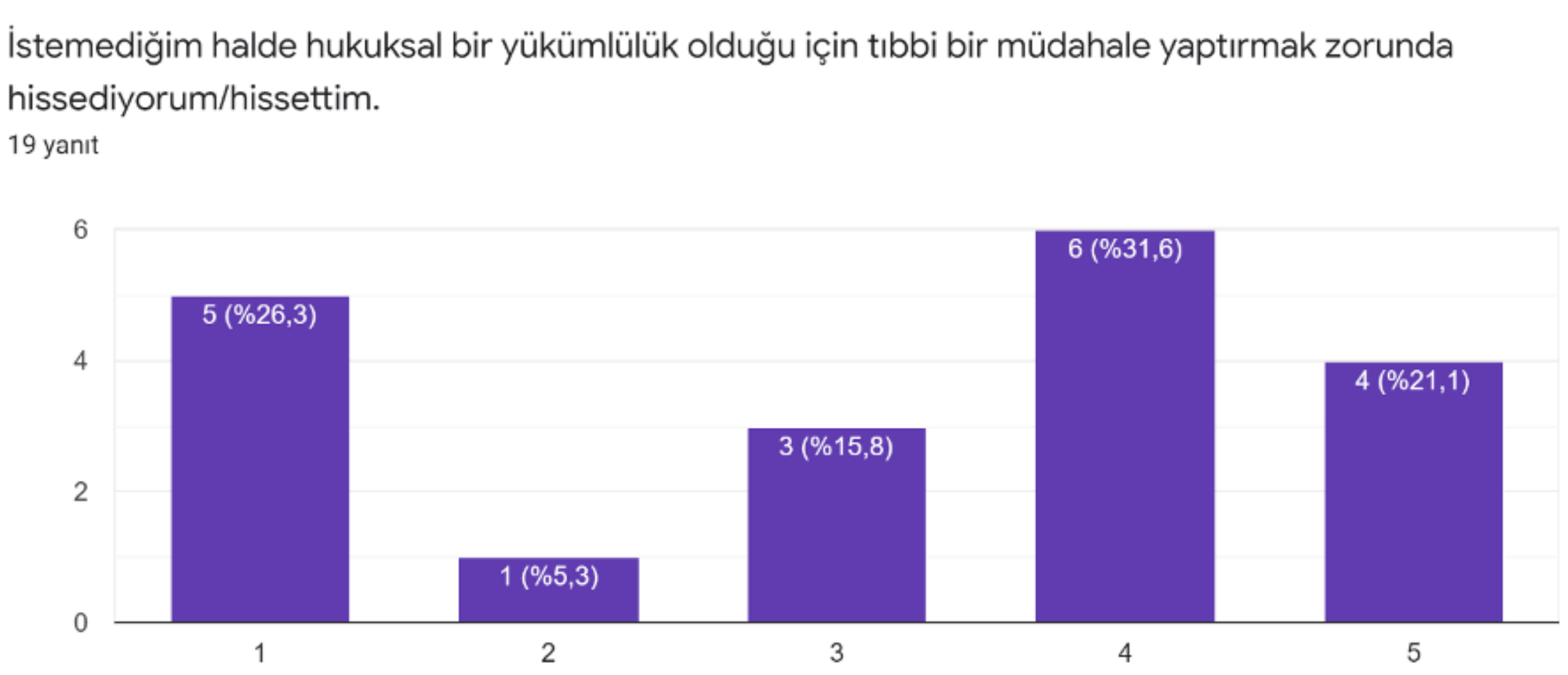
12 yanıt



While 5 of the 12 participants stated that they were never neglected by the medical personnel when they encountered a situation requiring intervention after their operations; 3 of them stated often; 2 of them stated occasionally; 2 of them stated that they were exposed to neglect very rarely. There is not any participant who always encounters this kind of negativity.

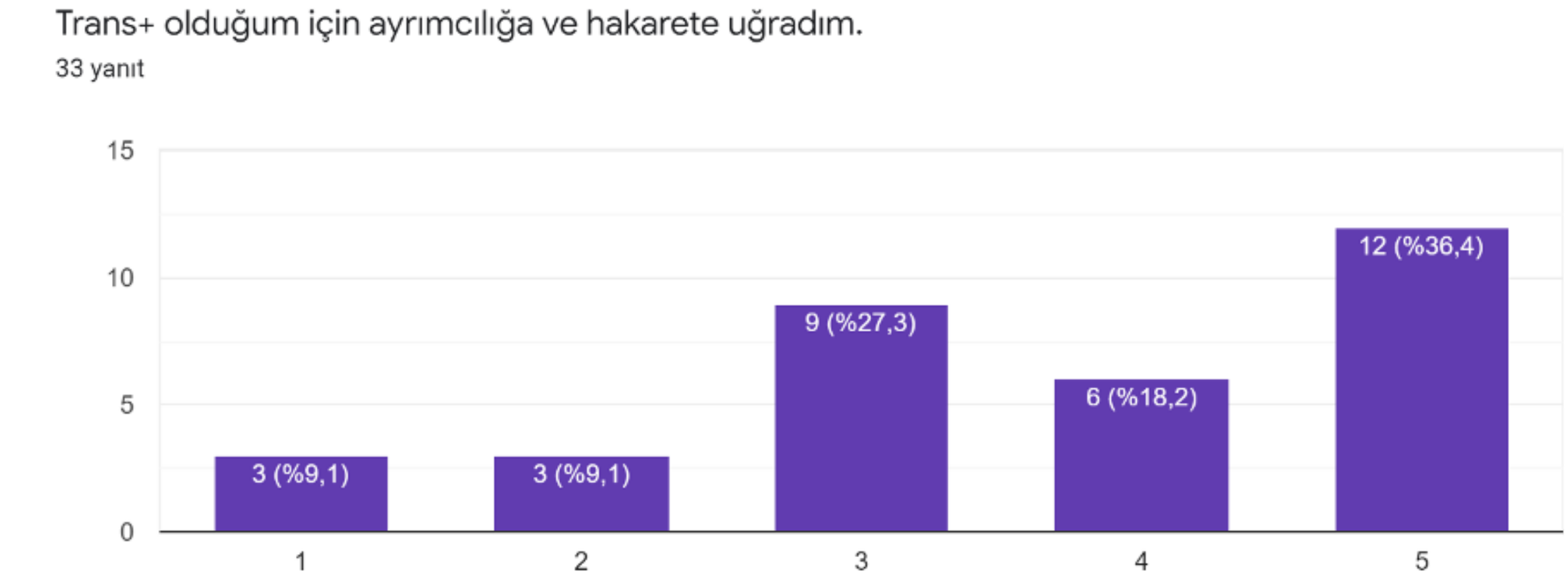


While 9 out of 16 participants stated that they were always worried about the unsuccessful operation and the possibility of reoperation; 1 of them stated often; 1 of them stated that very rarely had this concern; 5 of them stated that they had no such concerns.



6 out of 19 respondents who answered the question about whether they feel obligated to medical interventions in their transition because it is a legal obligation although they do not want to; 4 stated always; 3 stated occasionally; 1 of them stated that they felt this very rarely; 5 participants stated that they never felt this obligation.

6. DISCRIMINATION IN ACCESS TO HEALTH SERVICES



12 respondents stated that they are always discriminated against and insulted because they are trans+; 9 are occasionally; 6 are often; 3 are very rarely. There are 3 participants who stated that they have never been discriminated against or insulted based on their trans+ identity.

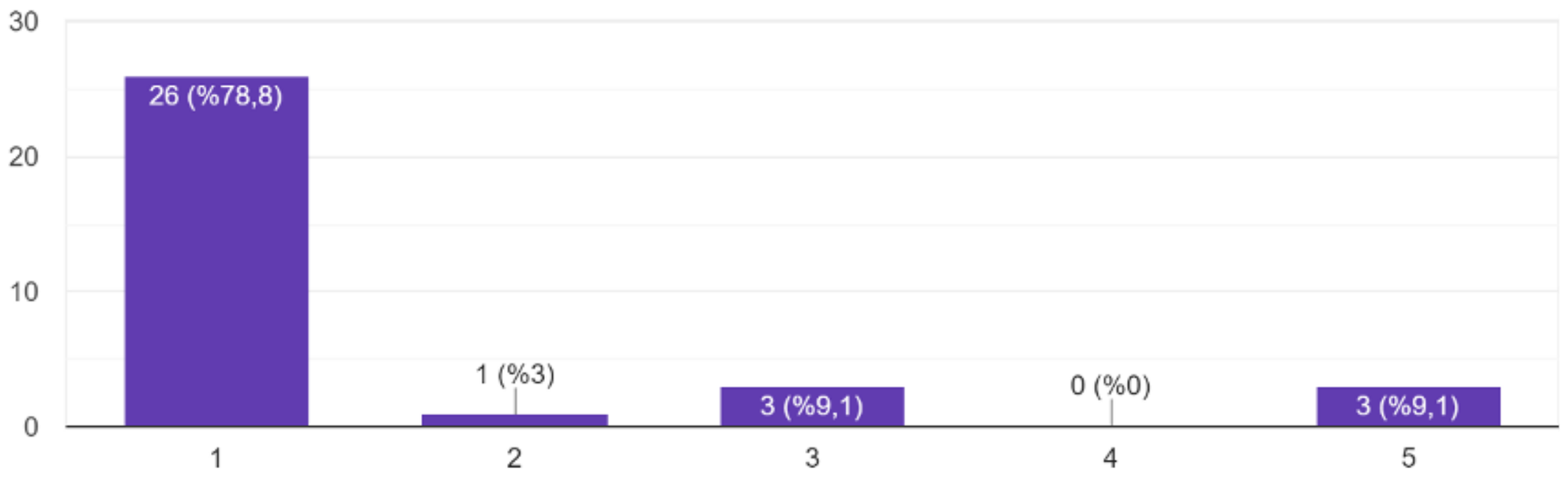
"Last year, I was harassed by a medical professional after seeing my surgical scars, and it had triggered my depression and anxiety. I regretted my surgery so much, I felt so helpless and disgusting. Thanks to my friends, I figured out that what I went through was harassment, but I didn't know what to do about it. After this experience, I became even more afraid and hesitant to apply to health-care institutions. Medical personnel should also be given proper training on LGBTI+s' needs."
- Participant 5

"I am often discriminated against more 'indirectly' because I am assigned as cisgendered. Addressing me by my assigned name and assigned gender makes me feel ignored and that is the situation I encounter most often."
- Participant 12

"Even if I go for a different ailment, they act as if the main reason for my illness is that I'm trans+ and bisexual. Once, a gynecologist who knew my gender identity and sexual orientation said 'wow! surprised!', because my test results were negative. I don't know what to do when I experience such things because the complaint mechanisms don't work well."
- Participant 20

Trans+ olduğum için gittiğim hastanede/muayenehanede fiziksel şiddete uğradım.

33 yanıt



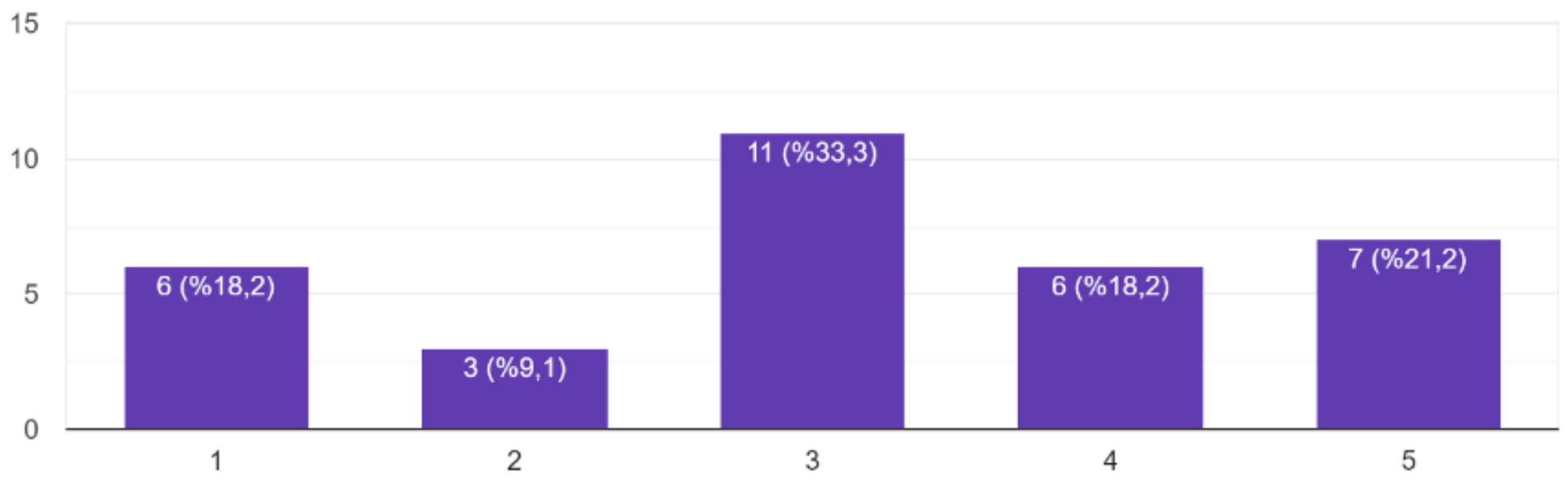
There are 26 participants who stated that they have never been subjected to physical violence based on their gender identity in the hospital or clinic they went to; 3 participant stated always; 3 of them stated occasionally; 1 of them stated very rarely.

"I may be one of the 'lucky' few who have not been subjected to physical violence at hospitals, but I worry about it every time I go to the hospital. That's why I don't want to go to the hospital alone and if I can't find a friend to come with me, I postpone going there even if I have an urgent situation."

- Participant 23

Sağlık personeli trans+ olduğumu anlayınca ilgisiz davranıyor.

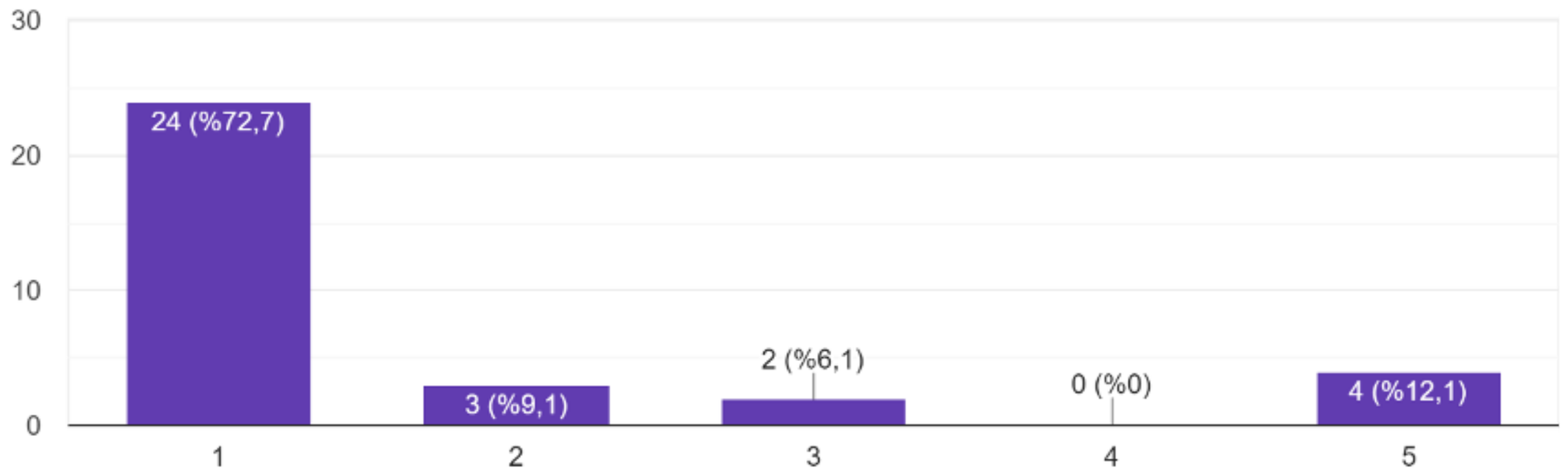
33 yanıt



When 11 of the participants stated that medical personnel were occasionally indifferent to their needs becuse they are trans+; 7 of them stated always; 6 of them stated often; 6 of stated they never had such an incident; 3 of them stated that in this situation, the health personnel very rarely acted indifferently.

Hastane/Poliklinik/Muayenehanedeki sağlık uygulamaları ya da doldurmam istenen formların trans+ları kapsadığını düşünüyorum

33 yanıt

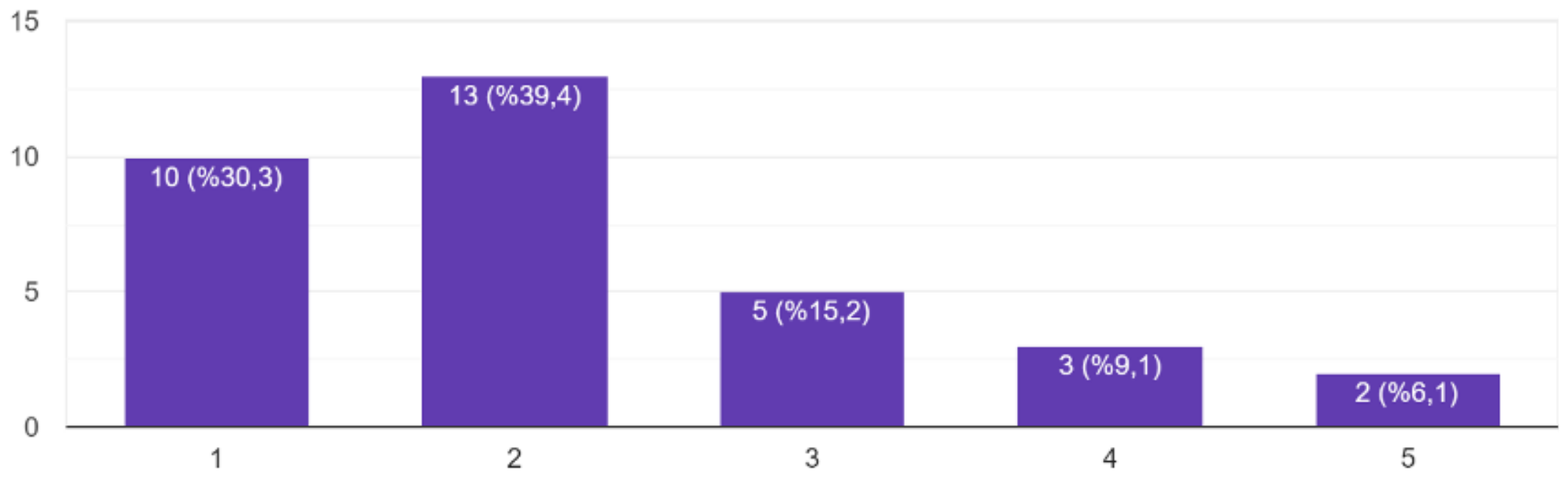


While 24 participants think that the applications in the places where they received health services and the forms they were asked to fill, never covered trans+s; 4 participant think always; 3 participant think very rarely; 2 of them stated that they think they are occasionally inclusive.

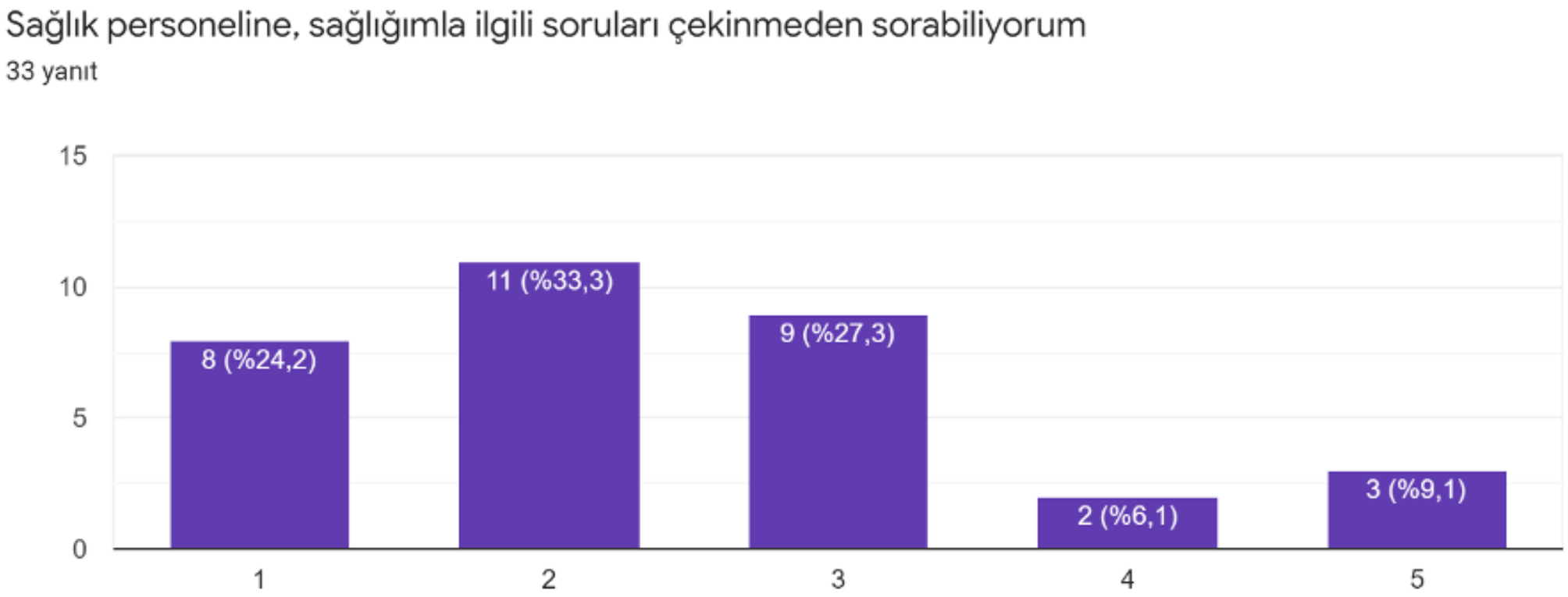
"I feel ignored as a trans nonbinary because the questions we were asked at the hospital and the forms we had to fill were based on binary gender system and heteronormativity. That's why I don't want to go to the hospital unless it's very urgent"
- Participant 11

Sağlık personeli genellikle benim ihtiyaçlarımı önemsiyor ve öncelikli kılıyor.

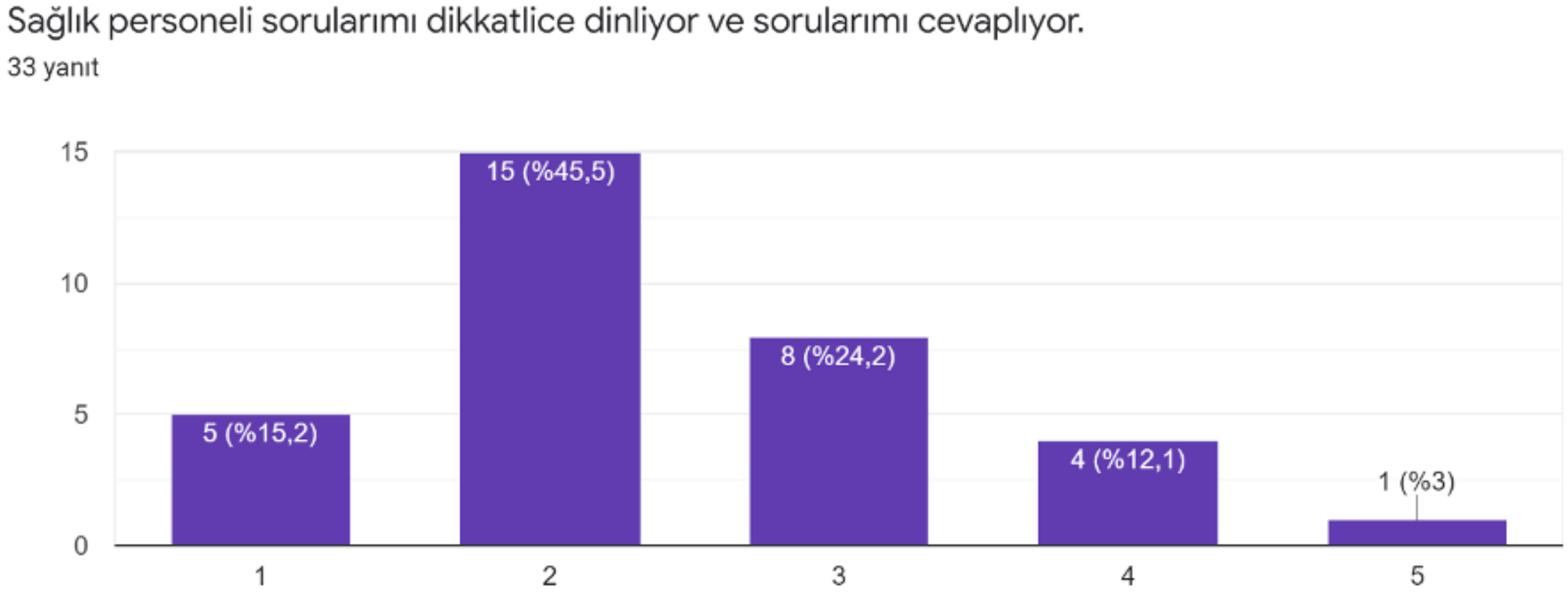
33 yanıt



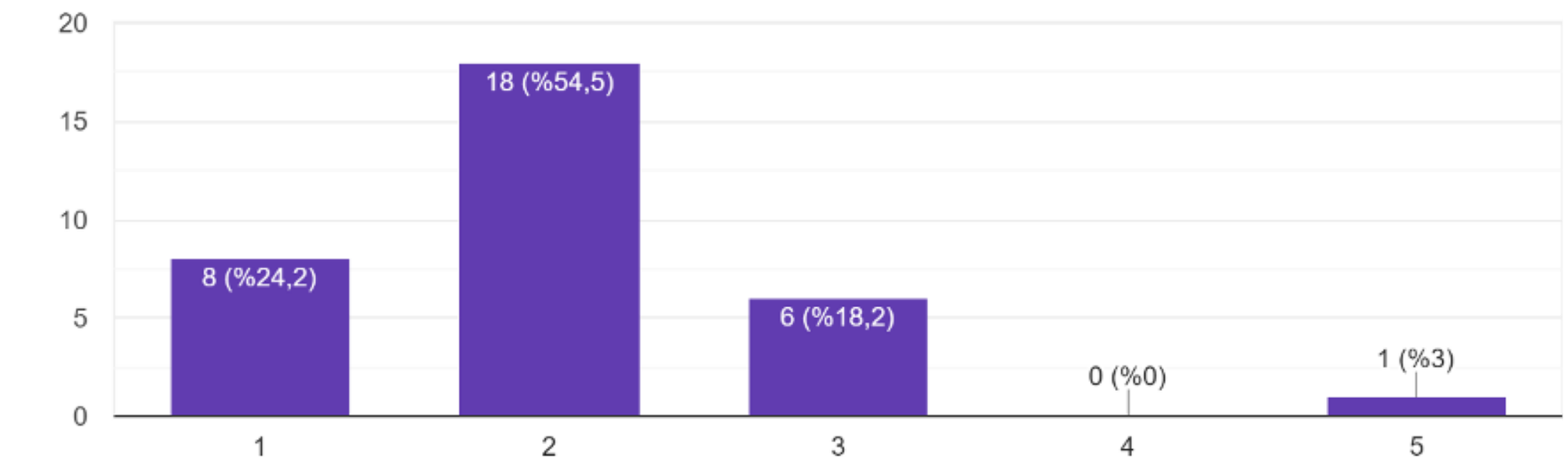
To the statement "Health-care staff usually cares about and prioritizes my needs", 13 of the participants said very rarely; 10 of them stated never; 5 of them stated occasionally; 3 of them stated often; 2 of them answered as always.



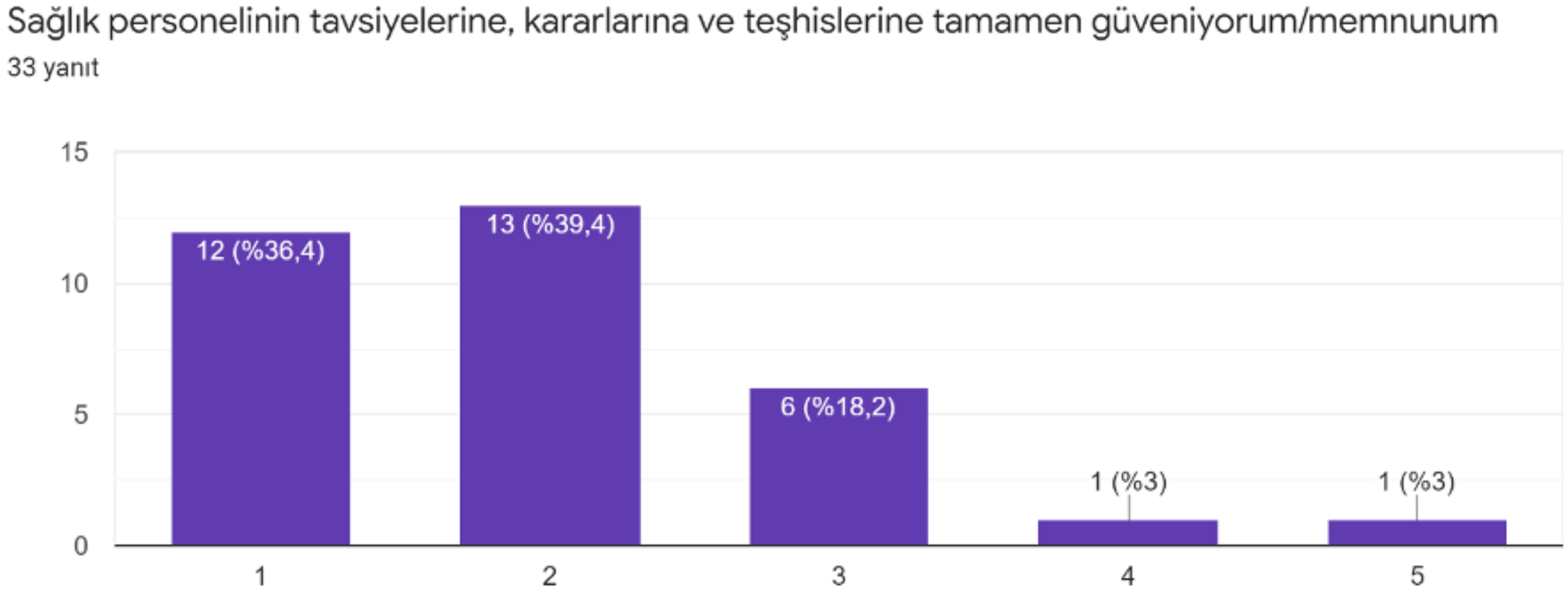
While 11 participants stated that they very rarely hesitated when asking health personnel about their health; 9 of them occasionally; 8 never; 3 always; 2 of them stated that they can often ask questions without hesitation.



15 participants stated that medical personnel very rarely listened and answered questions carefully; 8 of them stated occasionally; 5 of them statedalways; 4 of them stated often; 1 participant expressed as never.



18 participants were very rarely satisfied with the information they received from medical personnel and found it sufficient; 6 of them stated occasionally; 8 of them stated never; 1 parcitipant stated that they were alywas satisfied and found it sufficient.



As a response to "I completely trust/satisfied with the recommendations, decisions and diagnoses of the medical personnel" statement, 13 of the participants answered very rarely; 12 of them stated never; 6 of them stated occasionally; 1 of them stated often; 1 of them stated always.

7. CONCLUSION

In the light of the analyzes of the study, which aims to monitor the problems trans+ people experience in accessing health services, the transphobia and discrimination they are exposed to in hospitals and during the examination, to announce their demands and needs, and to produce solutions and reparative measures that will make healthcare services inclusive for trans+ people, various outcomes have emerged regarding different topics such as their physical and mental well-being; access to health services, the adequacy of health services regarding the transition and discrimination against trans+ people in health services.

Only 3 out of 33 participants stated that they have never been discriminated against or insulted when they access health care services. It is noteworthy that there were no participants who stated that they always felt physically good and who defined themselves as completely healthy according to the WHO definition of being healthy. In questions about mental well-being, only 1 participant stated that they always felt good and in a positive mood; only 2 participants stated that they are always optimistic about their future. Only 2 of the 33 participants stated that they consider the health services provided to be sufficient.

26 participant stated that doctors were among medical personnel group participants observed discriminatory and stigmatizing behavior the most. Only 2 of the participants stated that they had not received any discriminatory and stigmatizing behavior during medical examination.

In the question that the participants gave multiple answers about what are the reasons that prevent them from accessing health services even in case of need, 28 of the participants thought that they would be exposed to bad and discriminatory behavior by showing their sexual identity and orientation as a reason; 16 of them thought that patient privacy rights would not be protected; 4 of them stated that their health insurance was insufficient or that it does not fully cover the costs. The number of participants who do not have such hesitation is 3. 1 participant cited the lack of access to good doctors during the pandemic, and another participant cited the physicians' lack of knowledge about sexual identity and orientation as a reason of having hesitation.

While the number of participants who can access psychological support when necessary or whenever they want is 17; the number of those who cannot reach psychological support is 16. 13 out of 22 participants who have a psychiatric diagnosis or use medication cannot afford psychological support services because they are expensive. Among 13 people who stated that they could not receive psychological support services due to their income and insurance, 10 of them stated that they preferred LGBTI+ associations' Psycho-Social Support Units and only 3 preferred public hospitals. As it can be understood from the results and the quotations of the participants, the psycho-social support units of LGBTI+ associations are essential for the physical and mental well-being of all LGBTI+s.

While deciding the institution, doctor or therapist they will go to for a health problem, 24 participants preferred verbal experience sharing in the question where the participants gave multiple answers about which information sources they used; 20 participant preferred solidarity networks; 18 participants considered comments about medical personnel on the internet; 17 participants considered blogs and lists created in digital tool; 11 participants preferred WhatsApp groups; 10 participants preferred Facebook groups. One of the two participants who chose the other option preferred LGBTI+ associations; the other participant stated that they did not do any special research for this.

When they were asked which hospital units the participants postponed going to, 14 participants stated that they postponed going to the Gynecology and Obstetrics unit; 6 of the participants stated Dermatology; 5 of them stated Endocrinology; 5 of them stated Psychiatry; 4 of them stated Psychologists; 3 of them stated Urology; 3 of them stated Cardiology; 3 participant stated Dental Clinics; 2 of them stated General Health Check; 2 of them stated Neurology; 2 of them stated that they postponed going to Orthopedics departments. There is one participant each who postponed going to Gastroenterology, Infection Unit, Ear Nose and Throat, (ENT), Eye Polyclinic, and Family Physician. 2 of the participants who marked the "other option" postponed their transition, 1 postponed the check-ups after their transition; 2 people stated that they had reservations about going to any unit, but primarily gynecology. None of the participants stated that there was no unit they postponed going to.

For LGBTI+ associations that provide psycho-social support, see. *ÜniKuir Association, 17 Mayıs Association, GALADER Families Support-Line, Young LGBTI+ Association, Özgür Renkler Association, Pembe Hayat LGBTI+ Solidarity Association, KAOSGL, Pozitifiz Peer Counseling, SPoD Support-Line, Şişli Municipality Psychiatric & Psychological counseling service, Trans Transition Therapy Group*

5 people who postponed going to endocrinology and 3 people who postponed going to urologist get to transition. Also, 11 out of 14 people who postponed going to the gynecologist and 8 out of 9 people who postponed getting psychological support are in the transition. Considering the importance of regular and easy access to hormones by trans+s who want to take hormones during the transition; regular physical examination and psychological support for their well-being, the results of the study are striking in terms of access to health care services and rights of trans+ people who are in transition.

In the questions were asked only participants who get to transition, varied needs and challenges related to transition emerged. To the statement "Doctors have sufficient knowledge of trans+ identity and transition" marked by 20 of the participants; 9 participants said never; 6 participants said very rarely; 5 participants responded from occasionally. There were no participants who selected the option often and always. While 5 out of 16 participants stated that physicians never gave sufficient information about the transition and/or did not explain different options; 4 of them said very rarely; 4 of them stated occasionally, and 3 of them stated always.

6 out of 19 participants stated that they have never experienced a problem as not being able to find a suitable hospital/doctor in the city they live in; 5 of them always had this problem; 3 of them said very rarely; 3 of them said occasionally; 3 of them stated that they often encountered this problem. Of the 19 people who answered this question, 5 of them lived in the city and 4 answered "always" to the statement "I could not t find a suitable hospital/doctor in the city I live in"; 4 out of 13 people who answered as “never” live in metropolitan cities.

6 out of 19 participants stated they often had difficulties in accessing to hormones; 5 of them stated always; 3 of them stated occasionally; 2 of them stated that it is very rarely difficult; 3 participants stated that they have never had a problem with access to hormones. All three participants, who stated that they never had any difficulties in accessing the hormones, were living in metropolitan cities and whose income exceeded their expenses.

While 8 out of 18 participants stated that they always had difficulties in accessing a psychiatrist and endocrinologist for the transition; 3 stated often; 2 stated occasionally; 3 stated very rarely; 1 of them stated that they have never experienced such a problem.

The only participant who had no difficulty in getting a psychiatrist and endocrinology appointment, in addition to accessing hormones for transition, was a private sector employee with a higher income level than expenses. Everyone except this participant stated that they had difficulty in getting an appointment regardless of the metropolitan and city distinction.

10 out of 17 participants stated that an exaggerated femininity/masculinity performance is always expected from them in the psychiatric evaluation made during the transition; 6 of them said often; 1 of them stated that they have never encountered such an expectation. There was no participant who selected the option very rarely and occasionally. Of the 10 participants who marked the "always" option, 7 were non-binary and 1 were agender. 6 out of 19 respondents who answered the question about whether they feel obligated to medical interventions in their transition because it is a legal obligation although they do not want to; 4 stated always; 3 stated occasionally; 1 of them stated that they felt this very rarely; 5 participants stated that they never felt this obligation. 3 out of 4 participants who stated "always" are non-binary. In the light of these results, it is clear how far cisnormativity in health care services is from inclusiveness and equality for trans+ people who define themselves outside the gender binary system.

There are 26 participants who stated that they have never been subjected to physical violence based on their gender identity in the hospital or clinic they went to. However, when we look at the other aspects of violence and discrimination, the results of the research revealed that trans+ people are exposed to insults in accessing health care services, their needs are not taken into account, they hesitate when asking questions or their questions are not taken into consideration or are not answered, the answers they receive from medical personnel are not sufficient and satisfactory, and they do not fully trust advice, decisions and diagnoses of medical personnel.

8. INTERNATIONAL AND NATIONAL LEGISLATION ON THE RIGHT TO HEALTH

Atty. Mahmut Şeren

8.1. INTERNATIONAL LEGISLATION

8.1.1. United Nations System

It is stated in Articles 2 and 26 of the United Nations Covenant on Civil and Political Rights that discrimination is prohibited under all circumstances and that effective protection mechanisms should be available for those who have been discriminated against. Article 12 of the Covenant on Economic, Social and Cultural Rights recognizes the right of everyone to enjoy the highest attainable standard of physical and mental health. In the second subparagraph of the same article, some measures that states should take in order to realize the right are listed. The Committee on Economic, Social and Cultural Rights stated that all kinds of discrimination and sexual orientation discrimination that would prevent everyone from enjoying the right to health equally are prohibited [1]. It states that health policies, plans and programs should have a gender perspective [2]. It is stated that obstacles to access to education and information on sexual and reproductive health should be removed and discrimination should be prevented [3].

Article 12 of the United Nations Convention on the Elimination of All Forms of Discrimination against Women regulates that women and men should benefit from health services equally and all measures should be taken against discrimination. According to the CEDAW Committee, the supervisory body of the Convention, discrimination should be addressed as a multidimensional issue by considering the risk of discrimination that older women may face due to the age factor, as well as the factors of sexual orientation and gender identity [4]. In another decision, it is stated that states should legally recognize discrimination of sexual orientation and gender identity and prohibit discrimination in this respect [5].

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[1]Committee on Economic, Social and Cultural Rights 14th General Comment, 2000, 18th Paragraph; CESCR 22th General Comment, 2016, 2th Paragraph.
[2]Committee on Economic, Social and Cultural Rights, 14th General Comment, 2000, 20th Paragraph.
[3]Committee on Economic, Social and Cultural Rights 14th General Comment, 2000, 21th Paragraph; CESCR 22th General Comment, 2016, 9th Paragraph.
[4]CEDAW 27th Recommendation Decision, 2010, 13th Paragraph.
[5]CEDAW 28th Recommendation Decision, 2010, 18th Paragraph.

In the report [6] prepared by the Special Rapporteur on the Right to Health, which was accepted at the United Nations General Assembly (2009), it was stated that health service providers should be aware of the needs of LGBTI people and adapt to special situations, taking into account the Yogyakarta Principles.

8.1.2. European Council System

The prohibition of discrimination is regulated in Article 14 of the European Convention on Human Rights. According to this rule, the rights recognized in the contract should be provided to the right holders without any discrimination. The restrictive rule regarding the claim of violation of the prohibition of discrimination in the applications to the ECtHR can only be brought forward in connection with another right in the contract is abolished with Protocol No. 12 to the ECHR. Turkey signed Protocol No. 12 in 2001, but has not approved it yet. Therefore, the protocol has not yet entered into force.

Recommendation CM/Rec(2010)/5 of the Committee of Ministers of the Council of Europe to Member States includes measures to be taken to combat discrimination based on sexual orientation and gender identity. Among the recommendations are important articles concerning the right to health [8]:

- "Member states should take appropriate legislative and other measures to ensure that the highest attainable standard of health can be effectively enjoyed without discrimination on grounds of sexual orientation or gender identity; in particular, they should take into account the specific needs of lesbian, gay, bisexual and transgender persons in the development of national health plans including suicide prevention measures, health surveys, medical curricula, training courses and materials, and when monitoring and evaluating the quality of health-care services."(33. Paragraph)
- "Appropriate measures should be taken in order to avoid the classification of homosexuality as an illness, in accordance with the standards of the World Health Organisation." (34. Paragraph)

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[6]https://undocs.org/A/64/272, 46th and 49th Paragraphs. (Date of access: 18 June 2021)
[7]https://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf (Date of access: 18 June 2021)
[8]https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805cf40a, (Date of access: 18 June 2021)

- “Member states should take appropriate measures to ensure that transgender persons have effective access to appropriate gender reassignment services, including psychological, endocrinological and surgical expertise in the field of transgender health care, without being subject to unreasonable requirements; no person should be subjected to gender reassignment procedures without his or her consent.” (35. Paragraph)
- “Member states should take appropriate legislative and other measures to ensure that any decisions limiting the costs covered by health insurance for gender reassignment procedures should be lawful, objective and proportionate.” (36. Paragraph)

In addition to the stated recommendation, there are important statements in the explanatory memorandum prepared by the Chairman of the Committee of Experts on Discrimination Based on Sexual Orientation and Gender Identity (DH-LGBT) and the General Secretariat of the Council of Europe [9]:

- “Recommendation Rec(2006)18 of the Committee of Ministers to member states on health services in a multicultural society, adopted on 8 November 2006” recommends that states adapt their health services to the needs of multicultural societies, *inter alia* by developing 'culture competence' for health professionals, which may be defined as the ability to offer effective health services while having due regard, among other things, to the patient's sexual orientation." (33. Paragraph)

- "States should put in place the appropriate education and training policies and programmes to enable persons working in health-care sector to deliver the highest attainable standard of health care to all persons, with full respect for each person's sexual orientation and gender identity. This includes, for example:

i) encouraging studies and research on the health of lesbian, gay, bisexual and transgender persons to identify and meet their specific needs;
ii) taking account of lesbian, gay, bisexual and transgender persons' special needs in the design of national health plans, health surveys, medical training programmes, and training courses and materials, and in the monitoring and quality assessment of health-care services;
iii) guaranteeing that education, prevention, care and treatment programmes and services in the area of sexual and reproductive health respect the diversity of sexual orientatons and gender identity, and are equally available to all;

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[9]https://rm.coe.int/168047f2a6 (Date of Access: 19/06/2021)

iv) encouraging health professionals and social workers to create an environment that is reassuring and open to young lesbian, gay, bisexual and transgender persons, for example by conducting information campaigns."

- "When it comes to the issue of who has access to a hospitalised person and information on their state of health, as well as to the issue of medical decision-making in emergencies, states should recognise as 'next of kin' a person identified such by the patient themselves. In any event national rules on issues regarding 'next of kin' should be applied without discrimination on ground of sexual orientation or gender identity." (33. Paragraph continues)

- "Concerning the conditions governing gender reassignment procedures, international human rights law provides that no one may be subjected to treatment or a medical experiment without their consent. Hormonal or surgical treatments as preconditions for legal recognition of a gender change should therefore be limited to those which are strictly necessary, and with the concetn of the person concerned. Similarly, therapy to force transgender persons to accept their birth gender should be abandoned, and states should take appropriate measures to ensure that no child has their body irreversibly changed by medical practices designed to impose a gender identity without their full, free and informed consent, in accordance with their age and maturity, unless such medical interferences are necessary for other health reasons. (35-36. Paragraph)

The Parliamentary Assembly of the Council of Europe, in its Decision No. 1728 (2010), took note of rights violations, stigmatization and discrimination in the field of health based on sexual orientation and gender identity [10]. It is also envisaged that official documents reflecting an individual's declared gender identity will be provided to the person, without the obligation to undergo medical procedures including sterilization, transition surgery or hormone therapy.

According to Article 11 of the 1996 Revised European Social Charter;

"With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia:

1. *to remove as far as possible the causes of ill-health;*
2. *to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;*
3. *to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.*

[10]https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=17853&lang=en, 16.11 Paragraf. (Date of Access: 19/06/2021)

The 12th article of the 1996 Revised European Social Charter includes the right to social security, and the 13th article the right to medical assistance. In Article 30, it is indicated that the actual access to medical aid facilities against social exclusion should be encouraged. In Article E of Chapter V, the prohibition of discrimination is regulated. In Article G, there are rules regarding the restriction of rights.

Article 4/3 of the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention) contains the largest non-discrimination regulation among international human rights conventions. According to this article, it will be ensured that the measures to protect the rights of the victims are implemented without discrimination on any basis such as sexual orientation and gender identity. Article 21 of the Convention promises that measures will be taken to ensure that the victims have access to health services and that the professionals receive the necessary training in order to receive the service appropriate to the needs of the victims. In Article 30, it is stated that if the physical and mental harm of the victim is not covered by the perpetrator, financing, insurance company or the state according to the social insurance provisions, the state will pay appropriate compensation to the victim. However, the Republic of Turkey will withdraw from the contract, of which it is the first signatory, by the decision of the President as of July 1, 2021. It has been clearly stated by the Presidency's Directorate of Communications that the reason for withdrawing from the contract is that the contract was "manipulated by a segment trying to normalize homosexuality, which is incompatible with Turkey's social and family values." [11] This situation raises concerns that the picture regarding LGBTI+ rights in Turkey, which already has major problems, will deteriorate further.

Article 3 of the Council of Europe Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine regulates the right to benefit fairly from health services, and article 5 regulates the rule of obtaining detailed consent for medical intervention. In article 6, it is stated that medical intervention can be performed with the permission of the legal representative or those determined by the law to people who are not capable of giving consent (for example, babies). It is emphasized that this intervention can only be made for the direct benefit of the intervened. According to Articles 23, 24 and 25 of the Convention, the states parties

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[11]Turkish text: https://www.iletisim.gov.tr/turkce/haberler/detay/turkiyenin-istanbul-sozlesmesinden-cekilmesine-iliskin-aciklama (Date of access: 07 June 2021)

will recognize legal remedies, the right to compensation and sanctions in case of violation of the provisions of the contract. In Article 26, the rights in the contract; no restrictions other than those prescribed by law and necessary in a democratic society may be imposed for public safety, the prevention of crime, the protection of public health or the protection of the rights and freedoms of others.

The first of the international documents on patient rights is the World Physicians Union Declaration of Patient Rights, signed in Lisbon in 1981. This declaration was renewed in Bali in 1995 and in Santiago in 2005. The declaration includes the right to receive quality health care, the right to self-determination, the principle of informed consent, the right to privacy, the right to health education and the right to protect human dignity, which are important for protecting the rights of trans+ people.

The European Commission Against Racism and Intolerance, in its fact sheet [12] published in 2021, states that transgender+ people should ensure that the necessary medical services are provided for their transition and that the costs are covered by social insurance.

8.1.3. The Yogyakarta Principles

Article 17 of the Yogyakarta Principles on the Implementation of International Human Rights Law in Relating to Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics [13], which emerged as a result of the meeting of human rights experts in Yogyakarta, Indonesia on 6-9 November 2006 and updated in 2017, regulates the right to reach the highest standard of health.

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[12]ECRI, The Factsheet LGBTI Issues, 2021, 23-25th Paragraph. https://rm.coe.int/ecri-factsheet-lgbti-issues/1680a1960a (Date of access: 18 June 2021)
[13]https://yogyakartaprinciples.org, (Date of access: 18 June 2021)

8.2. NATIONAL LEGISLATION

The principle of equality is regulated in Article 10 of the Constitution of Republic of Turkey [14] and certain groups and issues that need protection against discrimination are listed. While there is a sex statement among these, there is no sexual orientation or gender identity statement. However, it is stated that the phrase “and similar reasons” in the article also covers discrimination of sexual orientation and gender identity [15]. A similar situation exists in international conventions on human rights. For example, despite the absence of SOGI concepts in Article 2 of the UN International Covenant on Civil and Political Rights, Article 2 of the UN Covenant on Economic, Social and Cultural Rights, and Article 14 of the European Convention on Human Rights, the expressions of “and similar/other reasons” include this. The only exception to this is Article 4 of the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention). This article clearly includes the concepts of “sexual orientation, gender, gender identity”. The purpose of the principle of equality or non-discrimination provisions regulated in all these articles is to ensure that everyone will have equal rights without any discrimination and that positive measures will be taken for individuals and groups who need to be supported in order to access the rights they have. The Republic of Turkey is defined as a social state of law in Article 2 of the Constitution.

In the 17th article of the Constitution, the right to personal immunity, the right to protect and improve person’s corporeal and spiritual existence, the right to health in the 56th article and the social security right in the 60th article are regulated. According to article 17/2, *“a person's bodily integrity cannot be touched, except for medical obligations and the cases written in the law.”*

It should be emphasized that, according to the last subparagraph of Article 90 of the Constitution, when it comes to fundamental rights and freedoms, international agreements will be given priority if the international agreements duly entered into force conflict with the law.

The main duty of the Ministry of Health is to ensure that everyone lives in a state of complete physical, mental and social well-being in accordance with the Decree-Law No. 663 and Decree-Law No. 703. The obligations of the Ministry are listed as protecting public health, conducting health services, developing health education and research

[14]https://www.anayasa.gov.tr/en/legislation/turkish-constiution/

[15]Ex: Turkish Constitutional Court, Case of Sadıka Şeker, App. No: 2013/1948, 59th Paragraph; Turkish Constitutional Court, Case of Kamil Çakır, App. No: 2013/997, 45th Paragraph.

activities, providing modern medical equipment, and managing the health system and policies.

The Social Insurance and General Health Insurance Law No. 5510 sets out the procedures and rules regarding the scope and functioning of the general health insurance, the right to social security and the conditions for benefiting from this right, and the provision of financing [16].

Family Medicine Law No. 5258 regulates the status and financial rights of health personnel who will be assigned or employed in order to provide family medicine services in order to develop primary health care services, to focus on preventive health services in line with individual needs, to keep personal health records and to ensure equal access to these services [17]. In Article 2 of the Law, family physician is defined as a physician who provides personal preventive health services and primary diagnosis, treatment and rehabilitative health services to every person without distinction of age, sex and disease.

The Public Health Law No. 1593, adopted in 1930, is one of the most important legal sources of the mixed legal status of sex work in Turkey. Although sex work is not a crime, it is subject to some sanctions with this law. Thus, especially transgender+ sex workers working informally are under pressure by the state.

Psychosexual disorder is defined as “transsexuality that has not completed the medical and judicial process of gender reassignment” in the list of diseases in the Health Conditions By-Law of the Police Organization. The same provision is also found in the Turkish Armed Forces Health Capability By-Law.

The Turkish Medical Association Law No. 6023 is the basic legislation of the Turkish Medical Association and medical chambers established to protect the rights and benefits of physicians [18]. In the first article of the law, in which the purpose of the union is stated, "to ensure that the practice of medicine is implemented and developed for the benefit of the public and the individual" was abolished with the Decree No. 663, but later on, the Constitutional Court's dated 14/2/2013; with the decision numbered 2011/50 and 2013/30, this provision was annulled. Among the obligations of the Union are to contribute to the development of issues concerning public health and the medical profession, to cooperate with and support official institutions for this purpose.

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[16]https://www.mevzuat.gov.tr/MevzuatMetin/1.5.5510.pdf
[17]https://www.mevzuat.gov.tr/MevzuatMetin/1.5.5258.pdf
[18https://www.mevzuat.gov.tr/MevzuatMetin/1.3.1593.pdf

8.A. Transition

The transition, together with its medical and judicial dimensions, is an important process within the scope of trans+'s right to access health. The transition is regulated in two stages in Article 40 of the Turkish Civil Law No. 4721. The first step is to obtain legal permission from the court in order to perform the necessary surgeries after the psychiatry and hormone therapy process. The conditions for granting legal permission are *"to be older than 18 years of age, not to be married, to be transgender, and to document the necessity of gender reassignment in terms of mental health and an official health board report to be obtained from a training and research hospital". The requirement "to be permanently deprived of reproductive ability"* in this section was cancelled by the Constitutional Court with its decision dated 29.11.2017 and decision numbered 2017/130 and 2017/165. Hormone drugs are not provided free of charge by social security institutions. The second stage is the correction of the gender part in the population records with the completion of the purposeful medical operations. "Purpose medical operations" are often understood by the courts as trans men having a penis and trans women having a vagina. In this context, there is no inclusive perspective for other identities within the transgender+ umbrella. On the other hand, even if the surgeries of those with social security are provided by health insurance, successful operations cannot be performed in public hospitals due to the lack of technology, experience and information. For this reason, most transgender+ people apply to the private sector. However, surgery costs in the private sector are quite expensive.

8.B. Patient Rights and Complaints Mechanisms

The Disciplinary By-Law of the Turkish Medical Association, published in the Official Gazette No. 25446, regulates the disciplinary actions to be applied to physicians. In the third article of the regulation, it is stated that the actions of *"using the professional effect on the patient for other than medical purposes"* and *"not respecting the patient's rights"* require a warning penalty. In the fifth article of the regulation, it is stated that the actions of *"disclosure of the secrets of patients learned during the practice of the profession and due to the profession, out of legal obligation"* and *"applying or suggesting scientifically unevidenced or unscientific methods in the diagnosis and treatment of diseases"* require temporary suspension from the profession. Forementioned legal regulations may be suitable for imposing sanctions on some of the rights violations experienced by transgender+ people in the field of health arising from doctors. However, it is far from providing full and effective

protection against discrimination. On the other hand, the "privileged practice" in the expression "to make a privileged practice according to the gender, race, nationality, ethnicity, religion and sect, moral and political thought, personality, economic and social status of the patients during the examination and treatment", which is determined to be temporarily suspended from profession, means privilege. In other words, if we interpret it literally, it is understood that the action to be sanctioned here is not discrimination. The Turkish Medical Association, which has published many ethical declarations to date, adopted the Gender, Gender Identity, Gender Expression, Sexual Orientation Equality and Health Services Declaration at its Extraordinary 71st Grand Congress on 24 November 2019.

The Medical Deontology By-Law is a binding text that regulates the ethical principles of physicians and dentists and was published in the Official Gazette No. 10436. However, it is frequently discussed in the medical community that the By-Law published in 1960 should be updated [19]. Harmonizing the By-Law with the Turkish Medical Association Ethics Declarations will ensure the formation of a contemporary and rights-based legislation.

Health workers who work in the public sector and who are not physicians are subject to the Civil Servants Law No. 657 in terms of disciplinary procedures. Although sexual orientation and gender identity discrimination is not openly, there is a prohibition of discrimination in the law. However, since the words “like, and similar” are not used in the regulation within the disciplinary procedures, it cannot provide protection for discrimination based on SOGI. Non-physician health workers in the private sector will be subject to employment contracts and general legal regulations.

The Patient Rights By-Law was published in the Official Gazette No. 23240 to protect the rights of patients receiving services from public or private institutions and to regulate legal remedies against rights violations. Various changes were made in the Regulation in 2014, 2016 and 2019. Although the principle of non-discrimination is included in Article 5 of the By-Law, where the fundamental principles are regulated, discrimination based on SOGI is not included. Within the regulation, the right to benefit in accordance with justice and equity, to obtain information, to choose the health institution and its personnel, to give information and consent, to take care, to provide privacy, to ensure

[19]Bkz: https://www.ttb.org.tr/makale_goster.php?Guid=f7933e30-923f-11e7-b66d-1540034f819c (Erişim Tarihi: 13/06/2021)

security, to access religious services, to have visitors and companions are recognized. In case of violation of rights, an application is made to the patient rights unit in the hospitals. If the Patient Rights Board detects a violation of rights, it makes suggestions and attempts to remedy it. In case of violation of rights, the right owner has the right to pecuniary and non-pecuniary compensation. Disciplinary action or criminal investigation may also be carried out against the personnel who cause the violation of rights.

In the In-Service Training By-Law of the Ministry of Health [20], the procedures and rules regarding the in-service training to be carried out in order for the health personnel to acquire the up-to-date knowledge and skills required by their duties, to increase productivity and to prepare them for higher positions are regulated. Human rights and discrimination issues are not included among the principles and goals of in-service training.

The Ombudsman Institution, established with the Law No. 6328, is the complaint mechanism dealing with the functioning of public services. The institution consists of the chief auditor, 5 auditors and the secretary general. These people are elected by the Turkish Grand National Assembly. In the law, it is stated that all kinds of actions, transactions and attitudes and behaviors of the administration will be examined in accordance with the law and equity, within the understanding of justice based on human rights. The institution makes a decision as a recommendation to the administration.

One of the fields of activity of the Human Rights and Equality Institution of Turkey, which was established with the Law No. 6701, is the prevention of discrimination. The Institution consists of the Board and the Presidency. All members of the Board and the President are appointed by the President. An application can be made to the Institution regarding the violation of the prohibition of discrimination. If the institution decides that the prohibition of discrimination has been violated, it can impose administrative sanctions. However, although the prohibition of discrimination regulated in the law does not include the concepts of SOGIIC, the forms of discrimination are limited. Due to this regulation and the case law created by the institution, it is not an effective mechanism for LGBTI+s.

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[20]https://dosyasb.saglik.gov.tr/Eklenti/279,hieyonetmelikpdf.pdf?0, (Erişim Tarihi:13/06/2021)

9.MEDICINE EDUCATION AND PROFESSION OF MEDICINE

Instr. Dr. Filiz Ak, MD MPA

The Pre-Graduate Medical Education National Core Education Program (UCEP) [21] has identified "Three Competence Areas" for medical faculty graduates, named "Professional Practices", "Professional Values and Approaches", and "Professional Individual Development" and every physician who graduates from the faculty of medicine is expected to be competent in these fields and to obtain competencies and sub-competencies related to the relevant field of competence. Every physician who has graduated from the Faculty of Medicine is expected to be able to conduct the "Basic Medicine Practices" stated in the National Core Education Program 2020 at the determined minimum level. In this sense, "identifying risk groups in society as one of the preventive and community medicine practices" is the fundamental practice of medicine that every physician is supposed to perform. A physician who graduated from the Faculty of Medicine must have acquired the necessary competencies to be able to effectively deal with or manage core behavioral, social and humanities-related core states and sub-states that may be encountered frequently at primary care level, and which must be managed alone or as an active member of a team.

When we analyze the core states and sub-states of the behavioral, social, and human sciences, "gender and discrimination, bias and stigma; child neglect and abuse, adolescent pregnancies and child marriage; violation of human rights and right to health, patient rights, psycho-social burden created by violations of rights in social life; violence against women, violence against children, violence against vulnerable groups; unprofessional/unethical behavior towards patients and their relatives, abuse of power in health and education processes; professionalism in medicine (social accountability, respect for privacy, professional values, professional identity development, continuous openness to professional and individual development); gender-based discrimination; reproductive health/sexual health (healthy sexual life and counseling, unwanted pregnancy/pregnancy prevention, adolescent pregnancy, reproductive health and ethics, sexually transmitted diseases and ways of protection, consent, sexual assault)" themes are among the states that any physician should be able to manage with the abilities they have gained.

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[21] Turkish Text: Mezuniyet Öncesi Tıp Eğitimi Ulusal Çekirdek Eğitim Programı (2020) https://www.yok.gov.tr/Documents/Kurumsal/egitim_ogretim_dairesi/Ulusal-cekirdek-egitimi-programlari/mezuniyet-oncesi-tip-egitimi-cekirdek-egitimi-programi.pdf

Using UCEP 2020 as a guideline, all physicians who have graduated from faculty of medicine should respect gender equality and approach every issue in the field of health from a gender perspective, practice their medicine without discrimination, gender-based discrimination, bias, and stigma, provide rights-based counseling to individuals in the fields of sexual and reproductive health, recognize violence against women, children and all vulnerable groups, prepare forensic reports of violence cases and make legal notifications; provide gender-based services to the survivors of violence, recognize and prevent the conditions that lead to violence, fulfill the requirements of the Code of Medical Ethics, and UCEP, and provide services with a biopsychosocial approach and observing human dignity.

The Statements of Ethics of the Turkish Medical Association were produced by working groups at two Ethical Statements Workshops held by the Turkish Medical Association (TTB) in 2008 and 2009 and were adopted and published in 2009. At the third Ethics Declarations Workshop, held on December 15-16, 2018, seven working groups comprised of representatives from the Departments of Medical History and Ethics, Specialization Societies and Medical Chambers, and members of the TTB Ethics Committee contributed to the updating of previous Ethics Declarations and the development of new declarations on the need for ethics. The Turkish Medical Association's Ethics Statements, which were examined by the TTB Ethics Committee with feedback from the working groups, were discussed, accepted, and published in 2020 at the TTB's Extraordinary 71st Great Congress on November 24, 2019. One of the new titles established in the third workshop, “Gender, Gender Identity, Gender Expression, Sexual Orientation Equality, and Health Services Declaration,” is a core statement that lays out the principles adopted by the Turkish Medical Association [22]. While Article 2 of the declaration, which includes the expression "Physicians should not engage in discriminatory attitudes and behaviors based on gender, gender identity, gender expression, or sexual orientation, and they should not refuse to provide health care to individuals based on these characteristics.", is an important step in terms of emphasizing the concepts of "gender, gender identity, gender expression, and sexual orientation" together, it serves as a reminder to physicians not to engage in discriminatory attitudes and behaviors, given the fundamental values that comprise the basis of the World Medical Association's Geneva Declaration, which is now acknowledged as the "Physician's Pledge”.

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[22] Turkish Text: Türk Tabipleri Birliği (2020). Türk Tabipleri Birliği Etik Bildirgeleri. Toplumsal Cinsiyet, Cinsiyet Kimliği, Cinsiyet İfadesi, Cinsel Yönelim Eşitliği ve Sağlık Hizmetleri Bildirgesi. Türk Tabipleri Birliği Yayınları. Ankara. ISBN 978-605-9665-57-5

While the core medical ethical values of the medical profession are a must for the profession, examples of physicians' discriminatory attitudes and behaviors toward their patients and clients in practice are the focus of the investigations pursued by the medical chamber. According to Article 5-t of the TTB Disciplinary Regulation, physicians might face disciplinary action for "behaving beyond the set medical ethical values and international documents and rules adopted by the Turkish Medical Association and/or the Turkish Grand National Assembly".

The public was made aware of an exemplary incidence of gender identity discrimination while seeking health treatment after a discriminated trans woman applicant and their lawyer disclosed the results of the investigation. A trans-woman client filed a complaint with the Social Policies, Gender Identity and Sexual Orientation Studies Association (SPoD) and the chamber of physicians in the province regarding the physician's transphobic and discriminatory attitude after a consultation on March 31, 2014 for the follow-up after the gender affirming surgery and the prescription of the necessary hormones, and the prevention of their right to health was investigated, and the investigation concluded that the physician did not comply with the TTB Disciplinary Regulations, highlighting that "the authority to refuse patients is not unlimited" and "Refusal should be based on a fair and acceptable cause, not on a cause regarded as offense" [23].

It should be emphasized that, in addition to the ethical statements that serve as a guide for the medical profession's practices, the legislation is also binding for the practice of medicine. The 33rd article of the Code of Medical Ethics stipulates that the physicians must follow "all human rights instruments, particularly the Universal Declaration of Human Rights, and common rules governing medicine".

The International Covenant on Economic, Social, and Cultural Rights [24] addresses issues such as health care, disease, old age, unemployment, work accidents, family and child benefits, maternity, disability, and orphanhood, lists legal obligations as respect, protection, fulfillment, international and core obligations, and emphasizes recommendations under the headings of gender equality, the right to be free from discrimination, working without social security, the informal economy,

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[23] Turkish Text: Bianet. (2016). TTB'den Trans Kadını Muayene Etmeyen Doktora Uyarı Cezası. BİA Haber Merkezi. 05 Şubat 2016. https://m.bianet.org/bianet/print/171838-ttb-den-trans-kadini-muayene-etmeyen-doktora-uyari-cezasi

[24] RG. Ekonomik, Sosyal ve Kültürel Haklara İlişkin Uluslararası Sözleşme, 10.07.2003. S. 5923.

indigenous and minority groups, non-citizens (migrant workers, refugees, asylum seekers, stateless individuals), and internally displaced individuals/emigrants [25]. When we read each of the social risk headings in the International Covenant on Economic, Social, and Cultural Rights as social determinants of health, and consider the intersectionality that each of them creates, it should be emphasized that the precautions and recommendations for all headings are prerequisites for health.

[25] UN Economic and Social Council. CESCR (Committee on Economic, Social and Cultural Rights). (2007). General Comment No. 19. The right to social security. Thirty-ninth session, 5-23 November2007. https://socialprotection-humanrights.org/wp-content/uploads/2015/06/CESCR-General-Comment-19.pdf

10. SOCIAL DETERMINANTS OF HEALTH AND TRANS+ INDIVIDUALS' RIGHT TO HEALTH FROM AN INTERSECTIONAL PERSPECTIVE

10.1. Multiple Discrimination and Intersectionality

The multiple discriminations they face on multiple grounds, belonging or justification, make the problems, impediments, and consequences faced by individuals even more complex and more severe [26]. When assessing constraints, impediments, social events, inequalities, and health concerns, an approach that evaluates not only gender, but also race, age, sexual orientation, and many other determinants combined is required. Given that individuals' social status is affected by factors such as class, ethnicity, race, age, sexual orientation, and so on, apart from their gender, the intersectional analysis evaluates the individual who is in the intersection of these with a combination of multiple effects, rather than examining each determinant individually [27].

Intersectionality is a term introduced by Crenshaw in 1989. Crenshaw argued that feminist and anti-racist discourses do not take intersecting identities into consideration when addressing violence against women, and that non-white women experience violence caused by both racism and sexism more deeply, therefore considering these categories individually is insufficient [28]. Structural intersectionality refers to black women's multifaceted oppression, political intersectionality refers to black women's belongingness in at least two marginalized groups, and representative intersectionality refers to how portrayals of non-white women overlook such women's intersecting interests [29].

Intersectionality, as a method, emphasizes the creation of inequalities as a result of the interactions of numerous belongings, situations, grounds, factors, and power relations, such as politics, law, religion,

[26] UN (2011) Discriminatory Laws and Practices and Acts of Violence Against Individuals based on their Sexual Orientation and Gender Idendity. Report of the United Nations High Commissioner for Human Rights. A/HRC/19/41

[27] Holley LC, Mendoza NS, Del-Colle MM & Bernard ML. (2016). Heterosexism, racism, and mental illness discrimination: Experiences of people withmental health conditions and their families, Journal of Gay & Lesbian Social Services, 28:2, 93-116,DOI: 10.1080/10538720.2016.1155520

[28] Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. University of Chicago Legal Forum, 1989, 139-168.

[29] Hopkins, P. (2019). Social geography I: intersectionality. Progress in Human Geography, 43(5), 937-947

and media, and seeks to comprehend individuals through these interactions. Privileges and exclusions within the categories of race/ethnicity, class, poverty, geography, age, gender, sexuality, ability/disability, religion, immigration/refugee are created by discrimination against the elderly, sexism, patriarchy, heterosexism, homophobia, transphobia, racism, discrimination against the disabled, ethnocentrism, colonialism, imperialism, globalization, capitalism, legal system, economy, education system, etc. [30]

Today, intersectionality is a practice, research, education, policy, and approach used by health sciences as well as fields such as sociology, political science, law, geography, philosophy and anthropology, ethnic studies, feminist and queer studies, and human rights [31]. It is a vital method for revealing all of the components that produce and exacerbate social problems, as well as the relationships between them, and for eradicating inequalities.

In the field of health, approaches used to conceptualize societal inequalities include "analysis based on sex and gender", "analysis based on gender", and "health impact assessment" based on social determinants of health. “Intersectional policy analysis” broadens the scope of these empirical methodologies by investigating the interconnections of social determinants/categories [32].

10.2. Social Determinants of Health

According to the definition adopted by WHO in 1946, health is a condition of complete physical, mental, and social well-being rather than the absence of sickness or disability [33]. This definition, which provides a broader view on health than previously, has been studied in numerous aspects later on, and dynamic model searches have arisen [34].

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[30] Hankivsky, O. (2014). Intersectionality 101. The Institute for Intersectionality Research & Policy, SFU. ISBN: 978-0-86491-355-5. http://vawforum-cwr.ca/sites/default/files/attachments/intersectionallity_101.pdf; Mason, N.C. (2010). Leading at the Intersections: An Introduction to the Intersectional Approach Model for Policy & Social Change. New York: Women of Colour Policy Network.

[31] Hankivsky, O. (2014). Intersectionality 101. The Institute for Intersectionality Research & Policy, SFU. ISBN: 978-0-86491-355-5. http://vawforum-cwr.ca/sites/default/files/attachments/intersectionallity_101.pdf

[32] ibid.

[33] WHO (1948). Preamble of the Constitution of the World Health Organisation as adopted by the International Health Conference: New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the WHO, No. 2, p. 100) and entered into force on 7 April 1948.

[34] Bircher, J. (2005). Medicine, Health Care and Philosophy, 8, 335–341.

The 1978 “Alma Ata Declaration on Primary Health Care Services" [35] and the established "Health Goals for All by 2000" [36] introduced the notion of community-oriented primary health care, and the 1986 "Ottawa Charter for Health Promotion" laid out the requirements for health: Peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equality. In order to promote health, interventions not only for the individual but also for the physical and social environment have gained importance [37].

In 2008, the WHO Commission on Social Determinants of Health issued a report with a global multi-subjective cooperation and three-year effort [38]. The World Health Organization's 2008 World Health Report also put primary health care on the agenda, highlighting issues in globalizing world, urbanization, aging, and socioeconomic determinants of health, and addressed the creation of public policies for public health and intersectional action. In this report, the complex consequences of unemployment and job change on health were described in one table as an example, and the substantial effects of socioeconomic determinants on health were highlighted [39].

In 2009, the World Health Assembly decided to "address health inequities via action against the socioeconomic determinants of health” [40]. In the 2011 World Conference on the Social Determinants of Health in Rio de Janeiro the urgent initiatives required in each country to enhance health, eradicate health inequities, and promote development were discussed [41]. In the World Health Assembly in 2012, it was underlined that “health equality is a shared goal and responsibility”, “participation of all sectors of government, all segments of society and all

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[35] Declaration of Alma-Ata. (1978). International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. https://www.who.int/publications/almaata_declaration_en.pdf

[36] WHO. (1978a). Health for All. Sr. No. 1.; WHO. (1978b). Formulating Strategies for Health for All by the year 2000. “Health for All” Series No. 2.

[37] Ottawa Charter for Health Promotion: 1986, Copenhagen: World Health Organisation, Regional Office for Europe.

[38] WHO. (2008a). Commission on Social Determinants of Health Closing the gap in a generation: Health equity through action on the social determinants of health. CSDH final report. Geneva.

[39] WHO. (2008b). The world health report 2008: primary health care now more than ever. ISBN 978 92 4 156373 https://www.who.int/whr/2008/en/

[40] World Health Assembly, 62.14. (2009). Reducing health inequities through action on the social determinants of health. World Health Organization. https://apps.who.int/iris/handle/10665/2257

[41] WHO. (2011). World Conference on Social Determinants of Health; 2011 Oct 19–21; Rio De Janeiro, Brazil. Meeting report. 2012. URL: http://www.who.int/sdhconference/resources/Conference_Report.pdf

international community members", that is, "all for equality" and "health for all" by referring to the Rio Conference, and social determinants of health were emphasized through the themes of "eliminating hunger and poverty, ensuring food and nutrition security; access to affordable, safe, effective and quality medicines, access to safe drinking water and sanitation services, employment and decent work and social protection, and protecting the environment" [42].

The social determinants of health can be listed as income, social status, job, education, social environment, physical environment, healthy child development, nutrition, shelter, personal health practices and habits, health care providers, social support network, biology and genetics, culture and gender [43]. Gender, which is among these determinants, leads to different results in terms of "exposure to risk or violence, severity or frequency of health problems, perception of symptoms, behavior to seek solutions to health problems, referral to health care centers, maintaining prescribed treatment, and health-related outcomes" [44].

The European Institute for Gender Equality (EIGE) defines disadvantaged groups as "groups of people who are more likely than the overall population to face poverty, social exclusion, discrimination, and violence" [45]. Thematic titles that define the disadvantage can be single, multiple, or numerous. None of these are independent of each other. Hence, it is essential to discuss the intersectional disadvantage that affects individuals/groups on a deeper, multi-layered level. These numerous inequities also have an impact on health-related processes.

Some groups are disadvantaged as a result of attitudes, behaviors, and practices that evolve as a result of the combined effects of social, cultural, economic, and political dynamics, as well as the discrimination, power imbalances, and inequalities they produce.

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[42] World Health Assembly, 65. (2012). Outcome of the World Conference on Social Determinants of Health. https://apps.who.int/iris/bitstream/handle/10665/80482/A65_R8-en.pdf?sequence=1&isAllowed=y

[43] WHO. (2020). Social determinants of health. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 (Erişim Tarihi: 01.10.2020); Marmot, M., & Wilkinson, R. (Eds.). (2005). Social determinants of health. OUP Oxford.; Gender and Health Collaborative Curriculum Project. (2005). Gender and Health Modules.. http://www.genderandhealth.ca/(Erişim Tarihi: 26.06.2007)

[44] Health Canada. (1999). Women's Health Strategy, Women's Health Bureau, Health Canada. http://hc-sc.gc/english/women/womenstrat.htm (Erişim Tarihi: 26.06.2007)

[45] EIGE. (2020a). Disadvantaged Groups. https://eige.europa.eu/thesaurus/terms/1083; EIGE. (2020b). People in vulnerable situations. https://eige.europa.eu/covid-19-and-gender-equality/people-vulnerable-situations

In order to decrease inequities between the general population and disadvantaged groups, social policies and social protection systems must cover vulnerable populations [46].

10.3. Health Requirements of LGBTI+ Individuals and Primary Health Care

Primary health care is a community-based health care that is provided throughout the world and in our country through family medicine or general practice disciplines, follows individuals from birth, performs periodic follow-ups based on age and gender, is both preventive and curative, and focuses on the individuals' needs in their own context. The core guidelines suggest that primary health care should also accommodate the health requirements of people who have varied gender identities and sexual orientations [47].

The findings of the studies reveal that primary care preventive health services in Turkey are not inclusive of LGBTI+s; they do not use guidelines incorporating the particular health needs of LGBTI+ individuals as a source, and they do not address the health problems and needs of LGBTI+ individuals in primary care. The results of the studies conducted on the field of health revealed that the reasons why lesbian and bisexual women do not want to discuss their health problems with their physicians include lack of trust, privacy issues, homophobic and biphobic physicians, and fear of being judged [48]. According to the reports, one of the major issues is that LGBTI+ individuals do not receive the services to which they are entitled because they are distrustful of service providers [49].

According to the report of the Amnesty International (2010), LGBTI+ individuals state that they cannot access health services because they fear the homophobic or transphobic attitudes of state officials or that their access to public services is quite limited due to the refusal of officials to provide services or treatment due to their sexual orientation

[46] Social Protection and Human Rights Platform. (2015). Disadvantaged and vulnerable groups https://socialprotection-humanrights.org/key-issues/disadvantaged-and-vulnerable-groups/
[47] GLMA. (2006). Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients, USA; Başar K. (2015). “Cinsel Yönelim ve Cinsiyet Kimliği Çeşitliliği: Birinci Basamak Sağlık Hizmetlerine Uygun Yaklaşım” Türkiye Klinikleri J Fam Med-Special Topics;6(2):17-22.
[48] Ak F, Tekiner AS, Ceyhun Peker AG, Dağlı Z, Ungan M. (2013). What are the Health Issues of Lesbians and Bisexual Women Concerning Family Medicine/General Practice. Abstract Book. European General Practice Research Network (EGPRN), The European Journal of General Practice, 19:3, p.178, DOI:10.3109/13814788.2013.822859
[49] Göçmen, İ., Yılmaz, V. (2017). Exploring perceived discrimination among LGBT individuals in Turkey in education, employment, and health care: Results of an online survey. Journal of homosexuality, 64(8), 1052-1068.

or gender identity. Trans+ individuals face difficulties whenever they are required to display their identity card because their gender identity statement does not correspond to their assigned gender as indicated on their identity card.

Trans+ individuals who have been deprived of their right to complete their education and to exist in working life cannot access health services because they do not have social security. Trans+ individuals are unable to apply to gender affirming surgery due to the exorbitant cost thereof. There are also trans+ people who refuse to have surgery since they must be deprived of their reproductive abilities as part of their gender affirming requirements.

According to the sources, trans+ individuals cannot receive health treatments because of societal discrimination; therefore they are exposed to increased health risks, and new health risks may develop as a result of the hormones and interventional procedures they use during the transition. A study on the health conditions, problems, risks, and needs of trans+ individuals regarding the primary care in Turkey revealed that 68.9% of the trans+ population in Turkey suffers from depression, and 49% had suicidal ideation. It was found out that the health needs and expectations of trans+ individuals are conscious health worker, improvement of health services, inclusion of trans+ health in medical education, sexual health education, access to HIV and HPV treatment, health counseling, psychiatric support, easy access to hormone therapy, coverage for surgery fees, information about GIS problems and diet, and regular check-ups. Physicians' unawareness, prejudiced behaviors, refusal to provide services for trans+ health, and discriminatory attitude are the most significant barriers to their access to health care [50].

The first of two "Workshops on Psycho-Social Support Mechanisms for Trans People," organized by Pembe Hayat LGBTİ+ Solidarity Association, was hosted on March 5, 2015, and the second on November 19, 2015, as part of the "November 20 Transgender Day of Remembrance". The third workshop was held on March 3, 2016, in Ankara Medical Chamber in collaboration with the LGBTI+ Working Group of the Ankara Medical

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[50] Ak Azar F, Köse SK, Arslan E, Ayyıldız A, Doğantekin H, Kesici Ö, Koca Z, Koçak BA. (2020). Transgender Bireylerin Birinci Basamağı ilgilendiren Sağlık Sorunları, Poster Bildiri XI. Ulusal Tıp Eğitimi Çevrim içi Kongresi, 12-14 Ekim 2020, UTEK'20. http://kongre.teged.org/UTEK2020/abstract/transgender-bireylerin-birinci-basamagi-ilgilendiren-saglik-sorunlari-ve-saglik-gereksinimleri

Chamber (ATO), as one of 3rd of March World Sex Workers Day events organized by the Pembe Hayat Red Umbrella Sex Workers Initiative on annual basis since 2008. The content and outcomes of workshops attended by officials from the Ankara Medical Chamber, the Turkish Medical Association, and certain Medical Specialization Associations are guiding health professional organizations in developing health policies that include LGBTI+ individuals:

- Transgender sex workers who face discrimination and violence in all fields require psychosocial counseling to cope with trauma. Access to these support mechanisms, however, is fraught with discrimination.
- It has been noted that rights-based organizations do not report trans+ people's human rights breaches.
- In addition to reporting rights breaches and providing post-traumatic psychosocial support mechanisms, collaboration and practices should be formed to improve awareness of institutions and non-governmental groups about various gender identities and to prevent violence.

The first workshop explored the problems and needs of trans women and attempted to offer solutions. The inclusion of concepts of sexual orientation and gender identity in the education and health education of professions providing psychosocial support, and the importance of coordination and experience transfer of non-governmental organizations, collaboration on reporting torture and ill-treatment and providing medical and rehabilitation support to victims, LGBTI+ individuals' access to shelters, and shelters for trans people were discussed. The second workshop covered in depth trans people's housing problems, the discrimination they experience in working life, barriers to accessing social support mechanisms such as shelters and nursing homes, needs, problems, and demands according to age groups, and difficulties in accessing health services, and included a mutual exchange of experience and cooperation proposals from participating organizations on the development of alternative mechanisms for access to support for victims of violence, shelters, and institutional services such as the Violence Prevention and Monitoring Center (ŞÖNİM). The third workshop addressed the issues confronting transgender individuals, particularly the discrimination and violence suffered by transgender sex workers, and concentrated on how to develop a network that would provide psychosocial support mechanisms. It is important to guarantee that trans individuals benefit from the health services given by primary care family physicians as a first step toward resolving the issues they face in accessing health care.

To achieve this, it is necessary to raise trans people's awareness of primary care services, as well as the awareness of health care professionals and family physicians in primary care. Aside from primary health care workers, the profession of medicine, professional chambers, and specialty associations, medical faculties that train physicians also have responsibilities for ensuring that trans people receive preventive health services and for establishing psycho-social-medical support mechanisms in cases of health problems and violence-related problems.

10.4. Why an Intersectional Approach Sensitive to Gender and the Determinants of Health

Final Word with an Intersectional Perspective on UniKuir NGO's Intersectional Feminism Project and Trans+ Individuals' Right to Health

It should be noted that an approach based on sex, gender, and socioeconomic determinants of health is critical for identifying the causes of inequalities in society and developing strategies to eradicate inequalities. Taking them into account alone, however, will not suffice. Both intersectionality and the perspective of the social determinants of health are addressed in the international literature on LGBTI health. As the generalization of the experiences of white women excludes black women, heteronormativity creates a barrier that excludes LGBTI+ individuals [51]. While policies on women's health, medical textbooks, undergraduate and postgraduate education, including only non-trans, heterosexual women, exclude trans women, non-binary gender people, lesbians, bisexual women, non-inclusive medical education, health services, and policies that do not include LGBTI+ health exclude all LGBTI+ individuals.

With Crenshaw's "mapping the margins" approach [52], it is essential to look at social groups and place the invisible ones at the center. This is called the “intersectionality health equity lens”. Intersectionality, as a method of addressing the social determinants of health with multiple identities and situations, is also a lens through which we may identify the deep individual, institutional, and structural power relations that cause inequalities [53].

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[51] Holley LC, Mendoza NS, Del-Colle MM & Bernard ML. (2016). Heterosexism, racism, and mental illness discrimination: Experiences of people withmental health conditions and their families, Journal of Gay & Lesbian Social Services, 28:2, 93-116,DOI: 10.1080/10538720.2016.1155520; López, N., & Gadsden, V. L. (2016). Health inequities, social determinants, and intersectionality. Expert Voices in Health & Health Care, 1-15.

[52] Crenshaw, K. W. (1994). Mapping the margins. In “The Public Nature of Private Violence”(Eds. Fineman,M. and Mykitiuk, R.)Routledge, Great Britain, 93-118.

This lens is recommended to be used to reduce inequalities and injustices in health. UniKuir NGO's Intersectional Feminism Project allowed participants to discuss their experiences and difficulties, as well as learn about intersectional feminism and transfeminism with the workshops held.

The findings of the study "Trans+ Individuals' Access to Health Care Services" are consistent with the literature on trans people's rights violations and barriers to the right to health indicated in this report. According to the results of the "Trans+ Individuals' Access to Health Services" survey, 69.7% of the participants living in metropolitan cities are mostly students, and they are at risk such as unemployment, inability to work, income equal to or less than expenditure, not having health insurance, belonging to an ethnic and/or religious minority, disability, being a refugee both in terms of social determinants of health and in terms of intersectionality and exposure to multiple discrimination. Doing statistical analyzes with a broader sample in the future showing how the health conditions and outcomes questioned in this descriptive study are affected by these independent variables and comparing them with the different demographic characteristics of the society and the non-trans population will contribute to the literature.

In terms of discrimination experienced by trans+ individuals in the realm of health and the barriers they confront in accessing health services, the following findings were obtained: Participants face discrimination while obtaining health services, believe that the health services offered are unqualified to satisfy their needs, are apprehensive before accessing health care services, and are unable to access psychological support to a considerable extent. Problems in the trans integration process can be listed as physicians' lack of competence and knowledge on this subject, not providing sufficient information, not making explanations, not being able to reach the appropriate physician and hormones, rejection by the health personnel, concerns on failure of the operation, feeling obliged to have medical intervention because it is a legal obligation.

In light of the findings of the study "Trans+ Individuals' Access to Health Services", I am of the opinion that a multi-component workshop titled "What sort of health care do LGBTI+ individuals want? What kind of medical education should be provided before and after graduation in order to achieve this?" should be organized with the participation of professional organizations, specialists in the field, educators, trade

unions, and LGBTI+ associations, and that ongoing collaboration in this sector should be ensured. Future objectives should include reviewing the national and international regulations mentioned in this report, developing guidelines for medical practice, and forming working groups to set medical care and follow-up standards based on international literature and evidence.

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