

OVERDIAGNOSED BUT UNDER SERVED

Trans Healthcare in Georgia, Poland, Serbia, Spain
and Sweden: Trans Health Survey

Imprint

Overdiagnosed but Underserved.

Trans Healthcare in Georgia, Poland, Serbia, Spain, and Sweden: Trans Health Survey

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Find out more about Transgender Europe and its work on health:

www.tgeu.org/issues/health_and_depathologisation/

The Trans Health Survey research project received honorary patronage from the Polish Commissioner for Human Rights.

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Introduction

It is well established that trans people score significantly lower in terms of health and wellbeing indicators than cis people – i.e. those who are not trans. In order to provide a detailed picture of the experiences of trans people in accessing, and attempting to access, general and trans-specific healthcare services across Europe, TGEU undertook two separate surveys in five countries. We surveyed both healthcare providers and trans people who have used or attempted to use healthcare services in Georgia, Poland, Spain, Serbia and Sweden – countries chosen due to their geographical and cultural disparities. A number of worrying conclusions can be drawn from these surveys. For example, a striking 50% of the trans respondents reported having delayed seeking general healthcare because of their gender identity – either due to a fear of receiving prejudice from healthcare providers or because of a lack of confidence in healthcare services. A majority of trans respondents expressed that they have not been taken seriously by healthcare providers due to their gender identity or expression; trans people who face multiple oppressions, due to their young age, economic status, engagement in sex work, or disability, are even more likely to face discrimination. One such example was given by an 18 year old trans man who said: “They referred to me as a “boy”, and talked about “seeing me as a boy” as if it [my gender identity] wasn’t so for real.”

While a clear majority of both groups surveyed – trans people and healthcare providers – agree that being trans is not a psychiatric disorder, the results suggest that a significant number (four in ten) of healthcare providers are content to maintain the status quo, with doctors continuing to act as gatekeepers between trans people and the healthcare that they require (fig. 27). TGEU believes that such service providers should question whether they are, in fact, providing a “cure,” or, more accurately, causing further pain to an already marginalised population. The conclusions from this report make one thing clear: an urgent overhaul of gender-affirming healthcare services in all countries surveyed is required. This needs to include:

- » a reduction in waiting times;
- » an increase in staff numbers and for those staff to be significantly better informed and educated; and
- » far more choice and self determination for healthcare recipients than they currently have.

We hope that this Trans Health Survey can contribute to discussions ongoing across Europe regarding the improvement of both general and trans-specific healthcare provision - to bring about improved health and wellbeing for all trans people.

Overdiagnosed but Underserved would not have been possible without the expertise and dedication of Adam Smiley, Aisa Burgwal, Carolina Orre, Edward Summanen, Isidro García Nieto, Jelena Vidić, Joz Motmans, Julia Kata, Natia Gvianishvili and Vierge Hård.

Chapter 1

About the Trans Health Survey

The overall goal of TGEU's research into healthcare provision for trans people was to provide a deeper understanding of the healthcare situation of trans people in Europe. Many previous studies have indicated that the experiences of trans people in healthcare situations are precarious, and information and knowledge from healthcare providers is often lacking¹. To gain a greater understanding of the situation of trans people in terms healthcare, TGEU conducted the Trans Health Survey in 2016-2017 in five countries: Georgia, Poland, Serbia, Spain, and Sweden.

1.1. METHOD

In collaboration with its partner organisations Women's Initiative Supportive Group (WISG), Trans-Fuzja, Daniela Fundación, Gayten LGBT, and the Riksförbundet för homosexuella, bisexuella, transpersoner och queeras rättigheter (RFSL), two surveys were written during research team meetings in 2016². This process of collaboration yielded information relevant for all partner organisations, and took into account the specificities of their country's situation, previous research findings in the five countries, as well as their requirements for specific topics to be included in the data gathering.

- » The first survey was aimed at users of healthcare services who self-identified as trans, people aged 16 or older, and who had lived in Georgia, Poland, Serbia, Spain, or Sweden within the 24 months preceding the survey. For the purpose of this survey, we used "trans people" as an umbrella term to refer to people whose gender identity and/or expression differs from the sex they were assigned at birth, including, but not limited to, non-binary, genderqueer, and gender non-conforming people. This survey will be referred to as the HCU Survey in this report.
- » The second survey was aimed at providers of healthcare in Georgia, Poland, Serbia, Spain, or Sweden, regardless of their experience in providing healthcare to trans people. This survey will be referred to as the HCP Survey in this report.

This constitutes the first research in which both healthcare users and healthcare providers have been questioned about the provision of general healthcare to trans people in the country they live and work in. It is also the first time in which attitudes on several aspects of the provision of trans-specific healthcare were measured, from both service users and providers. After a period of data gathering and data cleaning, results from 885 healthcare users (HCU) and 888 healthcare providers (HCP) could be retained for this report³.

¹ See for example (Fundamental Rights Agency, 2014), and (Fundamental Rights Agency, 2016) for two of the largest studies in this area.

² For both surveys, Joz Motmans, an experienced researcher in quantitative trans research, who was contracted by TGEU, provided methodological support.

³ The data gathering was conducted by the five partner organisations in their respective countries and through their networks (see country chapters for more information). The data-cleaning excluded respondents who did not give their consent, who were not living in the 5 countries under study or who had not lived there in the past 24 months preceding the survey, those who took less than 10 minutes to fill in the long questionnaire and those who indicated to be intersex.

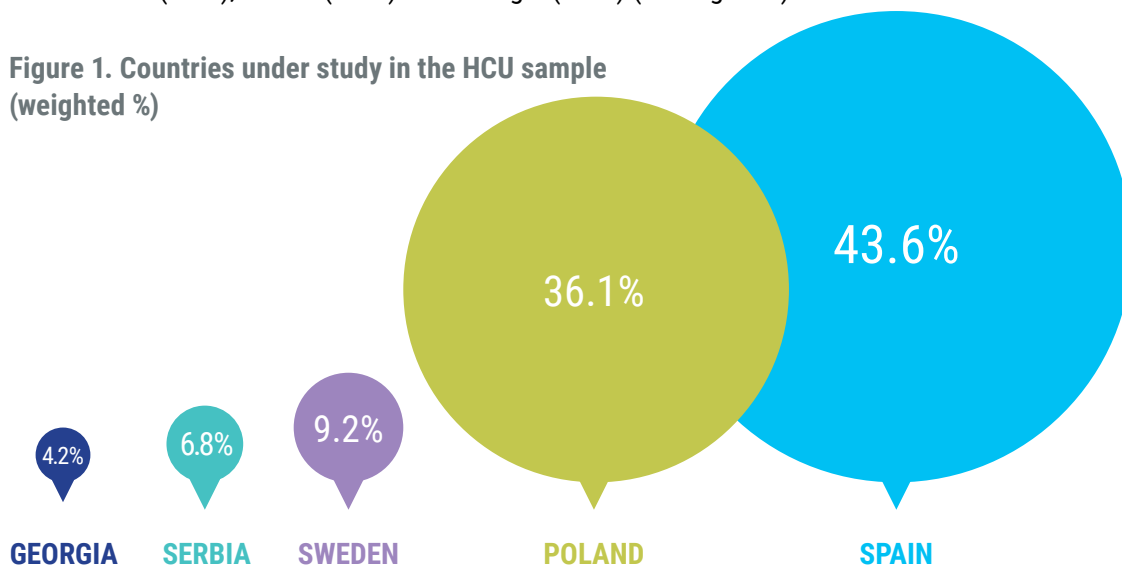
During the analysis of the data, great consideration was given to the possible effects of other socio-demographic variables such as gender identity, age, income, educational level, other minority status' due to disability, ethnicity, religion, sexual orientation, and so on – acknowledging the cumulative effects of these social positions. Significant disparities between gender identity groups across different countries are always reported in this report, along with other significant variables found during data analysis.

The survey results also contain enough participants in each country (except for Georgia, although the results are presented in the report) to allow comparisons between the countries under study. However, to avoid the influence of the under- or over-representation of some countries in the sample, the analysis adopted a weighting methodology when countries are compared⁴. In this report, the base number (N) of responses to each question is presented as an unweighted count, whereas the percentages of respondents selecting a particular answer, when comparing countries, are presented in weighted form.

1.2. RESPONSE: HEALTHCARE USERS (HCU)

In total, 885 respondents of the HCU Survey are included for analysis in this report. The majority of respondents came from Sweden (n=472) and Spain (n=276), with smaller numbers from Poland (n=76), Serbia (n=38) and Georgia (n=23) (see Figure 1).

Figure 1. Countries under study in the HCU sample (weighted %)



Question: q0003: Do you currently live, or have you in the past 12 months lived, in one of the following countries? If you have lived in more than one of these countries, please choose the country in which you have the most healthcare experience.

Base: Trans respondents in the TGEU survey (n=885).

Source: TGEU HCU survey, 2017.

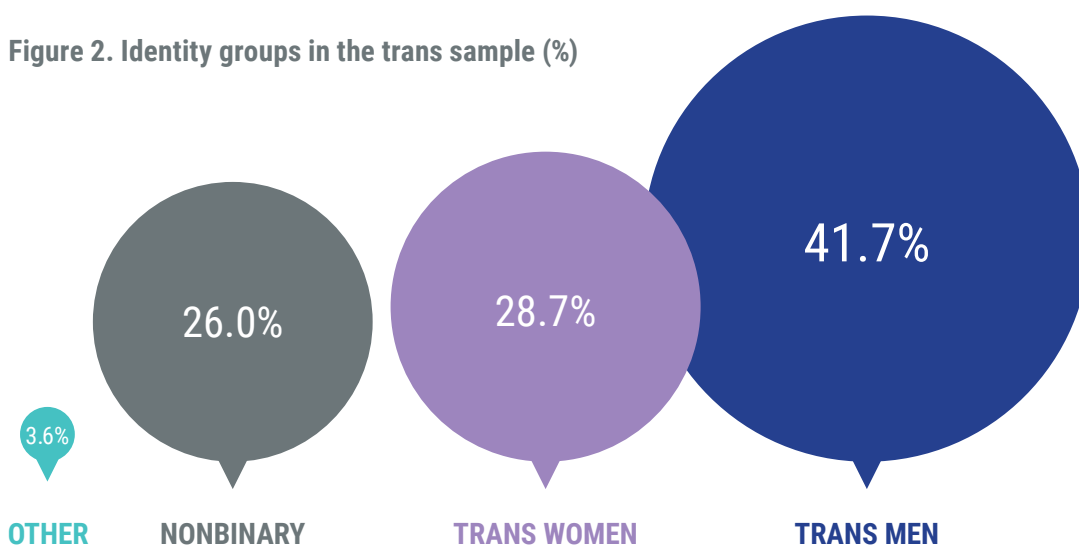
⁴ This procedure guarantees that the opinions of the trans respondents from each country are represented proportionally and reliably in the survey according to the country's population; country weights are computed based on Eurostat data (Eurostat, 2017).

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The trans sample of the survey is very diverse when it comes to gender identities and gender expressions, and the ways in which respondents manage these identities in terms of being open or not, and whether or not trans-specific medical care is desired. The trans respondents were offered different possibilities for self-identification (see Figure 2)⁵. After data analysis, 4 groups were retained: trans men, trans women, non-binary people and a group called 'other'. While acknowledging the limitations of such broad clusters, and without the implicit suggestion that these are the only or exhaustive categories, these four categories help us to understand the inherent differences that might exist within the larger trans population.

In general, more trans men (41.7%) than trans women (28.7%) took part in the HCU Survey, and a large group of non-binary people (26.0%) were represented in this study.

Figure 2. Identity groups in the trans sample (%)



Questions: Computed variable on the following survey questions: q0008: What sex were you assigned at birth, meaning on your original birth certificate? q0007: How do you describe your gender identity at the current moment? Please select the option that best fits you.
Base: Trans respondents in the TGEU survey (n=885).
Source: TGEU HCU Survey, 2017.

Further analysis revealed that the trans respondents were:

- » Young, with an average age of 26-27 years (ranging from 16 to 77 years of age). There was no significant difference in age between the five countries under study. There was a significant age difference between the gender identity groups, with trans women older on average (31 years of age) than non-binary people (24.7) and trans men (24.5).
- » Just as likely to be highly educated as not (49.4% versus 50.6%), with a significant difference across countries, Spain having a higher proportion of highly educated respondents (69.3%).

⁵ The full list of options were: Female, Male, Transfeminine/Trans woman/Male-to-female (MTF), Transmasculine/Trans Man/Female-to-male (FTM), Non-binary/Genderqueer/Gender non-conforming, 0 = other (please specify). All answer options were controlled with the question of sex assigned at birth as well as (when applicable) chosen trans healthcare pathways. The respondents who answered 'Transfeminine/Trans woman/Male-to-female (MTF)' were grouped together with those who answered 'Female' when their sex assigned at birth was 'male'. The same was done for those who answered 'Transmasculine/Trans Man/Female-to-male (FTM)' with those who answered 'Male' when their sex assigned at birth was 'Female'. In case of doubt, all open answers of the respondent were controlled together with the partner organisations ability to understand linguistic nuances.

- » Financially unstable, with only just over a quarter (30.8%) having no difficulties making ends meet, and 17.7% having (great) difficulty making ends meet. Respondents from Serbia experienced significantly greater difficulty in making ends meet (37.3%).
- » Likely to belong to one or more minority groups. 85.9% identify as being part of a gender identity minority due to being trans and 80.9% indicate belonging to a sexual minority group (gay, lesbian, bisexual, queer, asexual, etc.). Over a quarter (27.3%) report belonging to a minority group because of their disability status, 10.9% because of their religion and 9.0% because of their ethnicity.
- » Very diverse regarding their sexual orientation, with mostly straight or heterosexual orientations in Georgia (52.6%), Serbia (57.6%) and Spain (33.8%), bisexual (31.8%) in Poland, and pansexual (33.9%) in Sweden as largest proportions.
- » Experienced in accessing trans-specific healthcare. Of all the participants, almost three out of four (72.9%) have sought psychological or medical help at some point in their lives. Trans women and respondents from Serbia sought trans specific healthcare significantly more frequently than other identity groups and respondents from other countries (87.4% and 86.9% respectively).
- » Just as likely to have changed their legal gender marker as not. Almost half of all trans respondents (45.9%) have changed their legal gender marker. Of those who have changed their legal gender marker, most were trans women (64.6%). Poland was the country with the fewest number of people changing their legal gender marker (39.4%), and respondents from Spain were most likely to have done so (59.5%).

1.3. RESPONSE: HEALTHCARE PROVIDERS (HCP)

In total, 888 respondents of the HCP Survey could be included for analysis in this report. The majority of respondents came from Sweden (n=487) and Spain (n=234), with smaller amounts from Poland (n=93), Serbia (n=55) and Georgia (n=19).

Further analysis revealed that the healthcare providers were:

- » For the majority, assigned female at birth (n=707), with only 181 assigned male at birth.
- » On average, aged 41.7 years with a significant sample of younger practitioners from Poland (average age: 34.9 years).
- » As expected highly educated. Only 4.4% of all healthcare providers (n=39) had a low level of education.
- » Mostly cisgender (93.4%). No differences between countries were observed.
- » Less likely to belong to one or more minority groups. 4.7% indicate gender identity minority due to being trans and 27.0% indicate belonging to a sexual minority group (gay, lesbian, bisexual, queer, asexual, etc.). 6.0% report belonging to a minority group because of their disability status, 8.1% because of their religion and 7.2% because of their ethnicity.
- » Primarily nurses (25.3%), of which 32.0% have been practicing for over 15 years. There were also a lot of general practitioners (17.6%), psychologists (14.5%) and respondents working in pregnancy and post-natal care (11.5%).
- » Likely to have encountered a trans service user/client/patient at least once (66.6%), with 13.3% indicating that they don't know.

Chapter 2

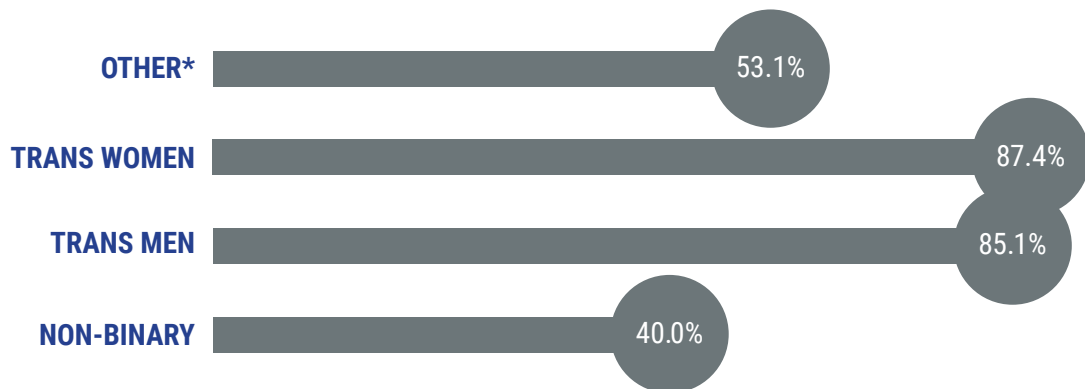
Experiences of trans people in general and trans-specific healthcare services

Trans respondents were thoroughly questioned about their experiences of receiving healthcare in general and trans-specific healthcare settings, with additional questions gathering their views on the organisations providing trans-specific healthcare. This chapter highlights the most striking experiences as well as looking into the impact of these experiences on their general wellbeing and mental health. Additionally, since trans people in sex work might be more vulnerable in accessing healthcare services, a special focus has been included to better understand their healthcare experiences.

2.1 ACCESSING TRANS-SPECIFIC HEALTHCARE SERVICES

Of all the participants, 72.9% had sought psychological or medical assistance for their transition at some point in their lives. Trans women (87.4%) sought transition-related medical care more frequently than other identity groups, as did participants living in Serbia (86.9%). Only four out of every ten non-binary people sought psychological or medical assistance.

Figure 3. Sought psychological or medical help, by identity group (% yes)



Question: q0042: Have you ever sought psychological or medical help for being trans?

Note: *Cases with fewer than 30 responses.

Base: Trans respondents in the TGEU survey (n=885).

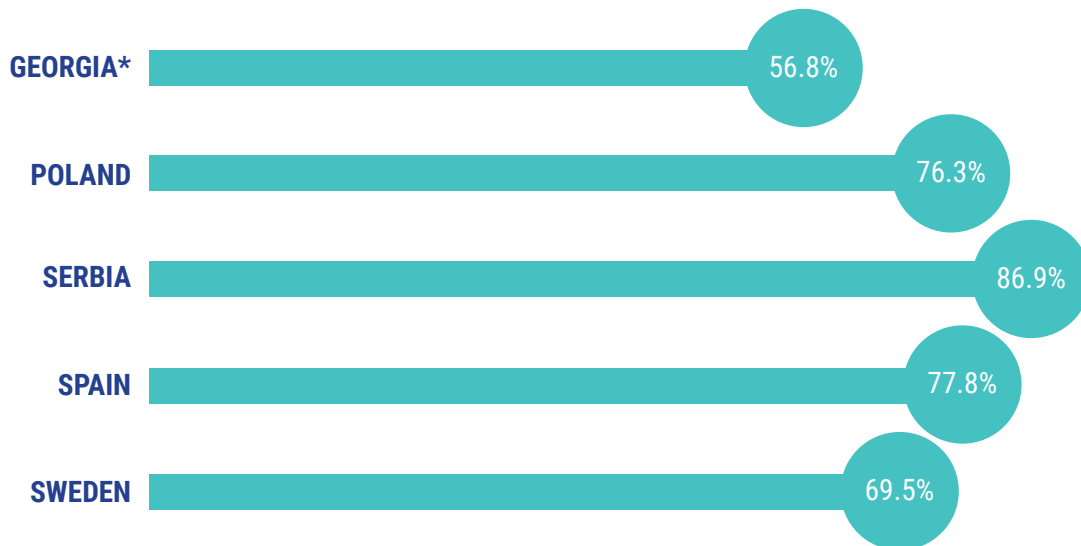
Source: TGEU HCU survey, 2017.

Respondents with a low education level, those who belonged to an ethnic or sexual minority group, as well as younger respondents had less frequently sought psychological or medical assistance for their transition. Respondents with no difficulty making ends meet were also significantly less likely to have sought psychological or medical care. Past research, for example in Georgia, has indicated that trans people are more likely to work in 'low paid' jobs where they don't have to submit identity documents⁶.

⁶ Aghdgomelashvili, Gvianishvili, Todua, & Ratiani, 2015.

The differences between the gender identity groups – with non-binary people seeking psychological or medical transition care significantly less frequently – remained even after controlling for these other background variables. This means that non-binary respondents – regardless of their educational level, income, sexual minority status or age – less frequently looked for psychological or medical transition care in comparison to trans men or trans women.

Figure 4. Sought psychological or medical help, by country (weighted %)



Question: q0042: Have you ever sought psychological or medical help for being trans?

Note: *Cases with fewer than 30 responses.

Base: Trans respondents in the TGEU survey (n=885).

Source: TGEU HCU survey, 2017.

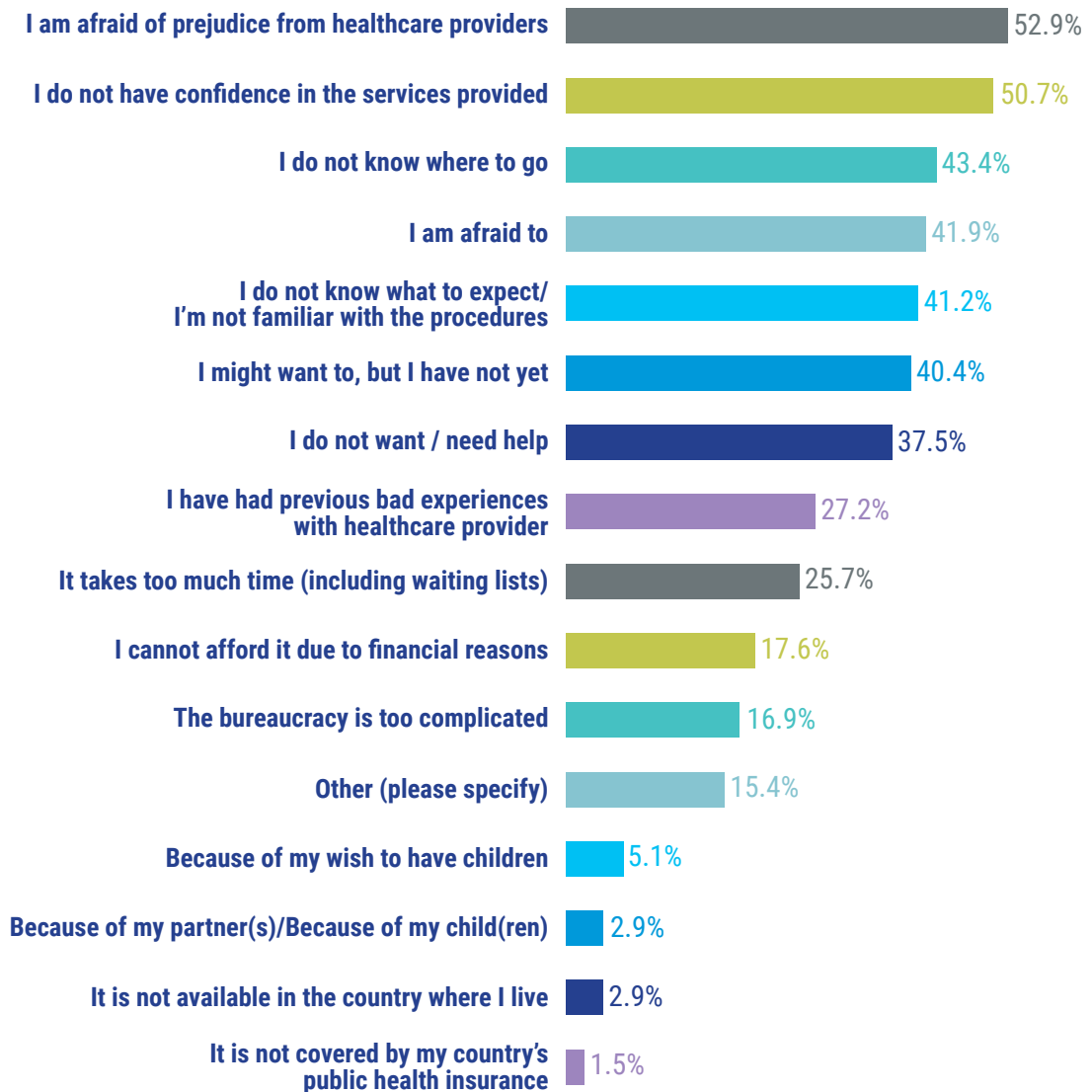
Respondents who had never sought help were asked for their reasons for not doing so. The most common reasons (cited by four out of ten respondents) were being afraid of prejudice from healthcare providers (44.1%) and not having confidence in the services provided (41.1%).

As stated above, non-binary respondents, more so than other identity groups, indicated that they did not seek help. One could hypothesize that this is because they might have no wish for psychological or medical assistance, however the survey results show that a high proportion may want to seek help at some point but have not yet done so (40.4% in comparison with 25.8 to 28.6% for other identity groups).

Half of all non-binary respondents who have not yet sought psychological or medical help state that they do not know what to expect or are not familiar with the procedure (41.2%), are afraid of prejudice from healthcare providers (52.9%), or have no confidence in the services provided (50.7%). Non-binary respondents also score significantly higher in these areas than any other identity group.

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Figure 5. Reasons for not seeking psychological or medical help
(% of cases , non-binary respondents)

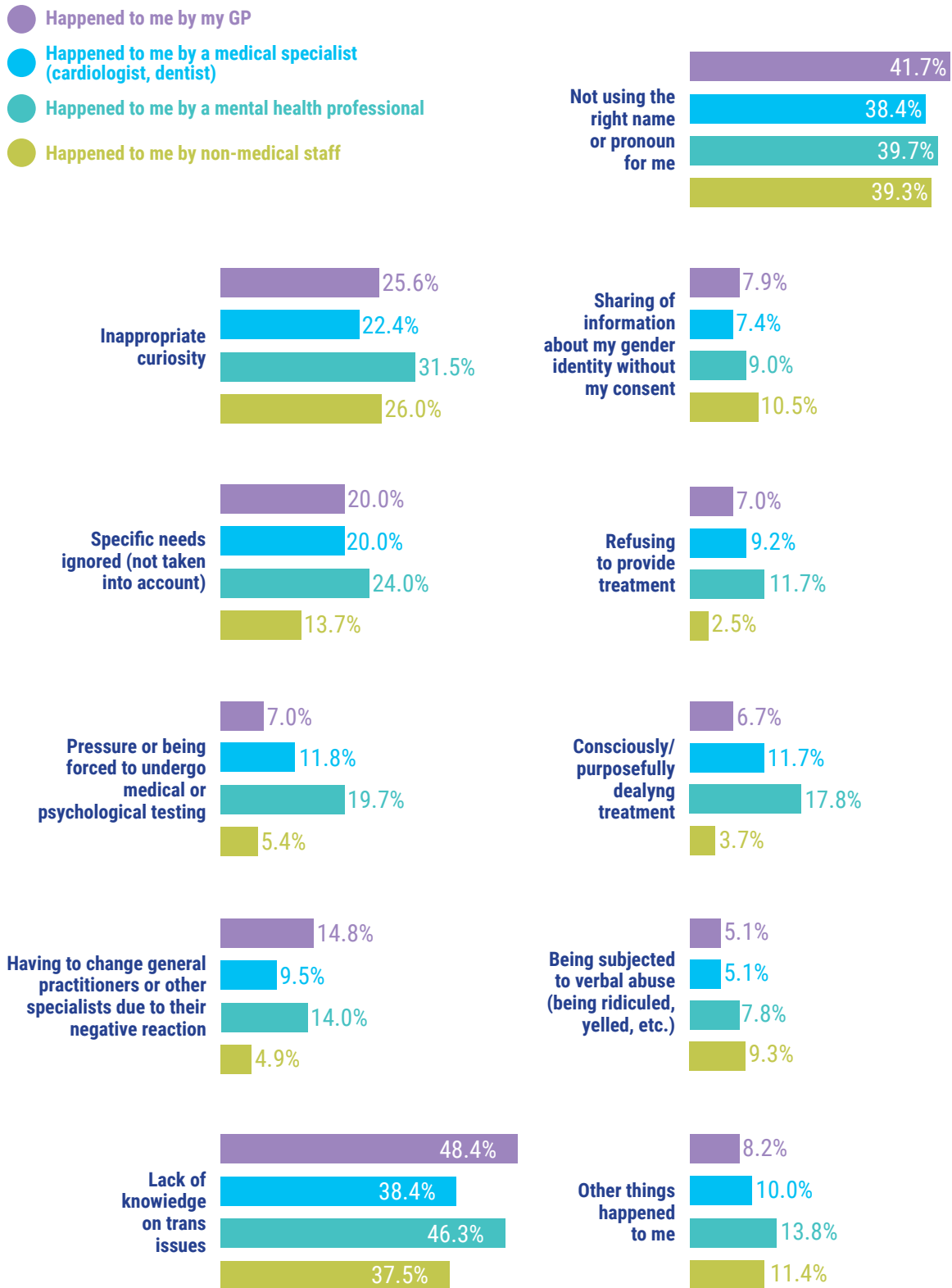


Question: q0043: Can you tell us why not (for you personally)? Please select all answers that apply to you.
Base: Non-binary respondents in the TGEU survey (N=136).
Source: TGEU HCU survey, 2017.

2.2 ACCESSING GENERAL HEALTHCARE SERVICES

The participants were asked about their experiences when accessing healthcare settings with different providers, such as their general practitioner (GP), a medical specialist (cardiologist, dentist), mental health professional, or non-medical staff. The most commonly cited experience with all of these care providers, indicated by 4 or 5 out of ten respondents, was a lack of knowledge on trans issues. Failure to use the correct name or pronoun was the second most commonly cited experience by 4 out of ten respondents.

Figure 6. Experiences when using or trying to access general healthcare (% of cases)



Question: q0070: Have you ever experienced any of the following situations when using or trying to access general healthcare services as a trans person? Please check all answers that apply to you.
 Base: Trans respondents in the TGEU survey (n=753).
 Source: TGEU HCU survey, 2017.

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More than half of all trans respondents (55.8%) reported delaying going to the doctor for general healthcare because of their gender identity (sometimes, regularly, or all the time). Trans men and respondents living in Serbia were significantly more likely to delay going to a doctor (64.5% and 70.4% respectively) than any other identity group or country.

Figure 7. Delaying healthcare needs, by identity group (% yes)



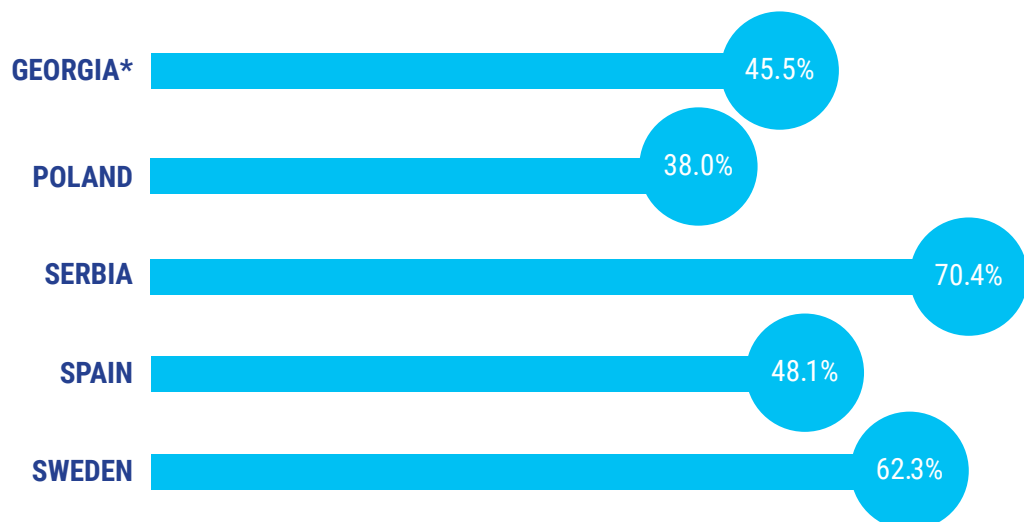
Question: Computed variable on the following question: q0065: Have you ever delayed going to the doctor for general healthcare because of your gender identity?

Note: * Cases with fewer than 30 respondents.

Base: Trans respondents in the TGEU survey (n=814).

Source: TGEU HCU survey, 2017.

Figure 8. Delaying healthcare needs, by country (weighted % yes)



Question: Computed variable on the following question: q0065: Have you ever delayed going to the doctor for general healthcare because of your gender identity?

Note: * Cases with fewer than 30 respondents.

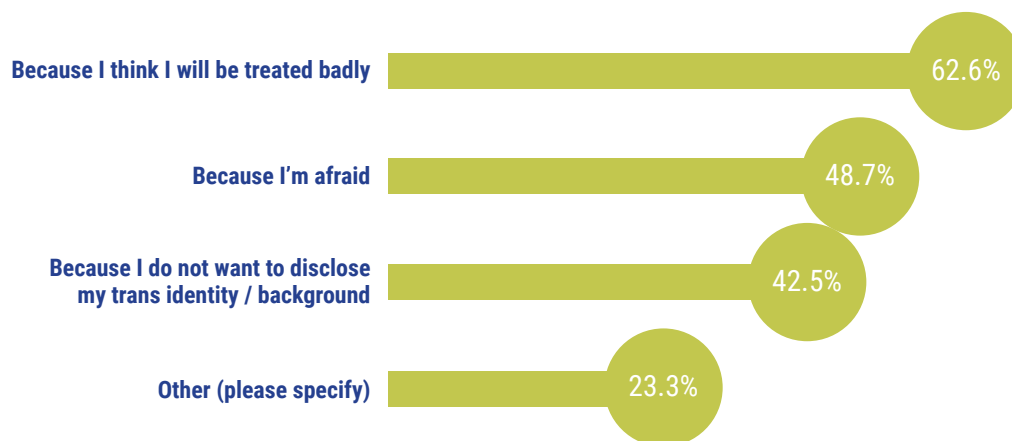
Base: Trans respondents in the TGEU survey (n=814).

Source: TGEU HCU survey, 2017.

Some background factors affecting the respondents increased the likelihood of delaying going to the doctor for general healthcare because of their gender identity, such as income: respondents who have (great) difficulty making ends meet were significantly more likely to have delayed going to the doctor. The results also show that belonging to a sexual or disability minority group increased the likelihood of delaying going to the doctor for general healthcare. Unsurprisingly, those respondents who identified as having poor health were also significantly more likely to delay going to the doctor (or: having poor health could just as well be the result of delaying seeking care, the results do not give a causal relationship).

When participants who delayed going to the doctor were asked why they delayed seeking consultation, most replied “because I think I will be treated badly” (62.6%). Other responses included: being afraid (48.7%) and not wanting to disclose their gender identity/background (42.5%) as reasons for delaying.

Figure 9. Reasons for delaying going to the doctor (% of cases)



Question: q0066: Please tell us why you delayed going to the doctor for general healthcare because of your gender identity? Please select all answers that apply to you.

Base: Trans respondents in the TGEU survey. Only respondents who delayed going to the doctor were presented this survey question (n=454).

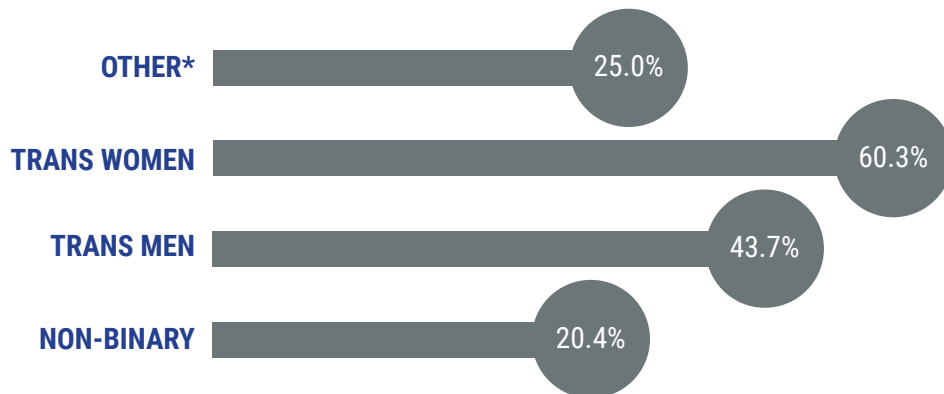
Source: TGEU HCU survey, 2017.

A quarter of all trans respondents (25.1%) felt discriminated against by a healthcare provider in general healthcare within the 12 months preceding the survey. There are no significant differences between gender identity groups, or between countries. Respondents belonging to a disability minority group, younger respondents and respondents who have (great) difficulty making ends meet were more likely to feel discriminated against because of their gender identity or expression by a healthcare provider in general healthcare.

When asked about knowledge of trans-friendly healthcare providers, almost six out of ten respondents stated they did not know of any (58.3%). Percentages differed significantly between gender identity groups and countries, as shown in the charts, on the next page with the greatest lack of knowledge among non-binary respondents (79.6%), and respondents in Sweden (72.7%).

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Figure 10. Knowing trans-friendly HCP, by identity group (% yes)



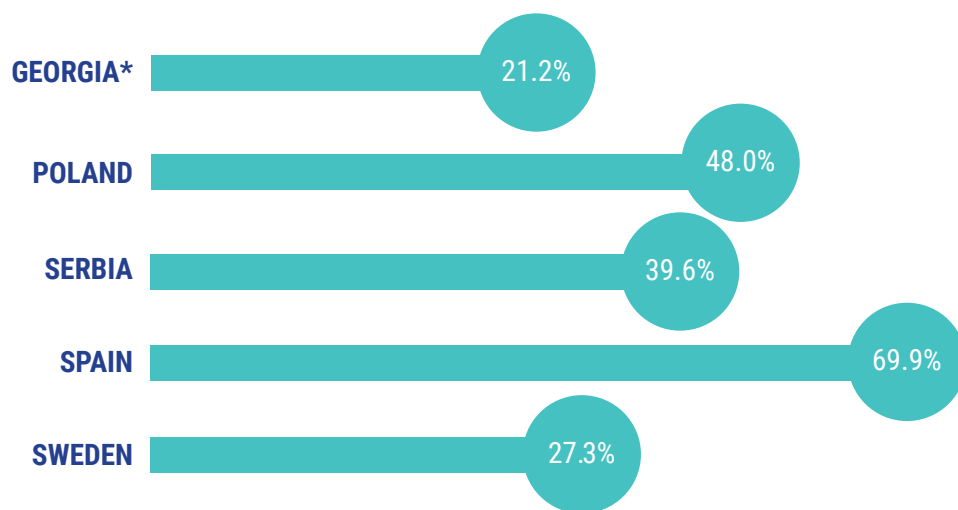
Question: q0067: In general, do you know of trans-friendly healthcare providers for general healthcare?

Note: *Cases with fewer than 30 respondents.

Base: Trans respondents in the TGEU survey (n=803).

Source: TGEU HCU survey, 2017.

Figure 11. Knowing trans-friendly HCP, by country (weighted % yes)



Question: q0067: In general, do you know of trans-friendly healthcare providers for general healthcare?

Note: * Cases with fewer than 30 respondents.

Base: Trans respondents in the TGEU survey (n=803).

Source: TGEU HCU survey, 2017.

Respondents with low-education backgrounds, young people, or those belonging to a sexual or disability minority group were less likely to have knowledge of trans-friendly healthcare providers.

If a trans-specific or LGBTI-specific medical centre for general healthcare was available, eight out of ten respondents stated that they would attend that centre (79.7%), especially trans men (84.1%) and respondents from Poland (87.3%). The willingness to go to a trans-specific or LGBTI-specific medical centre for general healthcare issues, if one was available, was significantly higher among those respondents who belong to a sexual minority group as well as younger respondents.

Figure 12. Willing to go to a trans-specific or LGBTI-specific medical centre if one were available, by identity group (% yes)



Question: q0068: Would you go to a trans-specific or LGBTI-specific medical centre for general healthcare issues if one were available?

Note: * Cases with fewer than 30 respondents.

Base: Trans respondents in the TGEU survey (n=807).

Source: TGEU HCU survey, 2017.

Figure 13. Willing to go to a trans-specific or LGBTI-specific medical centre if one were available, by country (% yes)



Question: q0068: Would you go to a trans-specific or LGBTI-specific medical centre for general healthcare issues if one were available?

Note: * Cases with fewer than 30 respondents.

Base: Trans respondents in the TGEU survey (n=807).

Source: TGEU HCU survey, 2017.

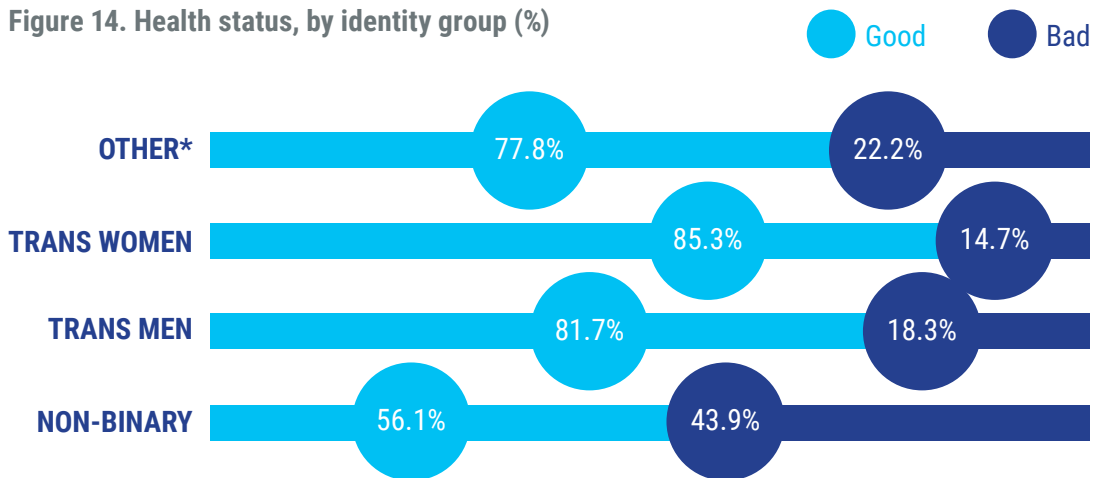
2.3 IMPACT ON GENERAL WELLBEING AND MENTAL HEALTH

The general wellbeing and mental health of trans people is often the focus of debate in research and activism. In this survey we wanted to find out about trans people's own perceptions of their general wellbeing and mental health.

Self-reported health status

The questionnaire asked the respondents to rate their overall health, ranging from very good to very bad. In general, 76.1% of all respondents rate their own health as good. Non-binary people were significantly more likely to report their health as 'bad' (43.9%) when compared to other identity groups. The same was true for respondents from Sweden (38.9%) when compared to other countries.

Figure 14. Health status, by identity group (%)



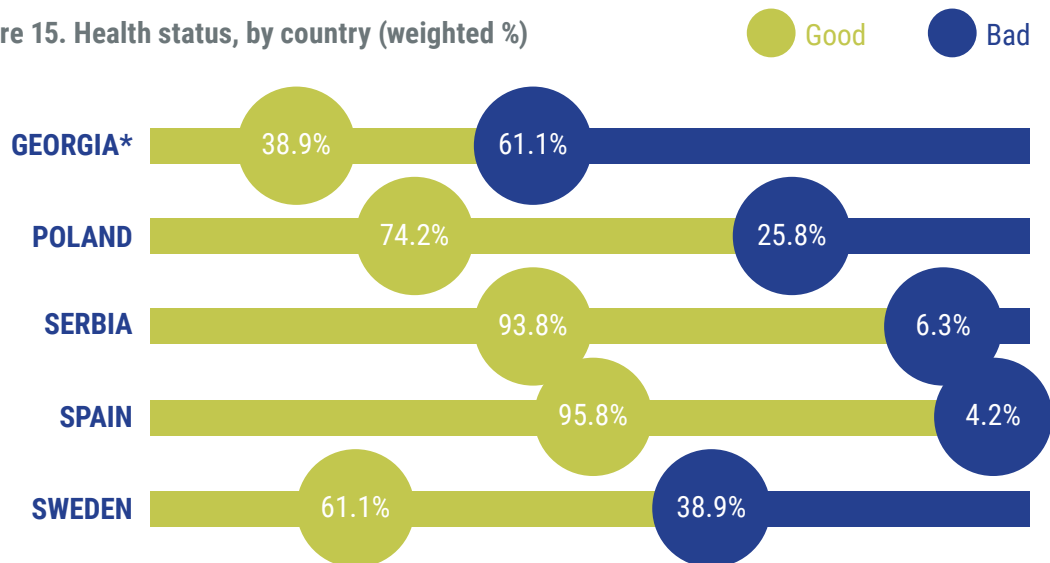
Question: Computed variable on the following survey question: q0024: In the next section, we would like to ask a few questions about your health. In general, would you say your health is...

Note: * Cases with fewer than 30 respondents.

Base: Trans respondents in the TGEU survey (n=636).

Source: TGEU HCU survey, 2017.

Figure 15. Health status, by country (weighted %)



Question: Computed variable on the following survey question: q0024: In the next section, we would like to ask a few questions about your health. In general, would you say your health is...

Note: * Cases with fewer than 30 respondents.

Base: Trans respondents in the TGEU survey (n=636).

Source: TGEU HCU survey, 2017.

There is also a significant difference between those on low income and high income with regards to health: participants who make ends meet (very) easily have better health than participants who make ends meet with (great) difficulty. Respondents with low-education backgrounds, as well as respondents belonging to an ethnic, religious, sexual or disability minority group were also more likely to describe their health as 'bad'. Discrimination and support from family were also important factors, because respondents that felt discriminated against and respondents reporting no support from close family were significantly more likely to indicate having 'bad' health.

General wellbeing

General wellbeing was measured with the WHO-5. The proportion of people 'at risk of poor mental health' is used as an indicator of mental health and is defined as having a 'WHO-5 index' of 48 or below⁷. Our results show that, in general, almost six out of ten trans respondents (57.6%) are at risk of poor mental health. When we compare the country scores from the trans respondents with the scores on the WHO-5 in the European Quality of Life Survey (EQLS) of 2012⁸, we see that the mean scores on the WHO-5 are much lower for all countries, indicating that trans people, in all countries under study, have a higher risk of poor mental health than their cis comparators.

**Figure 16. Comparison wellbeing (WHO-5)⁹
trans respondents and EQLS 2012 (MEAN SCORES)¹⁰**

	EQLS 2012	TGEU HCU survey, 2017
POLAND	59	39
SERBIA	54	48
SPAIN	65	52
SWEDEN	64	43

There were significant differences between gender identity groups and countries. The group with the highest risk of poor mental health are non-binary people (32.5% had a low mood and 38.2% likely had depression). Similar results were found for respondents living in Poland (24.9% had a low mood and 40.8% likely had depression).

⁷ Eurofound, 2014.

⁸ Sándor, Ahrendt, & Kuenzi, 2012.

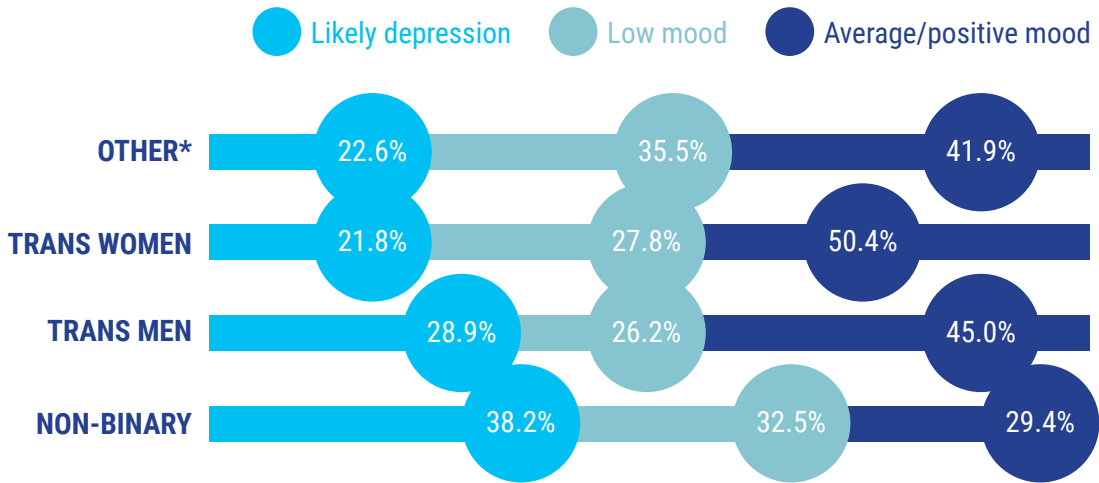
⁹ Measured by the 5-item World Health Organisation Wellbeing Index (WHO-5) (Regional Office for Europe WHO, 1998).

The WHO-5 index is calculated from the overall average score of responses to five statements in the third EQLS Q45: 'I have felt cheerful and in good spirits', 'I have felt calm and relaxed', 'I have felt active and vigorous', 'I woke up feeling fresh and rested', and 'My daily life has been filled with things that interest me'. Responses are scored on a 0–5 scale, where 0 = 'at no time' and 5 = 'all of the time' (Eurofound, 2014).

¹⁰ Georgia is not included in the EQLS 2012, so mean scores are not available.

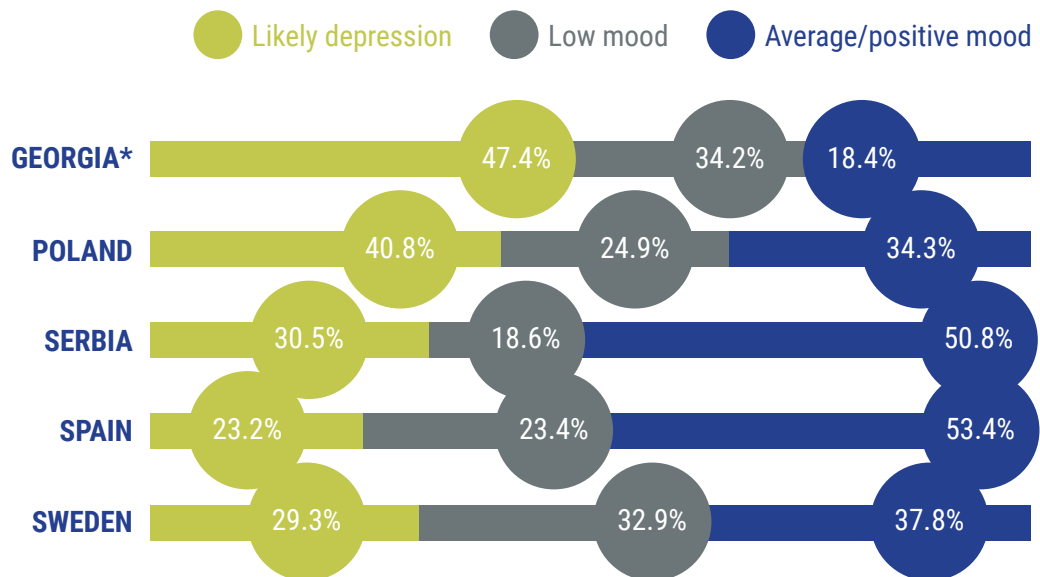
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Figure 17. Wellbeing, by identity group (%)



Question: Computed variable on the following survey question: q0027: Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks.
Note: * Cases with fewer than 30 respondents.
Base: Trans respondents in the TGEU survey (n=878).
Source: TGEU HCU survey, 2017.

Figure 18. Wellbeing, by country (weighted %)



Question: Computed variable on the following survey question: q0027: Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks.
Note: * Cases with fewer than 30 respondents.
Base: Trans respondents in the TGEU survey (n=878).
Source: TGEU HCU survey, 2017.

There were also some other variables, which had significant effects. Respondents without a higher education degree, respondents belonging to a sexual or ability minority group, younger respondents and respondents with (great) difficulty making ends meet had significantly lower wellbeing scores than respondents not belonging to one of these groups.

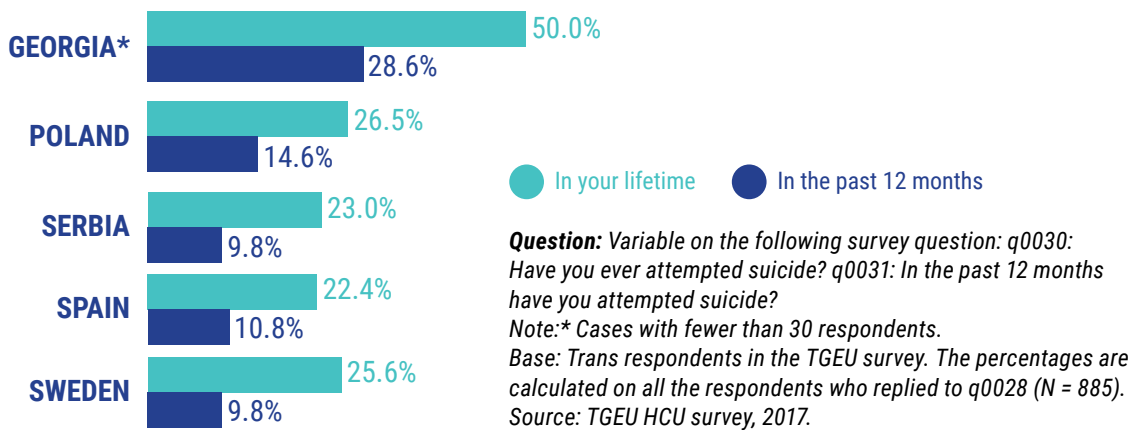
Suicidal ideation

The trans population is very vulnerable to suicidal ideation, as has been demonstrated in numerous studies¹¹. This study also indicated high rates of suicidal thoughts and attempts. 77.5% reported to have had suicidal thoughts in their lifetime, and 49.0% did so in the 12 months preceding the survey.

24.5% of all respondents have attempted suicide at least once in their life, with no significant difference between the gender identity groups.

When asking about suicide attempts in the 12 months preceding the survey, on average 10.8% of all respondents had attempted suicide.

Figure 19. Suicide attempts according to country (weighted % of cases)



In the majority of cases, the trans respondents who had experienced suicidal thoughts or attempts did not seek any help at first (63.1%). However, almost four out of ten (36.3%) did look for professional help at some point, with three out of ten turning to their peers, friends or family (31.5%) - with some respondents reported having done both.

Figure 20. Help for suicidal thoughts/attempts during the last 12 months (% of cases)

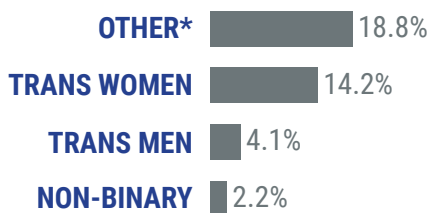


¹¹ See for example (Fundamental Rights Agency, 2014), (Dhejne, Lichtenstein, Boman, & Johansson, 2011), (Motmans, de Biolley, & Debunne, 2010).

2.4 FOCUS: TRANS PEOPLE IN SEX WORK

To better understand the healthcare experiences of trans people in sex work, the research team decided to ask all respondents if they had ever been engaged in sex work. A total of 7.0% of respondents answered this question positively. A significant difference was found between the four gender identity groups, with respondents belonging to the 'other' group and trans women showing the highest rates (18,8% and 14.2% respectively) of having been engaged in sex work.

Figure 21. Ever been engaged in sex work (% Yes)



Question: q0039. Have you ever been engaged in sex work?
Base: All trans respondents in the TGEU survey (n=885).
Note: *Cases with fewer than 30 respondents
Source: TGEU HCU survey, 2017.

Of all the respondents indicating yes on the previous question, only 42.4% were engaged in sex work during the 12 months preceding the survey (n=66). When asked why they were doing sex work, most indicated "because it is how I earn additional income" (48.4%), with 38.7% responding that it was "because of a lack of other opportunities". Only 11.3% replied "because I prefer sex work to other kinds of work".

Figure 22. Reason to be/have been engaged in sex work (% of cases)



Question: q0041: Can you tell us why you are/were engaged in sex work? Please select all answers that apply to you.
Base: All trans respondents in the TGEU survey who were engaged in sex work in the last 12 months (n=62).
Source: TGEU HCU survey, 2017.

Being engaged in sex work did not significantly impact respondents' health outcomes, whether they sought, medical or psychological help, delays in healthcare, had suicidal thoughts or had attempted suicide. It did however influence the feeling of being discriminated against. Respondents engaged in sex work were significantly more likely to have experienced discrimination from healthcare providers. There was also a significant connection between income and age when engaging in sex work. Those with (great) difficulty in making ends meet and older respondents were significantly more likely to have been engaged in sex work.

Chapter 3

Opinions on health: comparison between healthcare providers & users

Both healthcare users who self-identified as trans and healthcare professionals were presented with the same set of statements, with answers on a 6 point Likert scale from “strongly agree” to “strongly disagree”¹². In this chapter we will present both groups’ opinions together. In order to do so, 4 groups of opinions were compared, focusing on: diagnosis & pathologisation (3.1), informed consent (3.2) and legal gender recognition¹³ (3.3).

3.1 OPINIONS REGARDING DIAGNOSIS & PATHOLOGISATION

The diagnosis ‘transsexualism’ is still codified within the International Classification of Diseases (ICD-10)¹⁴, which is an internationally accepted manual of medical and mental health diagnoses. There is a realistic fear in countries, such as Poland, that removing the diagnosis from diagnostic manuals will prevent trans people from accessing trans-specific healthcare services¹⁵. Thus, a potential benefit of including a diagnosis in the ICD-10 is that its codification makes it a medically recognised condition requiring attention from healthcare providers. Trans-specific healthcare already has limited public funding, so retaining a diagnosis in internationally accepted manuals will help trans people with limited financial resources to access medical transition. The ICD-11, which is currently being developed and should be finalised in 2018, will no longer use the diagnosis of ‘transsexualism’, but will instead use the diagnosis of gender incongruence in adolescence and adulthood (GIAA)¹⁶. It is also important to note that the diagnosis in the ICD-11 will no longer be under the chapter of mental and behavioral disorders, but instead will be placed in a new chapter called Conditions Related to Sexual Health. As a consequence, the diagnosis should no longer psychopathologise trans people¹⁷. In the survey, both groups were presented with a list of statements and were asked to indicate to what extent they agreed on a 6-point Likert-scale ranging from strongly agree to strongly disagree or I don’t know.

Both groups agreed to a similar extent that having a psychiatric diagnosis has a stigmatising effect on a person (71.7% for healthcare providers and 70.7% for healthcare users respectively). Also, as might be expected, healthcare users agree to a greater extent that having a medical diagnosis is a better option for trans people than having a psychiatric one (74.2% for healthcare users versus 60.5% for healthcare providers).

¹² Likert, 1932.

¹³ The term legal gender recognition refers to the official procedure of changing trans people’s name and gender marker in official registries and documents such as their birth certificate, ID card, passport or driving license. (Köhler & Ehr, 2016)

¹⁴ World Health Organisation, 2010.

¹⁵ European Union Agency for Fundamental Rights, 2016.

¹⁶ Winter, De Cuypere, Green, Kane, & Knudson, 2016.

¹⁷ Winter et al., 2016.

Figure 23. Opinions regarding diagnosis & pathologisation (%)

	USERS			PROVIDERS		
	(Strongly) agree	Neither agree nor disagree	(Strongly) disagree	(Strongly) agree	Neither agree nor disagree	(Strongly) disagree
Gender incongruence among adolescents or adults is a psychiatric disorder	3,2%	5,0%	91,8%	4,6%	7,6%	87,8%
Gender incongruence among children (before puberty) is a psychiatric disorder	2,7%	5,9%	91,4%	3,2%	8,4%	88,4%
Having a psychiatric diagnosis of gender identity disorder or transsexualism or gender dysphoria has a stigmatizing effect on a person	65,2%	18,7%	16,1%	70,5%	15,2%	14,3%
Having a diagnosis which is not psychiatric but only medical would be a better option for trans people	74,2%	14,7%	11,0%	60,5%	25,3%	14,2%

Question: Computed variable on the following survey question: q0060/q0037: Please tell us to what extent do you agree with the following statements?

Base: Trans respondents and healthcare providers in the TGEU survey (HCU: n=728, HCP: n= 659). The answer option 'I don't know' was recoded as missing.

Source: TGEU HCU and HCP survey, 2017.

3.2 OPINIONS REGARDING INFORMED CONSENT MODELS

In general, the Standards of Care 7 (SOC7), developed by the World Professional Association for Transgender Health (WPATH), put forward an overview for gender affirmative treatment protocols for trans people seeking care¹⁸. The overall goal of the SOC is to provide clinical guidance for health professionals to assist in the provision of safe and effective pathways for trans people to achieve lasting personal comfort with their gender, in order to maximise their overall health, psychological wellbeing, and self-fulfillment¹⁹. However, these guidelines are not mandatory and therefore different options and protocols are available. In some countries there are no protocols regulating trans health care pathways, whereas other countries, such as Sweden, have translated the SOC7 into their national protocols.

The SOC7 shows a significant change in approach compared to the previous versions of the SOC, and places emphasis on the informed consent model.

¹⁸ Coleman et al., 2012.

¹⁹ Coleman et al., 2012.

The informed consent model, in turn, puts emphasis on the capability and the autonomy of a person to choose their own healthcare options, providing the right to seek treatment without requiring external evaluation or therapy from mental health professionals²⁰. In this model, the healthcare provider does not retain their gatekeeping position of deciding if and/or when a person is ready to undergo treatment. Through discussions about the risks and benefits of treatment options with the person (taking into account the current state of scientific knowledge and the social and cultural context of treatment options, as well respecting the person's capability for self-knowledge), clinicians work to assist the person in making the best decision²¹.

The SOC7 still maintains the requirement of a mental health evaluation before accessing gender-affirming treatments. Psychotherapy is highly recommended although not required. However, referral letters are required for medical interventions. The section titled Criteria for Hormone Therapy states that there is a referral required from the mental healthcare practitioner who conducted the assessment. The SOC acknowledges that hormone regulation can also be determined by healthcare professionals with experience of trans healthcare and qualifications in this area. In order to access surgical interventions, the SOC7 stipulates the requirement of two referral letters from mental health professionals in addition to having lived, for a period of 12 months, in a role congruent with their gender identity (also known as "real life experience" (RLE)). In this sense, the SOC sometimes places an unnecessary burden on people seeking gender-affirming hormone or surgical treatment. The guidelines are sometimes considered paternalistic, supporting a form of gatekeeping that actually limits access to gender-related care²².

When it comes to opinions regarding informed consent models, the results are more or less suggestive of the classic divide between providers and users. Firstly, questions regarding access to healthcare were given to respondents. There is a stark difference of opinion with regards to the question about access to puberty blockers and hormone replacement treatment. Healthcare users agree to a much greater extent (a difference of more than 25%) that hormone/puberty blockers and hormone replacement treatment should be available to adolescents than do healthcare providers. Treatment for adolescents is not available for all countries participating in the research. Also, a fairly significant proportion of healthcare providers do not have an opinion regarding access to trans-specific healthcare for non-binary people (17.3%).

²⁰ Cavanaugh, Hopwood, & Lambert, 2016.

²¹ Cavanaugh et al., 2016.

²² Cavanaugh et al., 2016; Wylie et al., 2014.

Figure 24. Opinions regarding access to healthcare (%)

	USERS			PROVIDERS		
	(Strongly) agree	Neither agree nor disagree	(Strongly) disagree	(Strongly) agree	Neither agree nor disagree	(Strongly) disagree
Hormone blockers / puberty blockers should be available to adolescents who enter puberty	94,2%	3,2%	2,7%	67,0%	19,6%	13,5%
Cross-sex hormones (such as oestrogen or testosterone) should be available to adolescents in puberty	87,5%	7,5%	5,0%	61,7%	23,0%	15,2%
Non-binary or genderqueer people should have access to trans-specific healthcare	86,5%	8,3%	5,2%	76,5%	17,3%	6,2%
The way a person expresses themselves should not influence their access or how they are treated	94,2%	2,8%	3,0%	95,2%	3,1%	1,7%

Question: Computed variable on the following survey questions: q0060/q0037 Please tell us to what extent do you agree with the following statements? q0061/q0038 Can you tell us to what extent you agree with the following statements?

Base: Trans respondents and healthcare providers in the TGEU survey (HCU: n=782; HCP: n=604). The answer option 'I don't know' was recoded as missing.

Source: TGEU HCU and HCP survey, 2017.

Secondly, statements referring to gatekeeping and informed consent were put to the respondents. Healthcare providers agreed to a much greater extent than healthcare users (42.9% compared to 17.9%) that a mental health professional should decide if a person is ready for hormone treatment/surgery. Also, the majority of healthcare providers (64.3%) agreed that a real life experience/test should be included in the transition process, in contrast with the minority of healthcare users (29.1%).

Figure 25.
Opinions regarding gatekeeping (%)

	USERS			PROVIDERS		
	(Strongly) agree	Neither agree nor disagree	(Strongly) disagree	(Strongly) agree	Neither agree nor disagree	(Strongly) disagree
A mental health professional should decide if a person is ready for surgery	15,2%	16,5%	68,4%	41,7%	29,3%	29,0%
A mental health professional should decide if a person is ready for hormone treatment	17,9%	16,5%	65,5%	42,9%	28,6%	28,5%
A real life experience/test (required living for a period of time presenting according to your gender identity) should be included in the transition process	29,1%	18,2%	52,6%	64,3%	21,4%	14,3%

Question: Computed variable on the following survey questions: q0060/q0037 Please tell us to what extent do you agree with the following statements? q0061/q0038 Can you tell us to what extent you agree with the following statements?

Base: Trans respondents and healthcare providers in the TGEU survey (HCU: n=782; HCP: n=604). The answer option 'I don't know' was recoded as missing.

Source: TGEU HCU and HCP survey, 2017.

3.3 OPINIONS REGARDING LEGAL GENDER RECOGNITION

In many countries, access to legal gender recognition (LGR) is based largely on medical criteria. Medical procedures and gender recognition are connected because, in many EU Member States, gender reassignment surgery (GRS) is required before a legal change can be made to a person's identity documents. 20 states in Europe require sterilisation before their gender identity can be recognised (including Serbia and Georgia)²³. However, the European Court of Human Rights ruled on April 6, 2017 that the sterilisation requirement in legal gender recognition procedures violates human rights²⁴. Setting a legal precedent for Europe, this decision will force the remaining countries implementing the infertility requirement to change their procedures. Other requirements may include a mandatory diagnosis of mental disorder, medical treatment and invasive surgery, and assessment of time lived in the person's gender identity²⁵.

The next set of opinions questioned both groups about aspects of legal gender recognition. Firstly, whereas providers generally score more negatively than healthcare users, more than two thirds (72.8% and 79.4% respectively) did agree that it would be good to have a third legal gender in their country. Secondly, there was also a big difference between healthcare users and healthcare providers regarding the decision to choose a legal gender or a name (a difference of about 20% between HCU and HCP). Lastly, almost 20% of healthcare providers did not have a clear opinion on minors and access to legal gender recognition. Overall, it is encouraging to note that more than half of both HCU and HCP agreed that LGR should be fully demedicalised and accessible to people regardless of their age.

²³ Transgender Europe, 2016.

²⁴ Gatineau-Fattaccini, Thouin-Palat, Boucard, Fournier, & Pierrat, 2017.

²⁵ Köhler & Ehrh, 2016.

Figure 26. Opinions regarding legal gender recognition (%)

	USERS			PROVIDERS		
	(Strongly) agree	Neither agree nor disagree	(Strongly) disagree	(Strongly) agree	Neither agree nor disagree	(Strongly) disagree
It would be good to have a third legal gender in our country	79,4%	11,8%	8,8%	72,8%	17,3%	10,0%
People under 18 years of age should be able to access legal gender recognition	93,3%	4,0%	2,7%	68,4%	19,5%	12,1%
Every person should have the right to decide their own legal gender, regardless of age	84,5%	8,6%	7,0%	58,3%	19,1%	22,6%
Every person should have the right to change their own name, regardless of age	92,4%	3,7%	3,9%	73,7%	13,1%	13,3%

Question: Computed variable on the following survey question: q0062/q0039: Can you tell us to what extent do you agree with the following statements (continued)?
Base: Trans respondents and healthcare providers in the TGEU survey (HCU: n=798; HCP: n=593). The answer option 'I don't know' was recoded as missing.
Source: TGEU HCU and HCP survey, 2017.

With regards to diagnosis-based legal gender recognition and a third legal gender, the most interesting responses come from non-binary people. Non-binary respondents indicated more than the whole trans sample that access to legal gender recognition should be possible without any medical requirements (98.1% against 84.4%) and that it would be good to have a third legal gender in their country (92.6% against 79.4%), whereas fewer non-binary people agree that legal gender recognition should be restricted to those with a diagnosis (9.0% against 17.0%).

Figure 27. Opinions regarding legal gender recognition among non-binary respondents

	(Strongly) agree	Neither agree nor disagree	(Strongly) disagree
It would be good to have a third legal gender in our country	92,6%	5,5%	1,8%
Access to legal gender recognition should be possible without any medical (diagnosis / hormones / surgery) requirements	98,1%	1,4%	0,5%
Access to legal gender recognition should be restricted to those with a diagnosis	9,0%	10,0%	81,1%

Question: Computed variable on the following survey question: q0062: Can you tell us to what extent do you agree with the following statements (continued)?
Base: Non-binary respondents in the TGEU survey (n=210). The answer option 'I don't know' was recoded as missing.
Source: TGEU HCU survey, 2017.

Chapter 4

Country reports

4.1 GEORGIA

Georgia – in brief

- » *There are no guidelines, protocols or system regulating trans-specific healthcare;*
- » *In previous surveys, a high level of depression and stress among trans people was reported;*
- » *Self-medication for general and trans-specific healthcare is common among trans people, in order to avoid contact with the official healthcare system;*
- » *There is a high level of transphobic attitudes in society and a high number of transphobic violent incidents;*
- » *There is no legislation regulating legal gender recognition.*

A. Country Context

In Georgia, the trans community remains one of the most marginalised. Despite the fact that Georgia included sexual orientation and gender identity in the legislation dealing with responses to hate crimes (2012) and non-discrimination (2014), legal gender recognition and important regulations relevant for desired medical transition, are absent from the legal framework. The Georgian government does not invest or engage in challenging the dominant gender and sexuality stereotypes (including homo-, bi- and trans-phobia) in society, while use and abuse of LGBT-specific topics by politicians perpetuates negative public attitudes. This contributes to the extreme social and economic marginalisation of the trans community.

LGBT organisations working in Georgia have only recently begun to specifically address issues affecting the trans community. There are two surveys exploring the situation of trans people in Georgia, conducted in 2012²⁶ and 2014²⁷ respectively by the Women's Initiatives Supporting

²⁶ (Japaridze, Aghdgomelashvili, Melashvili, Gvianishvili, & Vacharadze, 2012) http://women.ge/data/docs/publications/WISG_situation-of-lgbt-persons-in-Georgia_ENG-www.pdf

²⁷ (Gvianishvili, 2015) http://women.ge/data/docs/publications/WISG_Transgender_survey_2015.pdf

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Group (WISG). Both explore different aspects of the lives of trans individuals including violence and discrimination, access to healthcare and levels of stress and depression. Nine out of fourteen trans respondents that took part in the survey in 2014 stated that they face physical violence due to their gender identity and all fourteen stated that they regularly experience psychological violence from a variety of sources (strangers on the street, family, etc.), which seriously impacted their mental health.

The murder of two trans women in Tbilisi in 2014 and another in 2016 had a devastating effect on the trans community, while also providing the encouragement for more trans women to speak out about their situation and become more visible. While this is a positive reaction, the response of law enforcement agencies and the justice system to the murders mentioned above was absolutely not acceptable. In the case of Sabi Beriani, murdered in November 2014, no bias motive was outlined during the investigation. Furthermore, the court acquitted the murderer, sentencing him to only 4 years imprisonment for setting the apartment on fire when he was fleeing the scene. Only the Supreme Court, 2 years later, ruled that he was actually guilty of premeditated murder. Unfortunately, despite this final victory, the response of the Georgian justice system sends the wrong message to society: that the life of a trans woman is worth less than someone's property. In the case of Zizi Shekeladze, who was brutally beaten into a coma and later passed away, the murderer was caught and sentenced immediately, however prosecutor and investigators did not even try to look for a bias motive in this case. All of this is compounded by polarised gender roles, hostility towards gender equality issues, and the tabloid media preying on trans people. These actions and attitudes provide society with completely inadequate and incorrect information about gender identity and sexuality, thus contributing to transphobic public opinion.

Given the circumstances (lack of financial means, fear of discrimination, high levels of transphobia in society) it is not surprising that most Georgian trans people who start the process of transition avoid going to the doctor, self-medicate for general healthcare issues, and undergo hormone therapy without medical supervision based on peer advice.

This survey is another step towards improving the existing situation, by emphasising change of the healthcare situation of trans people living in Georgia, their relationship with the national healthcare system and their view on how it can be improved.

B. About the research

The healthcare survey was published and disseminated mostly online. However, it became necessary, to reach out to members of the trans community through trans activists to encourage them to fill out the questionnaires, as well as setting up meetings with individuals within the trans community in order to assist them in filling out the questionnaire.

The limitation of this study, for Georgia, is the low number of participants. While the researchers expected a higher number of participants to be willing to contribute to the online survey, it turned out (for future reference) that face-to-face interviews are more efficient. There may be several reasons for this. First of all, Georgia is a small country with around 4 million inhabitants and the trans community that is currently reached by the organisations constitutes a group of

only (approximately) 50 persons. This, of course, means that there are many more people forced to live in the closet and hide their gender identity on a daily basis (particularly in those regions outside the Georgian capital). The second reason may be down to lack of awareness about local trans activism and the importance of data collection within the trans community.

Twenty-three respondents took part in the Georgian survey; nine trans women, six trans men, six non-binary people and two respondents who checked the other option. Eleven respondents stated that their sex assigned at birth was female, while twelve respondents stated that they were assigned male at birth. All of them have citizenship or residence in Georgia. The age in the sample ranges from 17-43 years, which is in line with the Georgian LGBT community, constituted mostly of people under 50 years of age. Fourteen of the respondents have a low educational level, while nine have a higher education degree. Seventeen respondents indicated that they live in a city, town or suburb of a city, while only one indicated living in a rural area. Only nineteen respondents were willing to respond to questions regarding their financial situation and eight respondents stated that they are struggling financially to a great extent (with difficulty or with great difficulty). Only one respondent indicated that they could fairly easily make ends meet.

Despite the fact that the number of participants cannot be used to compare statistically with the studies simultaneously conducted in the four other participating countries, due to scarce empirical data on the trans community in Georgia, the findings are still valuable for shaping the work of local trans groups regarding the issues of trans-specific and trans-inclusive general healthcare.

C. Results and Discussion

Legal Gender Recognition

Legal gender recognition²⁸ is not regulated by Georgian legislation. The practice established by the Public Registry Office is to request proof of “sex reassignment surgery” from the applicants wanting to amend their gender marker. Despite the fact that reforming this practice, would not require significant effort from the authorities, there has been no expression of political will to do so. This remains a significant problem for Georgian trans people, preventing them from successfully integrating into wider society, finding proper employment and avoiding discrimination each time they have to show their documents.

Only one of our respondents stated that they have either changed or are in the process of changing their gender marker. This respondent identified as a man. The majority of the participants (14) stated that they would like to change their gender marker, five stated that they do not know whether or not they would like to change their gender marker and three, including two non-binary people, stated that they do not wish to change their gender marker. The common reasons given for these responses include having the need to change their gender marker (4), and because of their family (3). One respondent stated that they do not want to change their legal gender because the legal gender marker they want is not available and another responded that they cannot afford the current process. Furthermore one individual responded that they do not want to

²⁸ Aghdgomelashvili, Gvianishvil, Todua, & Ratiani, 2015.

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change their gender marker because they do not wish to undergo surgery, while another stated their belief that there should not be a gender marker on their documents at all.

Generally, most of the respondents agree with the principles of depathologisation and the separation of legal gender recognition from medical transition, as well as improving the availability of healthcare services, both trans-specific and general. Only three respondents believe that access to legal gender recognition should be restricted to those with a diagnosis.

Ability to Live According to One's Gender Identity

The issue of disclosure of one's gender identity and being able to live according to one's gender identity is a painful one for trans people living in Georgia. Considering the high level of hostility in society, being 'read' as non-cisgender can become quite risky in certain circumstances. For this reason, some of the respondents from the 2014 survey were not able to live according to their gender identity at all times and often had to express themselves as the gender considered socially 'appropriate' for their biological sex.

In the present survey, of all 23 participants, four stated that they are able to live according to their gender identity only occasionally, eleven almost always, and eight always. Only four respondents plan to do so more frequently. Those who are not able to live according to their gender identity at all times state that they cannot do so because of their parents (3), general reactions in society (3), and fear of discrimination (3).

The majority of respondents (20) are fully open about their gender identity with their friends, while eight are fully open and 12 are partially open with their close family and relatives. In school or work settings, only four participants are fully open, nine are partially open, five are not open at all and five respondents indicated that this doesn't apply to them.

Out of the groups that our respondents are open with, close friends are the most supportive of all (13 strongly supportive and 4 supportive, while 3 stated that they are neutral). Out of the 23 respondents, seven respondents indicated that their close family is (strongly) disapproving of their gender identity, while 5 respondents stated that they were disapproving.

Of all respondents (23), 11 stated that they are either, always, or most of the time addressed as someone of the sex they were assigned at birth, the rest of the participants (12) are addressed as their self-identified gender more often. Thirteen participants believe that the public rarely perceives them as trans and three believe that this never happens. A minority (11) of the respondents (strongly) agreed that they are fine with others knowing about their gender identity, that they are comfortable with revealing their gender identity, and that they prefer others to know and accept their trans history.

Self-Reported Health

15 participants stated that they are (fully) open about their gender identity in healthcare settings, while 4 stated that they are not open at all and one stated that this doesn't apply

to them. Eight participants stated that people in healthcare settings are either strongly disapproving or disapproving of their gender identity, with only one respondent indicating that their healthcare professionals are strongly supportive.

All 23 participants were willing to self-assess their health. Of those respondents, four participants stated that their health is good and seven stated that their health is bad. 15 respondents suffer from chronic illnesses or disabilities with nine being limited in their daily life because of this and one respondent stating that they are severely limited by the same. However, 14 participants stated that, all things considered, they are satisfied with their life, while nine stated that they are not.

A study from 2014 showed that the trans community pays attention to HIV and STI testing. In the current study, 17 know their HIV status (five stated that they are HIV positive). Most of the participants (14) underwent testing for HIV within the past 12 months.

Constant exposure to violence and discrimination has an extremely negative effect on the mental health of trans people living in Georgia. According to a study conducted in 2014²⁹, the average index of depressed mood among the group was 25, which is higher than acceptable (16). The highest indices were 45 and 39 and this was indicated by two respondents, both of whom have a long history of depression and are currently undergoing mental health treatment. In our current study, the average rate of wellbeing within the group of Georgian respondents was 35.1³⁰, which is quite low and indicates that respondents on average have a low mood. Wellbeing ranged from 0 (two respondents with likely depression) to 80 (which indicates a positive mood).

13 participants stated that they thought about ending their life multiple times, four only once and six never. Of the 17 who responded to questions about having suicidal thoughts, 14 participants stated that they thought about ending their life in the preceding 12 months. Seven participants stated that they tried to end their life multiple times and two have tried to end their life once (out of which five attempted in the preceding 12 months).

13 participants stated that they had never sought psychological help for being trans. Based on the assessment of healthcare services by users, mental healthcare professionals ranked highest among those who gave the participants the information and support they needed.

Access to General Healthcare

In the previous study on 'the Situation of Trans Persons'³¹ in Georgia, it was found that trans people, particularly those who had already started transitioning, tend to avoid going to the doctor and tend to self-medicate for most of their health issues. Many did not show any interest in the availability of public insurance, while still being unable to afford private insurance. In

²⁹ Aghdgomelashvili, Gvianishvil, Todua, & Ratiani, 2015.

³⁰ In the current study, a higher score means a better mood in comparison to the study conducted in 2014, where a higher score indicated a lower mood.

³¹ Aghdgomelashvili, Gvianishvil, Todua, & Ratiani, 2015.

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the present study, eleven respondents stated that they have access to public health insurance, three use private insurance, one has access to the healthcare system through another route, and 11 have no access to health insurance at all.

According to the WISG study from 2014, trans women pay more attention to HIV and STI testing than trans men. Avoidance of the healthcare system is based on two reasons. The first is fear of being treated badly by medical professionals, non-medical staff and other patients at the clinics. This is the main reason why most respondents choose not to use the public health insurance to which they are entitled for general healthcare. The second is financial, particularly in relation to sexual and reproductive health and rights (SRHR) and mental health and transition-related procedures. Most of our respondents are not able to seek proper employment because they have no access to legal gender recognition. According to research previously conducted, lack of access to legal gender recognition makes trans people in transition more vulnerable to discrimination by their potential employers (this is based both on real experience of discrimination, being refused employment, or being fired, as well as on perceived fear of such treatment) and fellow co-workers (if hired).

Nine participants stated that they have delayed going to a doctor for general healthcare issues because they are trans (one at all times, two regularly, six sometimes). Seven respondents stated that they delayed going to a doctor due to fear of discrimination, four because they were afraid, and four because they did not wish to disclose their gender identity. A majority (16) did not know of a trans friendly doctor that they could go to for general healthcare. Five participants reported being discriminated against by healthcare professionals due to their gender identity. Given the circumstances, it is not surprising that 15 participants indicated a preference for going to an LGBT or trans-specific healthcare centre if this were available.

Experiences of Trans-related healthcare

Trans-specific healthcare services are available only sporadically in Georgia. There are no guidelines or protocols with regard to trans-specific healthcare that is accepted by the Ministry of Labour, Health and Social Affairs. This gives individual doctors and clinics the freedom to choose the way in which they provide specific services, regardless of best practice as per the international guidelines from WPATH/WHO.

Overall, the assessment of the provision of trans-specific healthcare in Georgia is negative. Participants feel that they have to prove that they are “trans enough” (14), that they are being forced to fit into a binary gender system (19), and that healthcare professionals do not respect their gender identity (17). Furthermore, 16 respondents have faced transphobia and 16 are anxious while seeking care. 18 respondents felt that improvement is necessary in all fields of trans-specific healthcare. 8 participants stated that they know whom to contact for trans-specific healthcare services, 15 respondents did not know if there was a protocol for trans-specific healthcare.

When asked about the services they have used or would like to use, the overall response is that most have not had any surgeries related to transition (only one respondent underwent chest

reconstruction surgery), either because they are still thinking about the specific procedure, or because the specific service was not available at the time they wanted it. Some participants are not interested in such procedures. There were 12 participants that, within the preceding two years (with four within the last 12 months) have undergone psychological assessment. Only five respondents are taking hormones, and only two have undergone removal of their reproductive organs.

In the assessment of who was the most helpful, the majority of participants stated that they had not sought support from healthcare providers in relation to trans-specific healthcare. A few respondents indicated that some groups of healthcare providers were very informative. Of those services that were rated very informative and helpful, 12 respondents chose mental health professionals, nine chose support groups, five chose other medical specialists and two chose hormone prescribers.

D. Recommendations

Despite the fact that Georgia is being praised for improved hate-crime legislation that is now inclusive of the LGBT community, this legislation only applies to the issues of violence and discrimination (and is often not implemented efficiently), while issues that are important to trans people, including access to legal gender recognition and healthcare services, are not regulated at all. At the same time, the state is unwilling to engage in public awareness campaigns that would sensitise the general public towards different minority groups, including LGBT people. Thus, as trans people become more visible, hostility towards them gets worse.

Civil society organisations have only recently begun to acknowledge that trans people are a vulnerable group with specific issues and needs that differ greatly from other marginalised groups. However, within this short time, basic research, lobbying work and strategic litigation have been carried out to improve the procedures of legal gender recognition and to introduce guidelines on trans-specific healthcare. Unfortunately, this work is often blocked at policy level, highlighting a lack of political will for such improvements.

The present study highlights the constant struggle that Georgian trans people face regarding access to both general and trans-specific healthcare services. Based on this, we recommend that:

- » The Ministry of Justice, in coordination with the Ministry of Labour, Health and Social Affairs, should introduce quick, transparent and accessible procedures that will allow trans people to change their gender marker in all key documents issued by the state and non-state institutions. New administrative practices should be introduced to separate this process from the medical transition process, as much as possible.
- » The Ministry of Labour, Health and Social Affairs should adopt international clinical guidelines focused on the needs of trans, transsexual, non-binary and gender non-conforming people to ensure equal access to quality healthcare for trans people.
- » The Ministry of Education, in coordination with the Ministry of Labour, Health and Social Affairs, should revise the existing curricula of medical educational institutions and introduce correct and up-to-date information, conforming to international standards with regards to gender, sexuality and trans-specific healthcare.
- » Civil Society organisations should carefully examine the needs of trans people and ensure their active inclusion in shaping advocacy initiatives and processes of implementation.

4.2 POLAND

Poland – in brief

- » *There is no national protocol that regulates trans-specific healthcare;*
- » *The national health insurance does not cover any gender-confirmation surgeries, nor does it cover the majority of medical tests related to trans-specific healthcare;*
- » *There are long waiting lists for different types of trans-specific healthcare;*
- » *Legal gender recognition requires a psychiatric diagnosis and forces people to sue their parents in court for “having submitted the incorrect data on their (birth) gender”; if a person is married they need to obtain a divorce.*

A. Country Context

The Polish trans community, for many years, has been ignored as a social group, with requests for clear and transparent medical and legal gender recognition access, based on self-determination denied. In 2015, the President of Poland, Andrzej Duda, vetoed the Gender Accordance Act written by Anna Grodzka and Trans-Fuzja Foundation, stating that it was “full of gaps and inaccuracies” and “allowing multiple gender recognition”. This veto has been upheld by the Polish Parliament³².

Legal Gender Recognition is possible, but it requires a psychiatric diagnosis, with no access to self-determination. The current legal procedure also forces people to sue their parents in court for submitting the incorrect gender data on their birth certificate, thus engaging not just the trans person in the process, but also their family members (parents and individuals’ children in some situations). The whole process can only begin when the trans person is over 18 years of age. Those under the age of 18 are not allowed to file a lawsuit. A person must also be unmarried, which means, in many cases, forced divorce³³.

³² http://transfuzja.org/pl/artykuly/oswiadczenia/prezydenckie_weto_podtrzymane_sejm_nie_przeprowadzil_glosowania_ws_ustawy_o.htm

³³ (Śmiszek & Dynarski, 2014): http://transfuzja.org/download/publikacje/gender_recognition_in_poland.pdf

Before applying to the court, a person must first receive a psychiatric and psychological diagnosis. Many specialists are also demanding a “real life test” which may take from six months to two years. Several tests must be passed in order to get a diagnosis, including demonstrating that ‘irreversible changes’ (irreversible changes in an individuals’ physiognomy) have occurred. All tests and procedures for diagnosis are dependent on the leading doctor, as Poland has no National Protocol (e.g. the ICD-10 F.64 diagnosis). Hormone therapy can be prescribed with a discount (70% of the normal price will still be paid), but only when a person has National Health Insurance and their doctor (and psychologist) have a contract with the National Health Fund. However, most medical tests are not covered by insurance and waiting lists are often several months long. This forces people to pay for the required tests, and in many cases, to pay for diagnosis, which can take from a few months up to more than two years. All other trans-specific medical procedures (such as chest reconstruction, orchidectomy, hysterectomy, etc.) are not covered by insurance, and must be paid for privately.

There is no legal protection for the trans community, as the Polish Penal Code has no gender identity or gender expression premise (sexual orientation is also not included). Anti-discrimination laws only cover gender equality in binary terms (protection of equality between women and men in the workplace, etc.) without including trans-specific issues.

B. About the research

Outreach strategy

Trans-Fuzja Foundation distributed both questionnaires widely. Social media channels, Polish LGBTIQ organisations’ channels (including mailing lists, social media channels, and peer-to-peer information) were used to promote engagement with the survey. The questionnaire for healthcare users was also distributed in closed Facebook groups of the trans community in Poland (Trans-Fuzja supporting groups for particular cities, and general Polish groups). Beneficiaries of the Foundation were also informed about the survey during support group meetings (6 groups) and information was distributed by an e-mail support service Trans-Fuzja provides, as well as during various meetings.

The questionnaire for healthcare providers was also distributed through many professional medical associations in Poland. A large number of completed questionnaires were collected from the Association for Nurses and Midwives. Individual professionals were also informed directly about the research and asked to share it with their colleagues.

Sample

76 healthcare users participated in the first survey. Their average age was 25 years, and only 32.9% of respondents had a higher education qualification. This was the lowest percentage of higher education achievement from all countries. 60.5% of participants indicated that they had not changed their legal gender marker or were not in the process of changing their gender marker. 53.9% stated that they do not live in accordance with their gender identity or are only able to do so occasionally, compared to 88.6% of respondents who want to be able to express their gender identity more often.

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In the healthcare providers survey, 93 professionals participated, with an average age of 35 years, which was the youngest population amongst all 5 countries. 42.2% indicated to be 'another medical specialist (cardiologist, internist, etc.)', 41.9% indicated to have a profession belonging to the category 'other' and 34.1% of all healthcare providers were general practitioners. 64.5% stated that they have never received any training about trans people, transsexualism or gender dysphoria, which was the highest result amongst all countries.

C. Results and Discussion

Living according to one's gender identity

Due to the current political situation, with nationalists and far right movements gaining in power, and with implicit approval from other politicians in power, transphobia is widely spread in Poland, with no legal protection for trans people. Obstacles regarding access to healthcare and social interaction are other issues that must be taken into consideration.

Data confirms that living according to one's gender identity appears to be very difficult, as 44.7% stated that they cannot live in accordance with their gender identity ever, or only occasionally. 89.1% stated that they intend to do so more often in the future, and 48.7% strongly disagree that they feel comfortable revealing to others that their gender identity is different from their sex assigned at birth. As the trans group in this survey was very young (25 years of age, on average), we can predict that coming out and living in accordance with their gender identity might not be possible due to lack of openness with their close family and relatives (64.5% are only partially open, or not open at all with close family or relatives), as well as in the school/work environment (72.4% are only partially open, or not open at all at work/at school). For 25% of those who participated in the survey, close family and relatives' reaction to their gender identity has been (strongly) disapproving. In many cases, the only place where trans people can express themselves openly is on the internet / social media. For wider society, politicians and those who work with the trans community, this study should send a very clear signal that Poland requires not only social change, but also advances in many areas in order to create a safe and accepting society for trans people.

Awareness and education of healthcare professionals

As stated above, Poland has no National Protocol for working with trans service users. Alarming, 12.2% of healthcare providers believed that Poland does have a National Protocol, with 45.1% unsure if there was one.

Healthcare professionals are aware of the lack of training on trans issues, and most have not had any training on this topic. Only 35.5% of respondents received any training on working with trans people in general. The same percentage (35.2%) of healthcare practitioners agreed that training from trans groups or organisations has had a positive effect on healthcare, and a similar percentage (36.6%) agreed that having more visible trans people in the public sphere (politicians, media, etc.) has had a positive effect on trans related healthcare.

Experiences of trans HCU confirm the need for training for HCP. 38.8% of healthcare users who had approached a general practitioner indicated that the general practitioner was not referring to them using the right pronouns. 44.8% of those who approached medical specialists and 52.2% of those who approached general practitioners indicated that these healthcare providers were lacking knowledge on trans issues. 32.4% of respondents faced inappropriate curiosity from non-medical staff. Therefore, it is not surprising that in general, over 80% of healthcare users stated that regular mandatory training for all staff is necessary.

Based on the answers of both healthcare users and healthcare providers, it is clear that improvements in educating healthcare providers is necessary. Currently, when an individual enters the healthcare system, they cannot be certain that they will be treated with dignity and respect, or that they will have control over their own treatment.

Depathologisation and self-determination in general and trans-specific healthcare

Since there is no National protocol for providing services to trans people, the whole process of establishing a diagnosis is dependent upon individual specialists' decisions. This can be perceived as gatekeeping, controlling/holding power over the patient/client's autonomy.

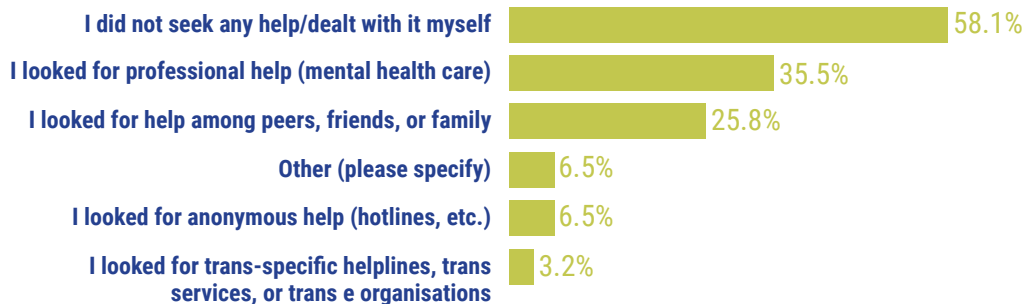
92.5% of healthcare users stated that they feel like they have to prove that they are "trans enough" in order to receive treatment. This can make access to healthcare for people with non-binary and 'other' gender identities extremely difficult, as they might not "fit in the box". 92.1% of HCU respondents felt forced into the gender binary when accessing trans-specific healthcare.

This data highlights that the Polish trans-specific healthcare system is preventing trans people's access to self-determination and controlling decisions about their own medical transition.

Suicide thoughts/attempts and seeking help

69.7% of respondents in the healthcare users survey stated that they had seriously thought about ending their lives multiple times, with 50% of those having had those thoughts in the past 12 months. 21.1% of respondents reported multiple suicide attempts, 5.3% reported one suicide attempt. The most alarming figure is that 58.1% of those who have had suicidal thoughts or attempted suicide did not seek any help, instead dealing with the situation by themselves.

Figure 28. Seeking help when suicidal (% of cases)



Question: q0032: Where did you turn to for help when you had suicide thoughts/attempts? Please select all answers that apply to you.

Base: Polish trans respondents in the TGEU survey (N=62).

Source: TGEU HCU survey, 2017.

Only 3.2% sought help from trans organisations and services or trans-specific helplines. This highlights the lack of safe spaces for trans people to seek help in, as well as a lack of options for professional medical assistance when confronted with this kind of issues. Professionals should be aware that this issue is very complex, and that many factors are causing such a high percentage of suicidal thoughts and attempts in this social group.

D. Recommendations

Training for healthcare providers on working with trans healthcare users

The survey shows that training for healthcare providers should be obligatory, as both parties (providers and users) have highlighted gaps in the healthcare system (both general and trans-specific) which need to be addressed. The most efficient solution would be for the Ministry of Higher Education to place this training within a long-term study plan. This needs approval, focus and willingness from the Ministry of Higher Education, and in the current political climate this seems unlikely. Other ways of improving knowledge within medical practice is establishing cooperation with universities (as they still have some independence from the government) in order to make trans-inclusive training part of the curriculum, or approaching Student Unions, as they provide spaces for those topics that are not included in study programmes to be addressed.

Training for mental health professionals on working with trans healthcare users, and improving cooperation between mental health professionals and trans organisations

As the percentage of suicidal thoughts and attempts is extremely high, more support services are needed, with emphasis on these services being readily available, free of charge and easy to access. This requires effort by mainstream support services to reach out to trans organisations and groups with expertise on trans issues, to establish cooperation in order for them to become trans-inclusive, including providing support service staff with trans awareness training. As the research showed, knowledge and training for mental health

providers needs to be improved, with an urgent focus on enabling them to understand the concepts of self-determination and depathologisation. Diagnosis based on self-determination helps people to decide their own transition pathway, tailored to their specific needs. Experiences in other countries with depathologisation and reducing mandatory medicalisation of transition can be applied in order to guide the way for better mental health services in Poland. Professionals should seek reliable and scientific knowledge provided by trans organisations, aiming for enhanced cooperation between both sides in order to benefit trans healthcare users.

Translation and dissemination of the World Professional Association for Transgender Health's (WPATH) Standards of Care 7 (SOC 7)

It is necessary to make healthcare providers aware of, and encourage their use of, WPATH's Standards of Care (SOC7), as Poland doesn't have manuals or standards of care for either general or trans-specific healthcare. SOC7 is standardised and can be easily applied to the Polish, healthcare context. It should be translated into Polish, made readily available to all relevant specialists, and be featured as a key element in all future training of trans healthcare providers.

Organisation of general healthcare and access for users

People should have unrestricted access to healthcare, without prejudice or inappropriate curiosity from healthcare professionals and support staff. Basic knowledge of trans issues on the part of healthcare professionals will improve trans people's trust in healthcare and healthcare providers, and will prevent delays in seeking treatment. The current system for recording people's appointments and calling forward patient/clients in healthcare settings forcibly outs trans people. It should be changed to ensure their right to confidentiality is respected.

Creating and adopting a National Protocol for providing healthcare to trans clients

As Poland is lacking clear procedures, creating a national protocol is required. The current situation reinforces gatekeeping, as well as many other obstacles (particularly for non-binary people) when accessing trans-specific healthcare.

Adopting legal gender recognition procedures based on self-determination

Establishing quick, accessible and transparent Legal Gender Recognition procedures based on self-determination would contribute significantly to the wellbeing of trans people in Poland. In particular, the mandatory involvement of family members and the forced divorce requirement need to be abolished. Poland is one of the last countries in Europe without clear procedures for Legal Gender Recognition.

4.3 SERBIA

Serbia – in brief

- » *There is only one medical gender team in the whole country;*
- » *Access to hormone treatment is based on psychiatric diagnosis and a mental health assessment. This lasts at least a year and is not accessible to non-binary people;*
- » *Puberty blockers are not available to everyone, and hormone replacement treatment is only available to persons aged 18 and over;*
- » *Hormone treatment is not covered by public health insurance, while 65% of the cost of some gender-confirmation surgeries is covered by general health insurance;*
- » *Sterilisation is a requirement for legal gender recognition.*

A. Country Context

The Republic of Serbia, situated in the Balkan Peninsula and once part of the Socialistic Federative Republic of Yugoslavia, is currently a recognised candidate for future membership of the European Union. After civil war in the 1990's, and a peaceful revolution in 2000, Serbia entered a period of political, economic and social transition. Although high unemployment rates and widespread corruption affects all citizens, the situation is worst for members of marginalised and vulnerable groups, including the trans community. Trans people face rejection, discrimination and violence on the basis of their gender identity and expression, due to living in a traditional, patriarchal society with restrictive gender norms.

Legislation of relevance for trans people

Serbia still has no legislation officially regulating legal gender recognition. The unofficial procedure, based on the existing practice and supported by the decision of the Constitutional Court in 2012, enables trans people to change their legal name and gender marker after completion of the process of "sex change", thus making sterilisation mandatory.

Significant improvements have been made in the area of anti-discrimination legislation. In 2009, Serbia adopted an anti-discrimination law, forbidding discrimination on the basis of

gender identity. Three years later, amendments to the Criminal Code were adopted, introducing hate crime legislation to incriminate perpetrators 'motivated' by the victim's gender identity. However, implementation of the existing legislation is not satisfactory: although anti-trans hate crimes were documented and reported to the police, no court decision prosecuting on the grounds of a victim's gender identity has yet taken place.

Trans-specific healthcare

A gender identity healthcare team was established in Belgrade in 1989, providing psychological/psychiatric assessment, hormone treatment and surgical interventions for Serbian trans people, both regionally and overseas. However, it was not until 2012 that the public expert commission for treatment of trans disorders³⁴ was officially registered. Their guidelines require those seeking gender confirmation surgeries to be trans, aged 18+, and seeking both hormone replacement treatment and surgical procedures. The public expert commission was formed within the public health insurance fund, making decisions for up to ten candidates per year for gender confirmation surgeries, partially funded by public health insurance. The commission bases its decisions on the 2011 amendments to health insurance law³⁵ and corresponding amendments to the guidelines on specific medical interventions covered by compulsory health insurance³⁶. The law regulating health insurance claims states that 65% of the costs of "sex change due to medical reasons"³⁷ should be covered by public health insurance.

Healthcare providers who are members of the Belgrade gender identity team work both in public and private healthcare clinics. The various clinics are located in Belgrade, which makes the whole process more complex for people living in other parts of Serbia. While trans individuals living in Belgrade require only a referral from their General Practitioner to access trans-specific healthcare, those living in other towns across Serbia have to visit their General Practitioner, a specialist medical commission and a local department for the public health insurance fund before they can get a referral. Although this process is the same for anyone living outside of Belgrade seeking medical treatment, regardless of their trans status, it is particularly challenging for trans people, who are forced to come out on several occasions before making their first appointment with gender specialists.

The process of medical transition follows in the steps of the former triad therapy model: psychiatric consultations and assessment; hormone treatment; and gender confirmation surgeries. In the public sector, there are two mental health centres with two psychiatrists certified to write recommendations for hormone treatment and surgeries. Despite the gradual positive changes reported in the past year towards a more individualised and flexible approach (instead of a strict one-size-fits-all model), the period between the first consultation with a psychiatrist and obtaining a referral letter for the endocrinologist is at least one year. There

³⁴ Gayten-LGBT wrote to the Ministry of Health asking them to change this pathologising name of the commission.

³⁵ Službeni glasnik RS, br. 107/2005, 109/2005 - ispr., 57/2011, 110/2012 - odluka US, 119/2012, 99/2014, 123/2014, 126/2014 - odluka US, 106/2015 i 10/2016 - dr. zakon.

³⁶ Službeni glasnik RS, br. 10/2010, 18/2010 - ispr., 46/2010, 52/2010 - ispr., 80/2010, 60/2011 - odluka US i 1/2013.

³⁷ Article 45. Mandatory health insurance covers 65% of the following interventions: hysterectomy, ovariectomy, metoidioplasty, orchidectomy and vaginoplasty. Phalloplasty, hormone treatment and interventions such as laser hair removal are not covered by public health insurance.

is only one Endocrinologist prescribing hormone treatment for the whole country³⁸. Hormone replacement treatment is available only to those aged 18 years or older, and it is not covered by public health insurance. Puberty blockers and hormone replacement treatment for minors are not available at all. The surgical team is well known for their innovative procedures and good results and has lots of clients from other countries. However, even with 65% of the cost of surgeries covered by the public health insurance, the remaining cost is still too high for many trans people living in Serbia (it is approximately equal to three months average salary).

B. About the research

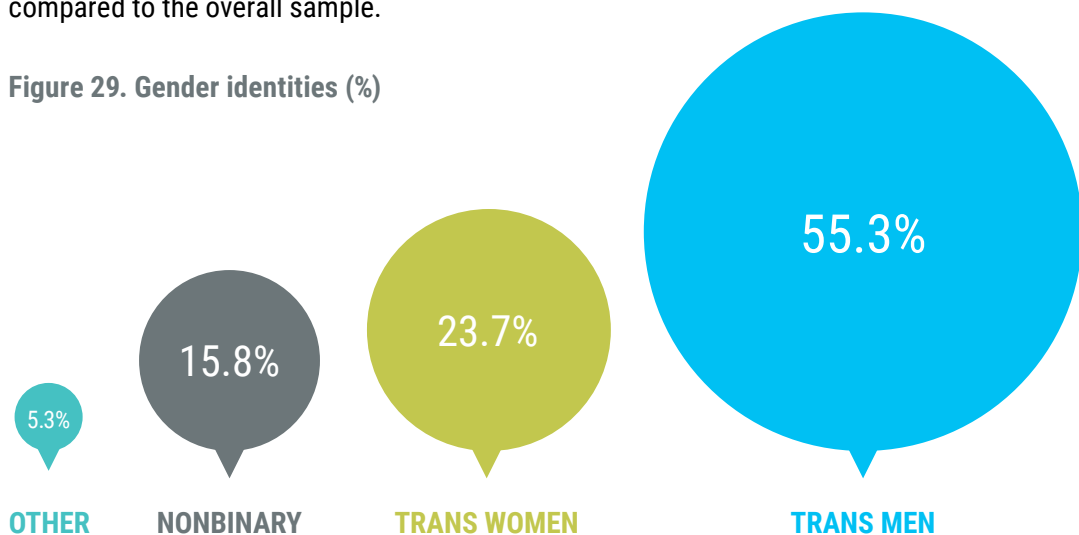
As with the other countries, both surveys in Serbia were administered online, linked to from Gayten-LGBT's website and Facebook page. The call for participants for trans healthcare users (HCU) was also disseminated through other LGBTI and trans organisations across their social media channels; LGBTIQ mailing lists; and regional trans networks. For healthcare providers (HCP), mailing lists for psychotherapists, Facebook groups for healthcare providers and our personal contacts with HCP (including members of the Belgrade gender identity team) were used, asking them to further disseminate the survey among their colleagues. Some of our contacts amongst HCP reported hostile reactions from their colleagues towards the research topic.

C. Results and Discussion: Trans Healthcare Users

Trans healthcare users in Serbia

55 respondents accessed the survey for trans healthcare users living in Serbia, and 38 people provided enough answers to be included in the analysis. Respondents were between 16 and 45 years old, with an average age of 27 years, similar to the overall sample. They mainly identify within binary categories of gender identity, with a smaller number of non-binary people (15.8%) compared to the overall sample.

Figure 29. Gender identities (%)



Questions: Computed variable on the following survey questions: q0008: What sex were you assigned at birth, meaning on your original birth certificate? q0007: How do you describe your gender identity at the current moment? Please select the option that best fits you.

Base: Serbian trans respondents (n=38).

Source: TGEU HCU Survey, 2017.

³⁸ According to our knowledge, there are two doctors specialising alongside the main endocrinologist.

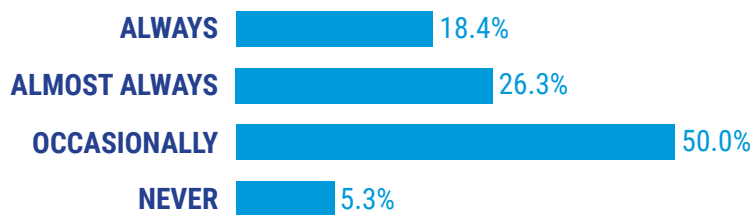
Almost all respondents are living in a city, the outskirts of a city, or a town (93.8%) and have public health insurance (89.5%). Less than half (44.7%) completed higher education. When it comes to living conditions, they mainly live with their primary family. Almost two third of the sample are living with their parents (62.5%) and/or other family members (31.3%), compared to less than one quarter living with their partner/s (15.6%) or alone (9.4%). More than one third (37.5%) reported having difficulties with making ends meet month to month, which is the highest rate across the sample.

Since legal gender recognition in Serbia requires sterilisation, it is not surprising that less than half of the respondents have changed or are in a process of changing their gender marker (44.7%). Of those who haven't changed their gender marker, a large majority (72.7%) stated that they would like to do so.

Openness about gender identity

Keeping in mind the strict gender norms within Serbian society, it is important to note that less than half of respondents (44.7%) always or almost always live according to their gender identity.

Figure 30. Living according to gender identity (%)



Question: q0015: At the present time, how often are you able to live according to your gender identity?

Base: Serbian trans respondents (n=38).

Source: TGEU HCU survey, 2017.

The highest level of openness is reported among their close friends (81.6% fully open and 10.5% partially open), and close friends are also perceived as the most supportive (81.6% of respondents perceive them as (strongly) supportive). A significantly lower number of respondents are open with their close family (57.9% fully open and 18.4% partially open), and at work/school (36.8% fully open and 5.3% partially open).

When it comes to healthcare, 44.7% of respondents stated that they are fully open, 18.4% partially open and 15.8% not open at all. Every fifth respondent (18.4%) had encountered disapproving or very disapproving reactions to their gender identity in healthcare settings, and only 31.5% described their healthcare providers' attitude as supportive of their gender identity.

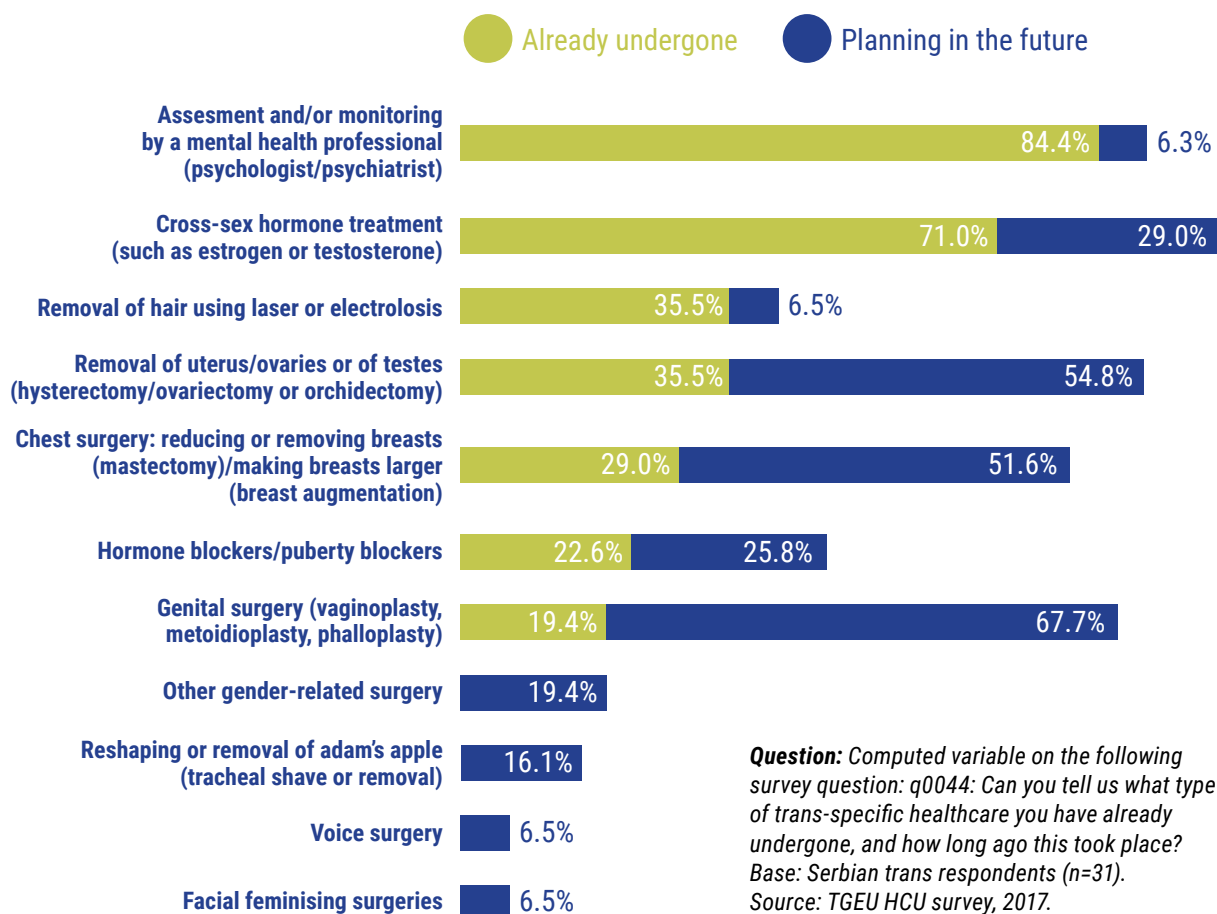
Experiences with provision of trans-specific healthcare

A large majority of trans healthcare users in this survey (86.8%) have sought psychological or medical help for being trans. However, only 64.7% stated that they know whom to contact when they want to access trans-specific healthcare. Most respondents have experience with trans-

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specific mental health providers (84.4%) and with hormone replacement treatment (71.0%). It is interesting to note that 22.6% stated that they have used puberty blockers, even though that kind of treatment is not officially provided in Serbia. Gender confirmation surgeries, depending on the type of intervention, were undertaken by 19.4% (genital surgery) to 35.5% (removal of uterus/ovaries/testes) of participants.

Figure 31. Type of trans-specific healthcare already undergone (%)



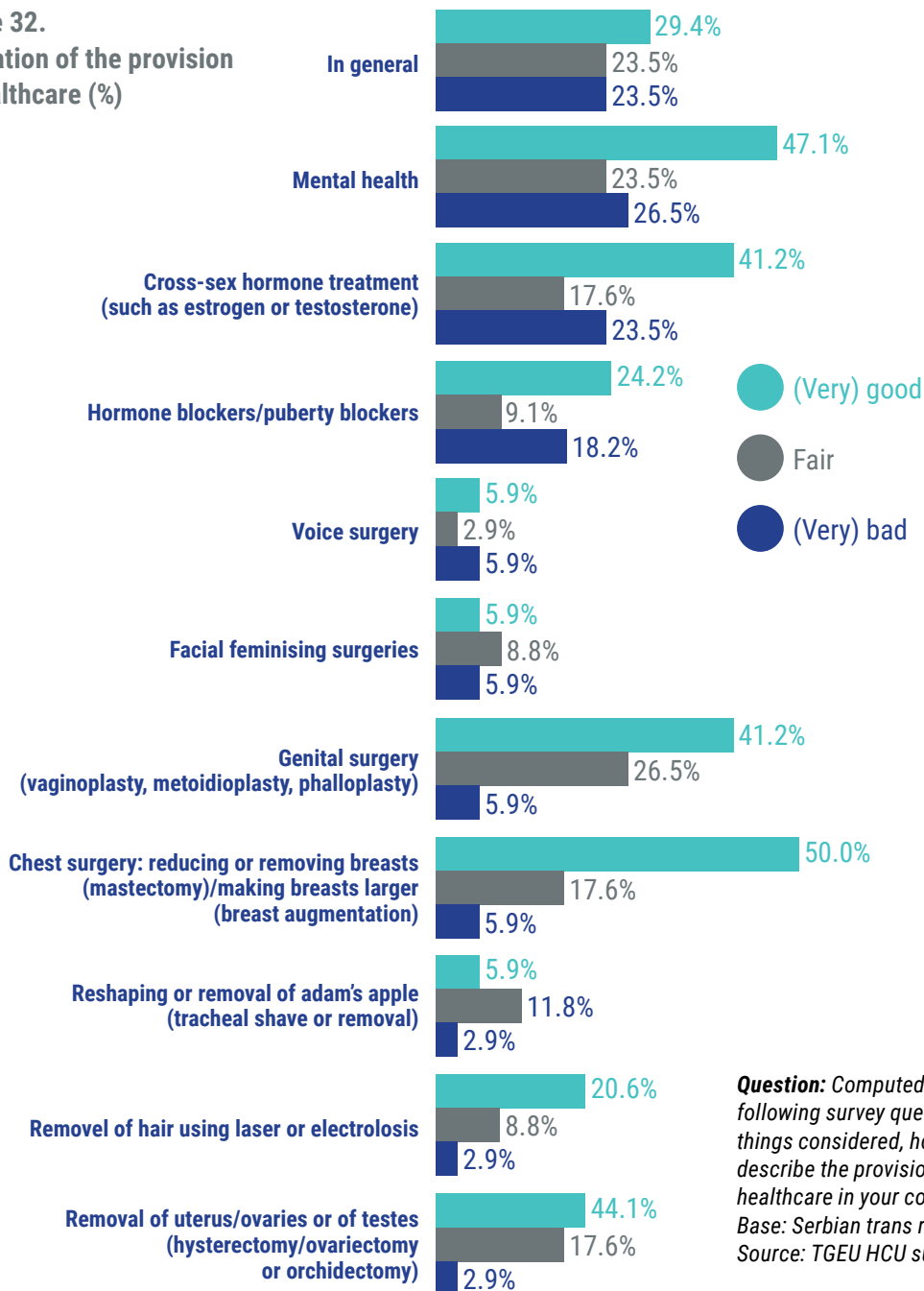
When we look at the percentages of respondents who have already undergone or who are planning to undergo different types of trans-specific healthcare in the future, we can see that all respondents want to undergo hormone replacement treatment, and that interest in chest and genital surgeries is very high. Depending on the type of intervention, not less than 80% of respondents have either already undergone or plan to undergo some of these procedures.

Perception of the provision of trans-specific healthcare

When it comes to the perception of trans-specific healthcare in Serbia, experiences vary depending on the type of service. In general, slightly more respondents rated the provision of trans-specific healthcare as good or very good (29.4%) than as bad or very bad (23.5%). The greatest dissatisfaction was reportedly with mental health services and hormone replacement treatment.

As stated by one of the respondents in the survey, "I've been going to doctors in (...) trying to get permission for sex change, but I have a feeling that they are not too interested to help me - they don't provide me with adequate psychological support, actually they still misgender me, and every session comes down to them attempting to give me medication against depression and anxiety, though I've been telling them that the cause of those problems is basically unavailability of the treatment I've been waiting for." (Trans man, age 22)

Figure 32.
Evaluation of the provision of healthcare (%)



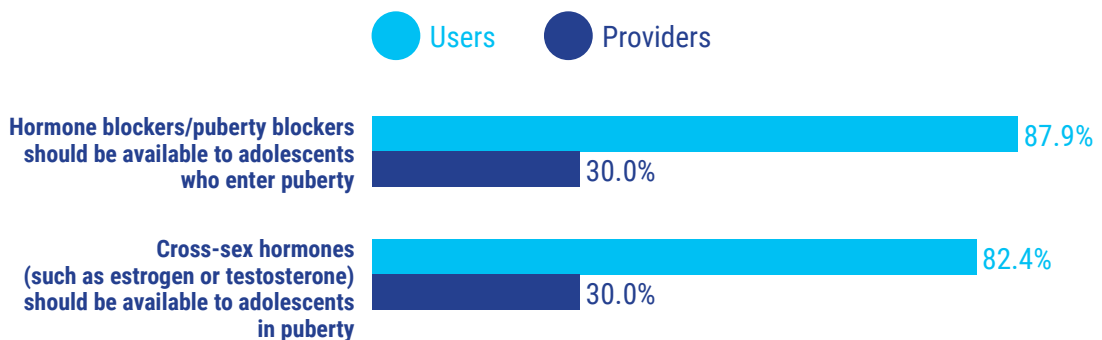
Question: Computed variable on the following survey question: q0058: All things considered, how would you describe the provision of trans-specific healthcare in your country?
Base: Serbian trans respondents (N=34).
Source: TGEU HCU survey, 2017.

Hormone treatment for adolescents

As stated in the introduction, with the exception of psychological/psychiatric healthcare, which is available from the age of 15 years, no other trans-specific healthcare service is available for minors. This means that treatment with puberty blockers is not officially provided in Serbia (although this survey indicates that approximately one-fifth of respondents accessed this kind of treatment), and that hormone replacement treatment is available only to adults.

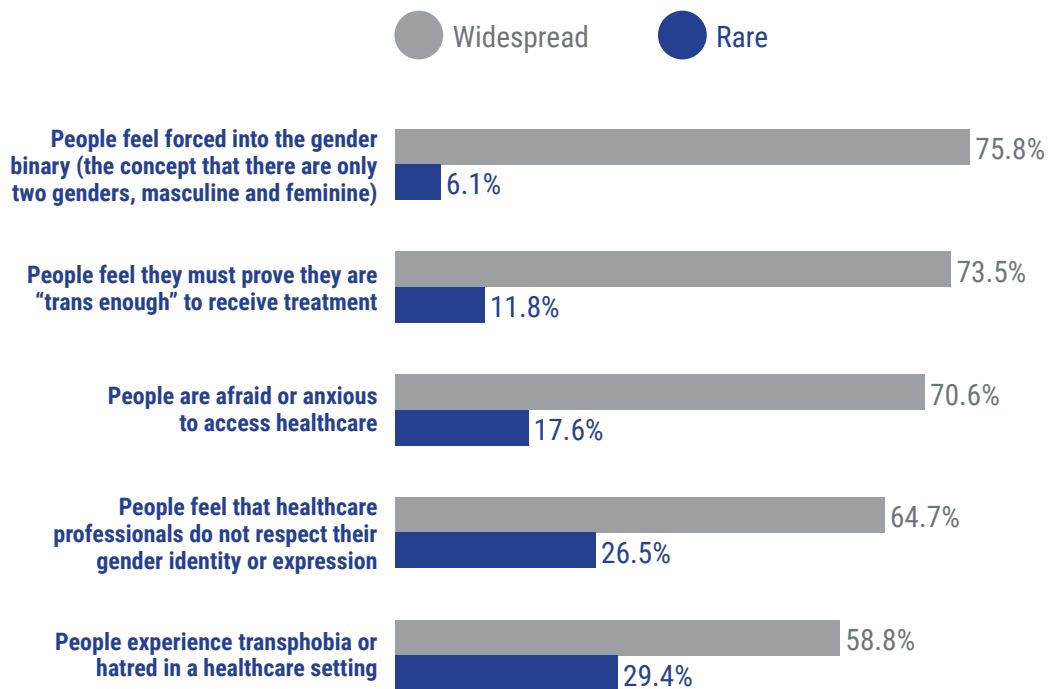
The provision of hormone replacement treatment to adolescents is an area where existing practice in Serbia differs significantly from recommendations made in WPATH’s Standards of Care 7, and it is also the area where opinions of HCP and trans HCU differ the most. Whereas 87.9% of trans respondents (strongly) agree with the statement that hormone/puberty blockers should be available to trans adolescents entering puberty, and 82.4% with the statement that hormone replacement treatment should be available to adolescents, less than one third of healthcare providers stated their support in this regard. Exemplifying the urgency for providing hormone blockers, one respondent stated “this kind of treatment could have stopped my body from being destroyed by unbearable masculinisation” (trans woman, 37 years old).

Figure 33. Opinions regarding cross-sex hormones and hormone/puberty blockers (% agree and strongly agree)



Question: Computed variable on the following survey question: HCU q0061 and HCP q0038: Can you tell us to what extent you agree with the following statements?
 Base: Serbian trans respondents (N=34) and healthcare providers (N=40) in the TGEU survey.
 Source: TGEU HCU and HCP survey, 2017.

We were interested in respondents’ perception of the prevalence of various obstacles when accessing trans-specific healthcare. Being forced into the gender binary and feeling that one must prove that they are “trans enough” was considered widespread by more than 70% of respondents, with experiences of transphobia and hatred in healthcare settings considered widespread by more than half of the sample.

Figure 34. Opinions on widespreadness in trans-specific healthcare (%)

Question: Computed variable on the following survey question: q0059: In your opinion, how widespread are the following in trans-specific healthcare in the country in which you live.
 Base: All Serbian trans respondents in the TGEU survey (N=34).
 Source: TGEU HCU survey, 2017.

Trans people and general healthcare

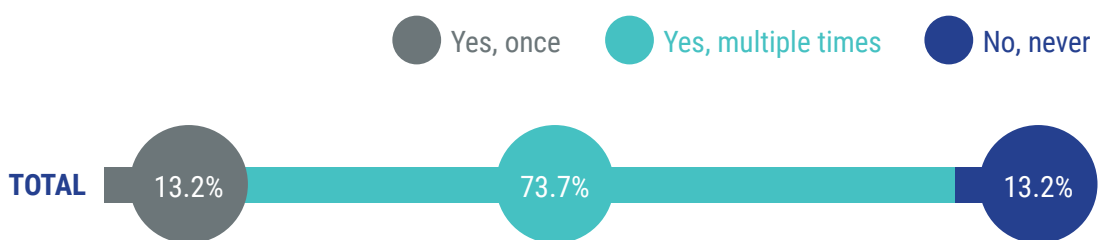
Accessing general healthcare can also be very difficult for trans people for various reasons: a belief or fear of being treated badly, or being forced to disclose their gender identity/sex assigned at birth, etc. This survey found that seven out of ten (70.6%) respondents reported having delayed going to the doctor at least once for general healthcare because of their gender identity. Among the most common situations that happened to trans users of general healthcare were: lack of knowledge on trans issues on behalf of the HCP, and being misgendered - both experienced by at least four out of ten respondents. Apart from these situations, one third (32.4%) stated that in the last 12 months they felt discriminated against by a healthcare provider because of their gender identity and/or expression.

With regard to the high percentage of trans people delaying access to general HCP due to negative experiences with general (but also with trans-specific) healthcare providers, it is important to note that a large majority of respondents (82.7%) stated that they would go to a trans or LGBTI-specific healthcare centre for general healthcare issues. Since this type of healthcare centre does not exist in Serbia (even members of the Belgrade identity team work within different clinics), this points to one possible solution to the current healthcare crisis faced by trans people in Serbia.

Suicidal ideation among trans healthcare users

Provision of psychological support to trans people relates to both trans-specific and general healthcare. Although research shows that trans people are at risk of poor mental health due to adverse life circumstances, they are not recognised as such, nor mentioned in national strategies or guidelines dealing with mental health in Serbia. On the other hand, trans people from Serbia have the highest percentage of suicidal ideation amongst the five countries: a shocking 85.9% of respondents reported that they have thought seriously about ending their life -, 73.7% multiple times, and 13.2% once.

Figure 35. Thoughts about ending their life (%)



Question: q0028: Have you ever thought seriously about ending your life?
Base: Serbian trans respondents in the TGEU survey (N=38).
Source: TGEU HCU survey, 2017.

When focusing on the past 12 months, 39.4% of all respondents stated that they have thought seriously about ending their life in that timeframe. This is exacerbated by the findings that 57.6% of trans people with suicidal thoughts didn't seek any help. Of those who did seek support, 21.2% did so among their peers, friends or family, and only 12.1% looked for support from a mental health professional. Although the reason why so few trans people seek professional help might be explained by the general reluctance of engaging with mental health services in Serbia, compounded by the insufficient number of mental health providers (especially those trained to provide support to trans people), it is important to also address the dual role of mental health professionals already engaged in trans-specific healthcare. At the moment, the same people who are making decisions about whether a person should access hormone treatment and surgical interventions are also supposed to provide psychological help to them. This significantly jeopardises the therapeutic alliance between healthcare professional and patient, and sometimes prevents trans individuals from asking for support due to fear of refusal for further trans-specific healthcare treatment.

D. Results and Discussion: Healthcare Providers

Healthcare providers

The final sample of healthcare providers consisted of 55 respondents. The average age is 43 years (range 30-65 years). Serbia is the only country where no healthcare providers identified as trans, but 15.1% of respondents did state that they belong to a sexual minority group. Almost

all HCP offer services to adults (96.4%), half of them work with adolescents (54.5%) and one-fifth work with pre-pubertal children (21.8%). They mainly work within the public healthcare system (86.8%). When asked about working with trans clients, two thirds (66.7%) stated that they have encountered a trans client at their workplace, 18.5% stated that they haven't, and 14.8% said that they don't know.

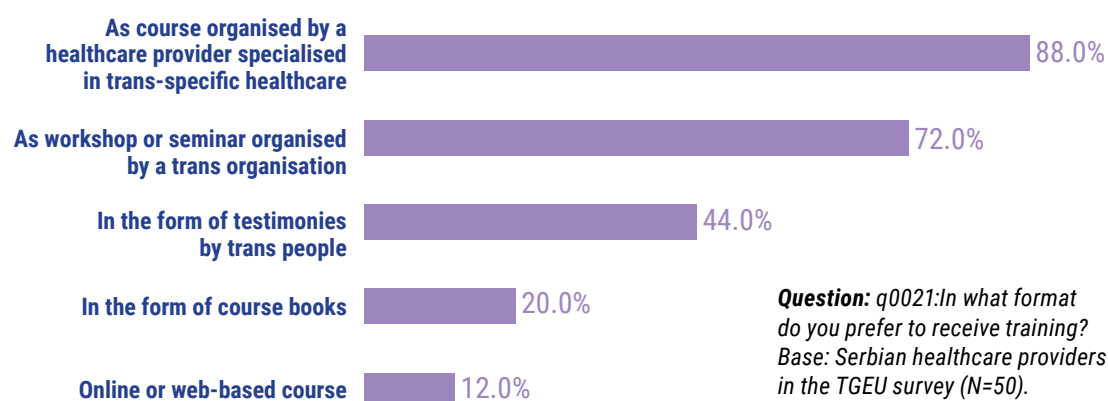
Training on working with trans clients

In this section we will focus on training, as both HCP and trans HCU identified the need for training for HCP. Of HCP in Serbia who responded to the survey, less than half attended training on working with trans clients (45.5%). Among those who did, the majority did so voluntarily, on their own initiative, and training was mostly organised by a trans or LGBTI organisation.

When asked about how confident they feel when working with trans clients, 46.2% of HCP said that they feel highly or very highly confident. It is important to note that there is a marginally significant difference in feelings of competence between those who received and didn't receive training on the topic. Almost all respondents (90.9%) stated that they believed their level of competence in working with trans clients would be improved with training.

We asked HCP what types of training for working with trans clients that they would most like to attend. Almost the same number of HCP stated that the training should be non-compulsory as part of ongoing mandatory professional development (64.0% and 60.0% respectively), and an additional 28.0% would prefer training to be provided as a part of the mandatory formal education program. The majority of HCP prefer the training to be delivered by a trans or LGBTI-organisation (80.0%), professional healthcare providers outside of the university (60.0%) or an instructor through the university (44.0%).

Figure 36. Preferred format of training (% of cases)



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When we look at the responses to particular training formats, the preference is for it to be organised either as a course by a healthcare professional specialised in trans-specific healthcare (88.0%), or as a workshop or seminar organised by a trans organisation (72.0%). The least popular options were textbook lessons and online courses.

Since HCP are required to attend a certain number of training hours as part of their mandatory continuous professional development, and because accreditation of trainings requires delivery by recognised healthcare providers, cooperation between HCP and trans organisations and activists is necessary in order to fulfill both formal qualification requirements and preferences of HCP.

E. Recommendations

Recommendations regarding provision of healthcare for trans people

The research shows that it is high time that accessible, individualised and flexible treatment in Serbia is provided that is based on informed consent and is inclusive of non-binary people and trans people of different age groups, both in general and trans-specific healthcare. This requires implementation of the following measures:

- » **The Ministry of Health, in cooperation with the Republic Commission for Treatment of Transgender Disorders and in consultation with trans organisations, should adopt a national trans-affirmative protocol for working with trans healthcare users**

A mandatory national protocol for working with trans healthcare users should be based on the latest version of Standards of Care of the World Professional Association for Transgender Health, and contain information on all trans-specific healthcare services provided in Serbia. It should be disseminated to all HCP working in general and trans-specific healthcare and it should be available online for all interested parties. The protocol should be inclusive of non-binary people and based on depsychopathologisation, individualised treatment and the informed consent model.

- » **The Republic Commission should ensure provision of hormone treatment for adolescents**

Trans healthcare users ranked the provision of hormone blockers and hormone replacement treatment for adolescents as one of the top priorities, urging endocrinologists working with trans healthcare users to access appropriate training to start providing these services.

- » **The Ministry of Health should recognise trans people as an especially vulnerable population in the upcoming suicide prevention strategy**

Trans people should be recognised in the upcoming suicide prevention strategy as a particularly vulnerable group, with specific measures planned and undertaken to ensure adequate support. Measures within the strategy should include training for mental health providers on working with trans clients.

- » **Ensuring provision of training for healthcare providers on working with trans people**

Both HCP and trans HCU agreed on the importance of regular training around working with trans people. Trainings should be delivered as part of continuous professional development, in the format of a workshop/seminar/session, provided in cooperation

with experts for trans-specific healthcare and trans organisations/activists. Training should ensure implementation of the above-mentioned protocol for working with trans healthcare users.

» ***The Ministry of Health and the Republic Fund for Health Insurance should ensure inclusion of all types of trans-specific healthcare under Article 45 of the Law on Health Insurance***

Article 45 of the Law on Health Insurance states that a minimum of 65% of the costs of “sex change due to medical reasons” should be covered by the public health insurance. However, as stated in the introduction, different types of hormone treatment, phalloplasty and various other medical interventions that can be key to a trans person’s health and wellbeing, such as hair removal, facial feminisation, etc. are not included in the implementation. As a first step, hormone treatment and genital surgery, such as phalloplasty should be included as services partially covered by public health insurance. In the long-term, any limitation to cost coverage by public healthcare providers for any type of trans-specific healthcare should be abolished.

Legal gender recognition

» **The Ministry of Labour, Employment, Veteran and Social Policy should adopt a law to recognise gender identity**

Trans people’s well-being and health would considerably improve if the Ministry of Labour, Employment, Veteran and Social Policy implemented the government’s commitment to the development of a gender identity law as envisioned in the action plan for the implementation of the strategy on prevention and protection against discrimination in 2016. The resulting process of legal gender recognition should be fast, transparent and accessible, with an explicit ban on the current practice of requiring sterilisation and thus implementing case law of the European Court of Human Rights (AP, Nicot, Garcon v France; 2017). Such a process should be based on self-determination, thus fully demedicalised, accessible for minors, and foresee a third gender category for those who seek it. The Ministry should take inspiration from, and work with, Gayten-LGBT who drafted and presented a model for legal gender recognition in November 2013, and has been advocating for its adoption ever since.

4.4 SPAIN

Spain – in brief

- » *There is an absence of a national law unifying the right to healthcare for trans people, and which establishes a medical criteria for the provision of healthcare;*
- » *Access to trans-specific healthcare and provision of healthcare services depend on the autonomous regions. This ranges from an absence of any kind of care, to psychopathologisation and gate-keeping, to depathologised, gender self-affirming and informed consent model;*
- » *Puberty blockers are available to youth, dependent on different legislation in each autonomous region;*
- » *Waiting lists for genital surgeries are too long due to a lack of economic and professional resources;*
- » *Non-binary people usually cannot access trans-specific healthcare due to a prevailing binary medical model;*
- » *Legal gender recognition at the national level requires psychiatric diagnosis and certification of having received at least two years of medical treatment.*

A. Country Context

The situation in Spain is complex; with Legal Gender Recognition (LGR) legislated at state level, and a series of autonomous laws that regulate the rights of trans people at regional level. Both are based on different approaches of addressing the needs of trans people. The LGR state law still requires a psychiatric diagnosis of “Gender Dysphoria” and a minimum of two years of certified medical treatment. However, in some of the autonomous regions there are laws that are pioneering the recognition of the rights of trans people, based on de-medicalisation and self-determination of gender identity, guaranteeing medical treatments for trans people (including minors), or providing regional administrative identifications based on the person’s self-affirmed gender. Unfortunately, there are also autonomous communities in which trans-specific healthcare is not covered by the national health insurance or regulated by any specific law.

Trans-specific healthcare in Spain

The National Healthcare System in Spain is the coordinating body which encompasses the provision of welfare benefits and healthcare services, whose regulations are based on the Spanish Constitution of 1978, the General Healthcare Act 14/1986 and Act 16/2003 on Cohesion and Quality in the National Health System. In Spain, the Department of Health, Social Affairs and Equality has taken on a coordinating role and oversees health matters at national level, according to the decentralisation principle laid down in the Constitution. Similarly, the seventeen autonomous regions have adequate funds to create and manage healthcare services for their region. All Spanish citizens have the right to health protection and care under the umbrella of the National Healthcare System, regardless of their financial situation or employment. Access to services is granted on presentation of the individual's Health Card. European foreign nationals may access these services through their European Health Insurance Card. Lastly, non-EU nationals, whose rights are recognised by law, treaty and bilateral agreement between Spain and their country of origin, may be eligible to access healthcare services in Spain. It is important to note that until 2012, access to the healthcare system was universal, but the economic crisis has significantly changed this, particularly for migrants.

Healthcare for trans people through the National Healthcare System (SNS in Spanish) is not integrated into the public health service portfolio, but is not excluded either. Therefore, granting access and health coverage for trans people is delegated at the discretion of each autonomous region to a centralised service unit (Gender Identity Unit (GIU)). The first step, in order to gain access to the National Healthcare System, is to access primary healthcare (healthcare from a general practitioner). When a person shows up to their appointment with a primary healthcare professional (medicine, nursing, social work) they will be subjected to a comprehensive assessment (bio-psychosocial evaluation). Once the assessment is complete, the primary healthcare professional will provide information and guidance, as well as providing a referral to a healthcare specialist. The primary healthcare professional will follow up on the patient's case throughout the whole process. Gender Identity Units can be accessed by a referral from various healthcare professionals including: a general practitioner; through mental health professionals; and through specialists such as endocrinologists or paediatricians (in the case of adolescents/youth). It is in Gender Identity Units that the trans person will be able to initiate their transition process, following the Standards of Care 7 of the World Professional Association for Transgender Health (WPATH).

Autonomous regions assisting trans people through Gender Identity Units include the following: Catalonia, Asturias, Navarra, Basque Country, Zaragoza, Madrid, Balearic Islands, Canary Islands and Valencia. Trans people residing in regions lacking GIUs will be referred to the closest unit available or to one of their choosing, depending on the existing conventions between the different autonomous regions. This results in unequal access to treatments at regional level. The existing legislation covering trans-specific healthcare differs considerably from one region to the next. As already mentioned, not all of the autonomous communities offer trans-specific healthcare within the public health service portfolio, and not all those who offer these services allow hormone treatment for trans people under 18 years of age. Fortunately, in recent years, many autonomous communities have enacted their own regional laws that protect the rights of trans people, including their health rights. The regional laws, in these autonomous communities, guarantee the following:

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- » Medical treatment for trans people who require it from a depathologised perspective including not having to undergo any psychiatric or psychological review, or submit any psychiatric/psychological report to access treatments.
- » Medical treatment is based on self-affirmation of the individual's gender identity.
- » The public healthcare system will provide trans people with a beneficiary identification card (Health Card) according to their name and gender identity, even if they haven't been able to access legal gender recognition procedures to change their name and gender on their national identity document.
- » The public healthcare system guarantees trans-specific healthcare for minors. They will be able to access Gonadotropin-releasing hormone (GnRH) analogues (puberty blockers) and hormone replacement treatment during puberty for trans adolescents and young people who so desire it.
- » Decentralisation of healthcare for trans people, meaning it is not obligatory to go to the Gender Identity Units for those who want to be cared for by other health professionals outside this system. This is in accordance with the right to choose a treatment pathway with close proximity to home. A legislative proposal has been presented to unify healthcare throughout Spain. It was presented in the past months in the parliament and hopefully it will be approved by the start of 2018.

B. About the research

Fundacion Daniela disseminated the questionnaire for trans healthcare users through their webpage, through social media (especially as they have a lot of followers among youth workers and trans youth, YouTubers, etc.), and in cooperation with the Spanish Federation of LGBTIQ Organisations of Spain (FELGTB) that further disseminated the questionnaire to all LGBT collectives in Spain.

For dissemination of the questionnaire for healthcare providers, Fundacion Daniela used its previously established contact with professional associations of doctors, nurses and social workers, with close cooperation with the Spanish Federation of Paediatricians in Public Healthcare and the Spanish Association of Medical Students.

C. Results and Discussion: Trans Healthcare Users

The sample

The questionnaire was completed by 276 trans healthcare users between the ages of 16 and 62, with an average age of 26. This makes this research the first to give us information about experiences and views of the current generation of trans youth in Spain. When asked about their gender identity, 49.3% of respondents self-identified as (trans) men, 36.6% as (trans) women, and 12.7% as non-binary. Two thirds (69.2%) of respondents have completed higher education and almost all (94.2%) are living in urban settings. Nine out of ten (91.3%) have public health insurance, and 20.7% have private health insurance. A majority of respondents live with their parents (64.4%) and/or with other family members (30.2%), while 13.8% are living alone, and 11.6% with their partner/s. 18.4% of respondents stated that they have (great) difficulty with making ends meet on a monthly basis.

A large majority of respondents (83.3%) rated their health as (very) good. However, 27.2% stated that they have some chronic physical or mental health problem, illness or disability affecting the daily life of more than half (57.3%) of those individuals. It is alarming that 39.3% have never received any kind of preventative information on STIs and 54% have never been tested for HIV, out of which one fifth (18.9%) didn't do so because they didn't know where to go for HIV testing.

Legal gender recognition

More than half of the respondents (59.4%) have changed or are in the process of changing their legal gender marker, with a significant difference among the various gender identity groups. 70.3% of trans women, 64.0% of trans men and only 14.3% of non-binary respondents have completed/are in the process of completing LGR. Of those whose gender has not been legally recognised, eight out of ten (79.5%) stated that they would like to change their legal gender marker, again with a significant difference between groups (95.9% of trans men, 83.3% of trans women and 53.3% of non-binary people stated that they would like to). This difference may be explained by the current LGR procedure in Spain, which puts non-binary people in an even more marginalised position, not only because the third gender option is not available in Spain, but also because the process requires diagnosis and a certificate of medical treatment of at least two years, which is not accessible (nor acceptable) for many non-binary people.

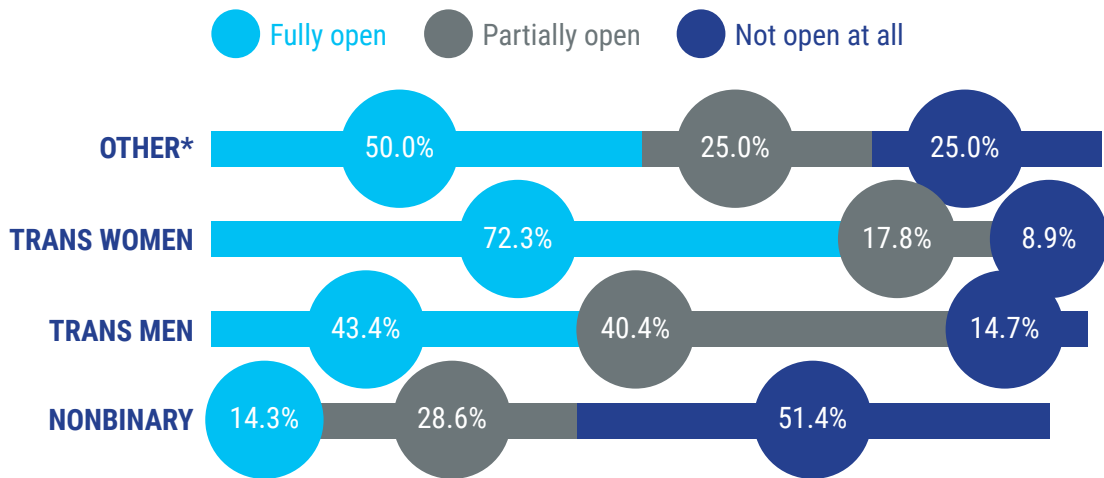
Openness about gender identity

When it comes to living according to one's gender identity, we can see that only 37.1% of non-binary people are living (almost) always in accordance with their gender, compared to 79.9% of trans men and 83.2% of trans women. The most common reasons given for not living in accordance with one's gender identity are general reactions in society (67.6%), parents (63.4%) and fear of discrimination (62.0%). Almost all of the respondents (91.5%), regardless of their gender identity, stated that they would like to live according to their gender identity more frequently in the future. These results are indicative of high levels of transphobia, despite the constant efforts of trans organisations to make society a safe place for all trans people. A significant proportion of the sample consists of young people (19.6% are 18 years of age or younger), which highlights the importance of more work being done to ensure that they have access to trans-affirmative educational environments and programmes.

The significantly lower percentage of non-binary people who are living in accordance with their gender identity can possibly be attributed to a lack of awareness of non-binary identities in society, as well as the lack of social acceptance towards those who do not identify within the gender binary. This is evident even within the Spanish language, which is a gendered language, and usage of non-gendered language is neither accepted nor understood, which makes living in accordance with gender identity for non-binary people much more difficult.

When it comes to openness in healthcare settings, half of the respondents (50.4%) stated that they are fully open, 30.4% are partially open and 17.4% not open at all. Again, the situation differs depending on the individual's gender identity, with trans women being the most open, and non-binary people the least.

Figure 37. Openness in healthcare settings (%)



Question: q0018: At the present time, how open are you about your gender identity around the following people? In each case, please select the option that is most applicable to your life nowadays.
Note: * Cases with fewer than 30 respondents.
Base: Spanish trans respondents in the TGEU survey (N=276).
Source: TGEU HCU survey, 2017.

On the other hand, the majority of trans HCU described attitudes of healthcare providers as (strongly) supportive (41%) or neutral (36.2%).

Experiences with general healthcare

An important issue for trans people using healthcare services are health cards. While in some regions a person can change their gender on a health card independently from the LGR legislation on a national level, it is not possible in all regions, which forces some people to disclose their trans identity when accessing health services. On the other hand, the results of this study show that many trans people (28.7% of all Spanish respondents) have felt discriminated against or were treated incorrectly in healthcare settings. Thus, it is not surprising that almost half of the respondents (48.1%) stated that they have delayed going to the doctor for general healthcare because of their gender identity. The reasons stated included being afraid (50.9%), not wanting to disclose their gender identity (36.2%), or expecting to be treated badly (34.5%). On the positive side, 69.9% said that they were aware of trans-friendly healthcare providers in general healthcare.

“The doctor I went to (GP) had no information on the subject, she treated me by my assigned gender and not by my preferred gender even after asking her repeatedly to do so. I also asked her for an appointment with an endocrinologist, and she refused.”
 (Trans woman, age 25)

"[...] she refused to treat me as I told her. I told her to please address me in the masculine and to use the name I had told her, not as it was written on the health card. After saying that, she looked at me with disgust and made a dismissive gesture saying that she was going to call me as I was described on the health card, regardless if I liked it or not [...]." (Trans man, age 16)

"They told me how my country worked, and that they did not give a shit if anything would happen to a transvestite like me. They told me that there were people who needed operations to cure diseases and not physical whims like mine, that I was never going to be operated on and that he would not help me while he was alive. I suppose that this doctor had a bad day and I had to pay the price..." (Trans man, age 26).

Experiences with trans-specific healthcare

Eight out of ten respondents (83.9%) stated that they knew whom to contact if they want to access trans-specific healthcare, and the same percentage (77.9%) had sought transition-related psychological or medical help at some point. However, there is a significant difference between identity groups, with just over half of non-binary people knowing whom to contact (63%) and actually seeking help due to being trans (51.4%) compared to a significantly higher percentage among trans women (90.1% knew who to contact and 86.1% sought help) and trans men (83.5% knew who to contact and 78.7% sought help).

"As a non-binary trans person, I am afraid to go to any professional who does not have full respect and an accompanying approach to non-binary identities, and this lack of respect reflects the majority of professionals who serve trans binary people. I could not receive treatment in a GIU (Gender Identity Unit) because I felt forced to lie and pretend to be a binary trans man, and this in my case would be unfeasible because what I'm doing is a low hormone treatment dose to reach only a certain level of changes and when changes have taken place I will lower the dose. Conventional professionals would most likely not respect this type of process and pressure me to accept a binary transition pack or to remain without treatment." (Non-binary person, age 34)

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Almost nine out of ten (86.1%) respondents accessed services of mental health professionals, 71.3% used hormone replacement treatment and 27.4% used puberty blockers. One quarter underwent chest reconstruction surgery (24%), and every tenth person underwent genital surgery (9.1%) and removal of ovaries/uterus/testes (9.6%). However, more than half of the respondents stated that they are either planning to undertake these gender-confirmation surgeries in the future, or that they would like to, but they were/are not available. Besides the availability of different procedures, it is important to note that waiting lists for gender confirmation surgeries in public healthcare clinics are on average from six to eight years, and that the cost of surgeries in private clinics are often too high, and thus not accessible for many trans people. Long waiting lists are forcing trans people to leave the public health system for private healthcare.

"I had to make the transition to private doctors (including surgery) because at the GIU in Madrid, at the age of 18, I could not start hormonal treatment, and the surgeries take years because of the long waiting lists." (Trans man, age 19)

The issue of un/availability of treatment is also obvious with puberty blocker treatment, where more than one-third of respondents (38.0%) stated that they would (have) use/d puberty blockers, but they were/are not available. This is a treatment that unfortunately is not available in all the autonomous territories (in regions that have not legislated on this matter).

Figure 38. Use of puberty blockers (%)



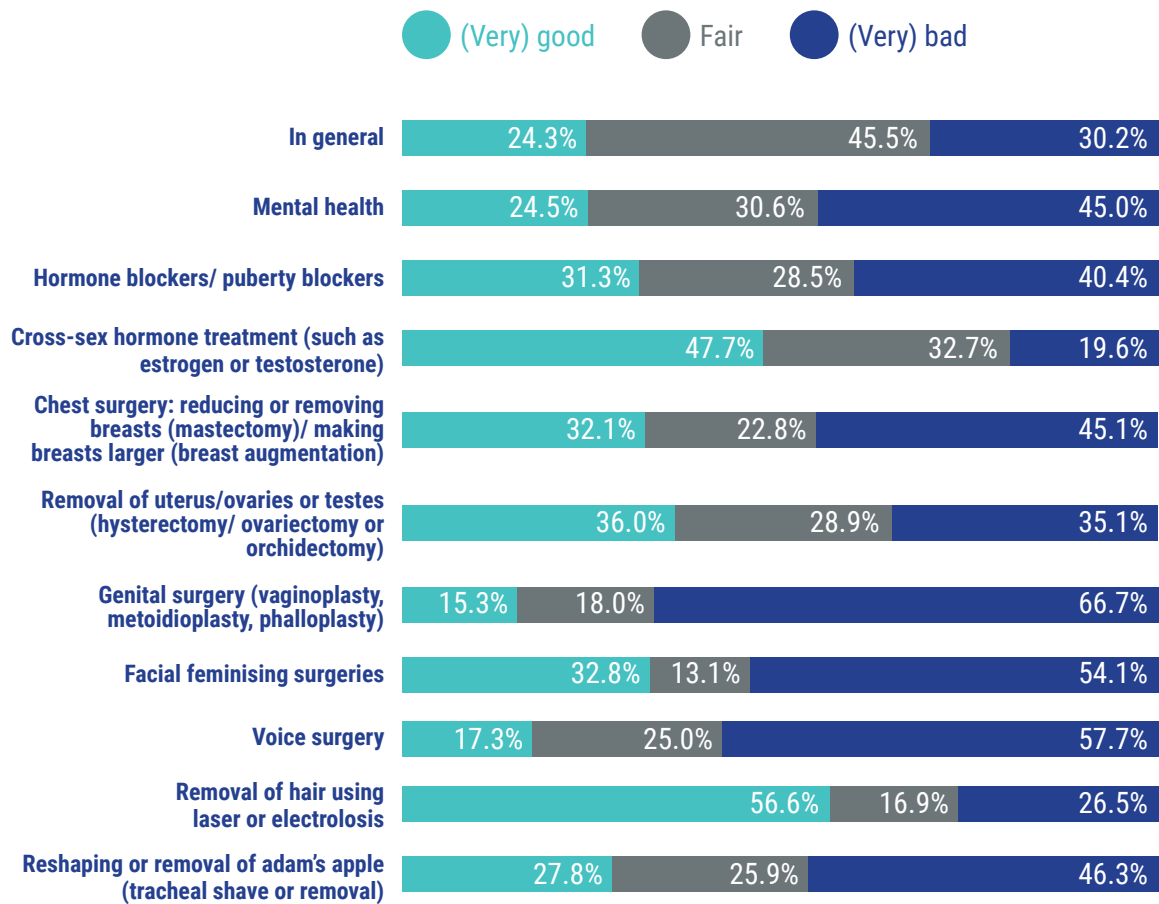
Question: q0044: Can you tell us what type of trans-specific healthcare you have already undergone, and how long ago this took place?
Base: Spanish trans respondents in the TGEU survey (N=208).
Source: TGEU HCU survey, 2017.

When asked to describe the provision of trans-specific healthcare in Spain, more respondents rated it as (very) bad (30.2%) than (very) good (24.3%), with hormone replacement treatment being the type of service they are that most satisfied with (47.7% rated it as (very) good), which is also the type of gender confirmation intervention undertaken by the highest percentage of respondents (71.3%).

“The healthcare from psychologists in the Gender Identity Treatment Unit was not only unhelpful, it was also humiliating and degrading. There is inadequate information about treatments and surgeries, and authoritarian, paternalistic and pathological attitudes abound.” (Trans woman, age 22)

“A few years ago, the Ramon y Cajal gender unit was very pathological in its treatment. I hope it has changed over the years. I stopped going there because of the incorrect treatment I received.” (Trans woman, age 22)

Figure 39. Evaluation of trans-specific healthcare (%)

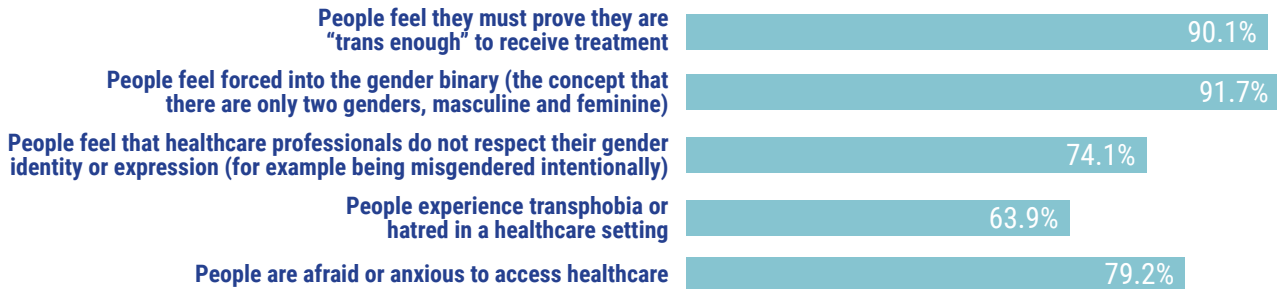


Question: Computed variable on the following survey question: q0058: All things considered, how would you describe the provision of trans-specific healthcare in your country?
 Base: Spanish trans respondents in the TGEU survey (N=137).
 Source: TGEU HCU survey, 2017.

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Similar to other countries, trans people in Spain are also exposed to a variety of other negative experiences in trans-specific healthcare and these are estimated to be (very) widespread by a large majority of respondents.

Figure 40. Widespreadness in trans-specific healthcare (% (Very) Widespread)



Question: Computed variable on the following survey question: q0059: In your opinion, how widespread are the following in trans-specific healthcare in the country in which you live.

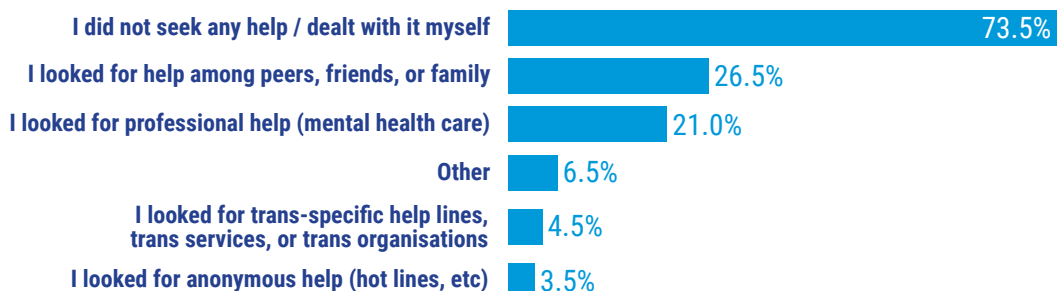
Base: Spanish trans respondents in the TGEU survey (N=223).

Source: TGEU HCU survey, 2017.

Suicidal ideation and suicide attempts

Previously conducted research found high rates of suicidal ideation and suicide attempts among trans people, which has been confirmed by this survey. 72.5% of respondents had seriously thought about ending their life at some point (of which 49.6% on multiple occasions), and four out of ten (40.9%) in the whole sample had experienced suicidal ideation in the past twelve months. It is especially worrying to note that almost one fourth (22.5%) of trans people participating in this research had attempted suicide at least once, which is the highest rate in all five countries, and that 10.9% have attempted suicide in the past 12 months. Three-quarters of them (73.5%) didn't seek any help at all, and only one in every five sought support from mental health professionals (21.0%).

Figure 41. Help for suicidal thoughts/attempts (% of cases)



Question: q0032: Where did you turn for help when you had suicide thoughts/attempts? Please select all answers that apply to you.

Base: Spanish trans respondents in the TGEU survey (N=200).

Source: TGEU HCU survey, 2017.

This data is much more alarming when we focus our attention on the suicidal ideation data of those under the age of 18. 61.1% of those under-18 have had suicidal thoughts in the past

12 months, whereas with adults this percentage is 36%. After attempting suicide, only 30% of these minors sought help from a mental health professional, or through friends or peers (35%), while more than 60% did not seek any help at all and dealt with the situation by themselves.

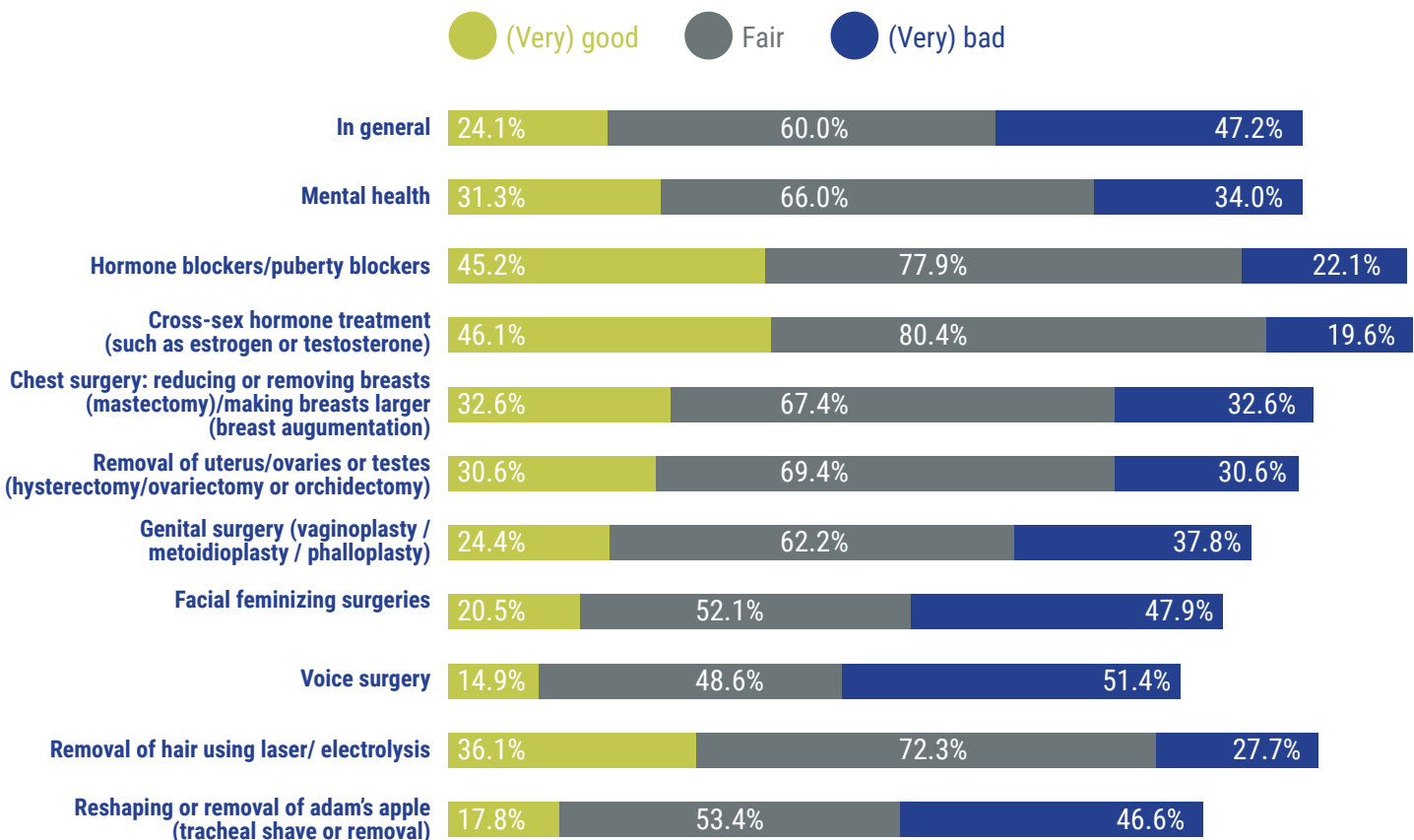
D. Results and Discussion: Healthcare Providers

The sample

The questionnaire for healthcare providers was completed by 234 respondents. The average age of the sample is 46, with the youngest respondent being 17 years of age, and the oldest, 73 years. Healthcare providers are mainly working as general practitioners (43.6%), paediatricians (38.5%) and nurses (15%). A large majority work within the public healthcare system (79.8%) and 13.6% work within the private healthcare system. Exactly half of the HCP (50%) have encountered a trans healthcare user.

When asked to describe the provision of trans-specific healthcare in Spain, we can see that they rate it similarly to trans HCU: more HCP rate it as (very) bad (47.2%) than (very) good (24.1%), with mental health services and hormone treatment rated as (very) good by more than one third of respondents (31.3% and 45.2% respectively).

Figure 42. Evaluation of trans-specific healthcare (%)

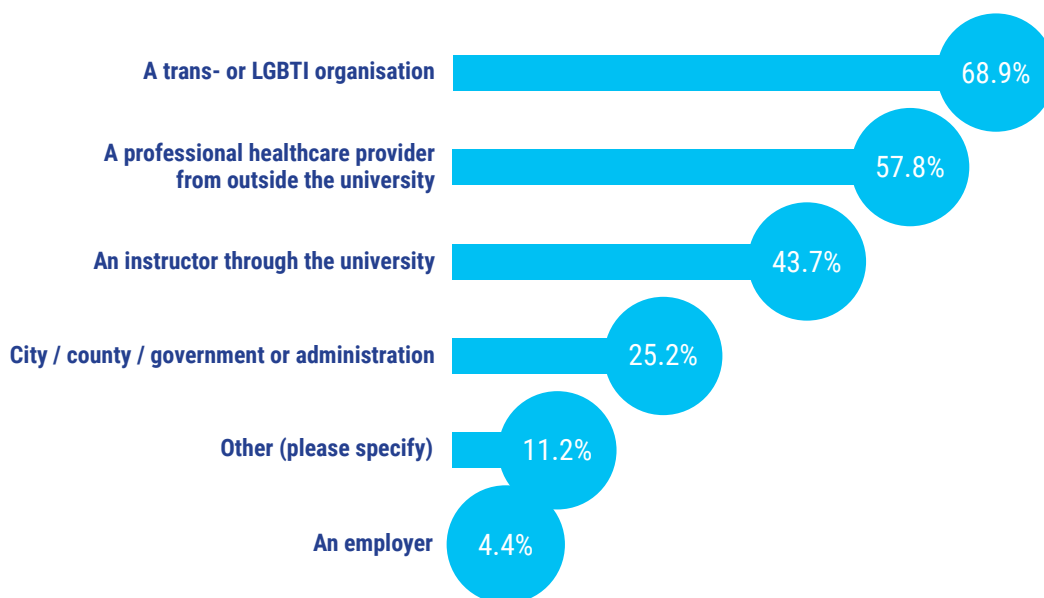


Question: Computed variable on the following survey question: q0028: All things considered, how would you describe the provision of trans-specific healthcare in your country?
 Base: Spanish healthcare providers in the TGEU survey (N=96).
 Source: TGEU HCP survey, 2017.

Training on working with trans clients

Almost half of the respondents (45.7%) had training on working with trans clients. Similar to other countries, a majority of respondents did so on their own initiative (78.8%), with one quarter undertaking it as a mandatory activity, either as a part of the mandatory formal educational program (13.5%) or as part of mandatory professional development (11.5%). Training was mainly provided by a professional healthcare provider from outside the university (42.2%) or a trans or LGBTI organisation (41.2%), in the format of a workshop, seminar or conference (68.6%), lecture or a topic within a course (23.5%), or as a topic in a course book (19.6%). It is interesting to note the vastly different preferences for types of training: most respondents prefer to have training as a non-compulsory activity (66.5%), but also as a part of mandatory professional development (55.8%) or as a formal education program (50.5%). When asked about the preferred provider of the training, 68.9% stated that they would prefer a trans or LGBTI organisation to deliver the training.

Figure 43. Preferred training (% of cases)



Question: q0020: By whom would you like to receive this training?
Please select all answers that apply.
Base: Spanish healthcare providers in the TGEU survey (N=206).
Source: TGEU HCP survey, 2017.

E. Recommendations

After analysing the data collected in this study, we have reached a series of conclusions that are fundamental to promoting the health of trans people in Spain, to improve the healthcare that they receive and to avoid discrimination in healthcare environments.

Healthcare

De-medicalising and depathologising trans identities

The lack of understanding of sexual and gender diversity has a seriously stigmatising effect on trans people and their health. Encouragement from the Spanish Government is necessary

in order to adopt a new national protocol on trans health, or to amend the current law, with the main objective of ending the current classification of trans identities as mental disorders.

Encouraging the establishment of new healthcare protocols, based on:

- » Informed consent models.
- » Flexibility in medical procedures. These procedures should be based on the needs and desires of the person receiving them.
- » Avoidance of discrimination of non-binary trans people in their access to trans-specific healthcare. At the moment, they are the group of trans people with the most difficulties in accessing all available trans-specific medical treatments that they may need, or to exercise their right to equitable healthcare.
- » Guarantee of medical treatments for trans people under 18 years of age who request it, with hormonal blockers once they reached Tanner II's pubertal development stage and hormone replacement treatment at an age similar to the rest of adolescents³⁹, taking into account the maturity and evolving capacities of the minor.
- » Improvement in the quality of medical services offered to trans people. It is essential to equip trans specific healthcare services with more resources in order to shorten the waiting lists for trans people, who currently have to wait too long in order to be able to undergo certain medical procedures.

Providing trainings for healthcare providers

The data collected in this study show us how the treatment of many trans people in healthcare settings is inadequate and is likely to have a direct impact on their physical and mental health. This is why it is fundamental that all professionals working in healthcare environments must be mandatorily trained on the specific needs of trans people in healthcare settings. As demonstrated by the results obtained in this study, the format of this training should be a workshop, seminar or clinical sessions, delivered by experts in the provision of trans-specific healthcare and, if possible, carried out primarily by trans or LGBTIQ organisations.

Establishing strategies to prevent suicide of trans people

The data collected in this study shows that trans people this, (particularly young trans people), are particularly vulnerable to suicidal ideation and suicide attempts. It is therefore necessary to develop a specific suicide prevention strategy for trans people that contains measures to ensure the necessary support is available and to offer specialised training to mental health professionals on how to tackle this work in a more effective way.

Legal Gender Recognition

De-medicalising Legal Gender Recognition

The current law 3/2007, about the modification of the name and the gender of people needs to be reformulated to allow legal recognition of the name and gender of trans people, without being based on pathologising trans identities or requiring trans people to prove that they have

³⁹ Comunidad de Madrid, 2016.

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undergone medical treatment for at least two years. The lack of legal gender recognition for those under 18 years also needs to be addressed.

One state law for the provision of services for all trans people in Spain

Currently, not all autonomous communities have resources dedicated to trans-specific healthcare. In those communities that do have trans-specific healthcare, not all have self-affirmation of gender, de-medicalised procedures or access for minors. It is therefore necessary that, as soon as possible, a new law should be passed establishing a fair and equitable process for all trans people in Spain. A single framework that regulates rights and obligations for trans people is needed, without the current disparities based on place of birth.

Healthcare Cards respecting trans people's name and gender identity

The Spanish government should take the necessary steps to enable all autonomous communities to provide trans people with healthcare cards reflecting their name and gender without having to obtain legal gender recognition. The current situation continues to forcibly out many trans people and makes healthcare spaces unsafe for them. This may negatively affect their health as they will tend to avoid healthcare environments and delay preventative and ongoing treatment.

4.5 SWEDEN

Sweden – in brief

- » *Non-mandatory guidelines on trans healthcare for adults and children, inclusive of non-binary people and based on individualised treatment, not fully implemented across Sweden;*
- » *Costs for trans-specific healthcare covered by national health insurance;*
- » *Long waiting lists to access gender clinics and long assessment period;*
- » *Previous research shows high prevalence of violence, self-reported bad health and suicide ideation and attempts among trans people;*
- » *Legal gender recognition can be obtained after a psychiatric diagnosis and application to the social board for health and welfare.*

A. Country Context

Sweden established a law on gender recognition in 1972, making it the first country in the world to enable trans people to access legal gender recognition. This law has been updated since, removing the requirements for sterilisation and divorce as prerequisites for being eligible for legal gender recognition. The existing law states that you have to 1) have been identifying as the “the other” gender for a long time, 2) have been living in that gender role for some time, 3) be assumed to continue to live according to that gender in the future, and 4) be over 18 years of age. Additionally, you have to be a citizen or a permanent resident of Sweden (SOU, 2014) to be able to access legal gender recognition. There is no obligation to undergo genital surgery or any other treatment in order to be able to change your legal gender. Thus, the Swedish law does not demand a diagnosis per se, but in practice the diagnosis F64.0 of transsexualism, and a positive statement from a gender identity clinic is needed to get approval for legal gender recognition (Socialstyrelsen, 2015b). An update to the law has been proposed, separating the legal process from the medical. The new law will, if accepted by the parliament, be implemented in 2018⁴⁰.

⁴⁰ The Swedish Government, 2017.

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In 2015, guidelines on trans healthcare for adults and children were adopted, providing guidelines for gender identity clinics on how best to provide care for gender dysphoric individuals. The guidelines state that both binary and non-binary trans people should have access to medical transition if required, and that the process should be tailored according to the patient's needs. It also gives guidelines for how young people under the age of 18 should be treated⁴¹. However, these guidelines are not mandatory, resulting in varying procedures by the different gender identity clinics that are located in six places in Sweden. This study is the first, to our knowledge, to be conducted after the guidelines were adopted.

Long waiting times to access the gender identity clinics is a big problem for trans people in Sweden, as well as the actual time that the assessment takes, as forcing trans individuals to wait is used as a diagnostic tool, to make sure that people do not change their minds⁴². In order to access care, one often needs a referral from a psychiatrist within general healthcare. This referral can be hard to obtain, making the waiting time even longer. Some gender identity clinics have started to accept direct referrals from the patients themselves, thus simplifying that part of the process.

A recent Swedish study, with 800 trans respondents, showed that about half reported good health, and about a fifth reported poor health. Poor self-reported health was associated with having a history of negative healthcare experiences, as was needing, wanting or having accessed legal gender recognition, in addition to low income and insecure employment status⁴³. The survey also showed that about one fifth of the respondents had been subject to violence because of their trans identity. More than one third of the respondents had been subject to psychological violence in the year preceding the study, primarily in public spaces. More than half of the respondents had been subject to demeaning or abusive treatment in the previous three months because of their trans identity⁴⁴.

Suicidal ideation and suicide attempts are common within this group, with a greater number (37%) reporting having seriously considered suicide in the past year⁴⁵, compared to the general population (3%)⁴⁶. Suicidal ideation within the last year among the trans respondents was associated with unemployment or long-term sick leave, country of birth other than Sweden and alcohol consumption risk. Older age was associated with less suicidal ideation. Also, having been subject to offensive treatment in the last 3 months, having been exposed to trans-related violence, dissatisfaction with contact with friends and dissatisfaction with psychological wellbeing was associated with suicidal ideation. Hence the level of suicidal ideation was the same for people with different trans experiences, regardless whether or not they had accessed legal gender recognition⁴⁷.

41 Socialstyrelsen, 2015a, 2015b.

42 Bremer, 2011; Linander, Alm, Hammarström, & Harryson, 2017.

43 Zeluf et al., 2016.

44 Folkhälsomyndigheten, 2015.

45 Zeluf et al., 2017.

46 Folkhälsomyndigheten, 2016.

47 Zeluf et al., 2017.

B. Results and Discussion

The respondents

472 trans people responded to the Swedish survey. The vast majority had Swedish citizenship or a valid residence permit in Sweden (99.2%). The age range of the respondents was 16-77 years and the mean age was 27 years. 35.6% were trans men, 36.4% were non-binary, 23.3% were trans women and 4.7% identified as other. The last group, “other”, contains only 22 respondents. Therefore, the group is too small for the findings to be used for analysis. 41.3% of the respondents had completed some form of higher education. 69.7% were assigned female at birth and 30.3% were assigned male at birth. Of the non-binary respondents, 84.3% were assigned female at birth and 15.7% were assigned male at birth.

41.1% of the respondents had changed, or were in the process of changing, their legal gender marker at the time of the survey. 69.1% of trans women, 60.7% of trans men and 6.4% of non-binary people had done so or were currently in the process of doing so. Out of the 58.9% who had not changed their legal gender marker, 57.2% were interested in doing so in the future.

Figure 44. Would like to change legal gender marker, by gender identity (% Yes)



Question: q0010: Would you like to change your legal gender marker?

Note: * Cases with fewer than 30 respondents.

Source: Swedish trans respondents in the TGEU survey (n=278).

Base: HCU TGEU survey, 2017.

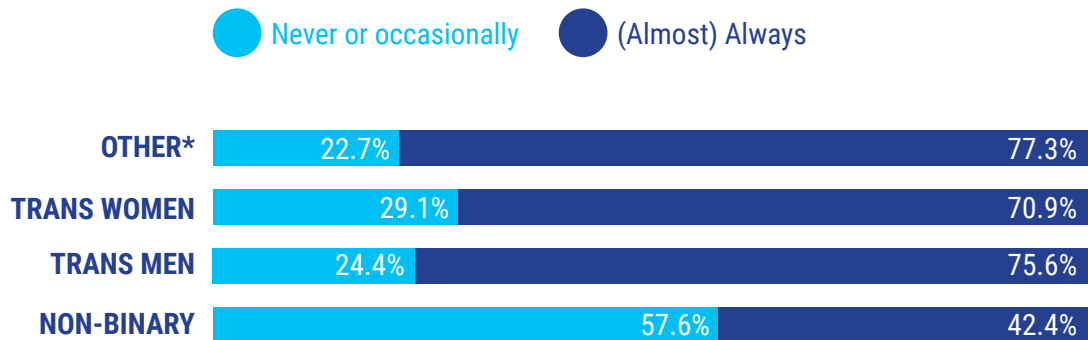
Among the respondents who did not want to change their gender marker, the two main reasons were that they didn't feel the need for it (42.9% of cases); or that the gender that they would want is not available (53.8% of cases). Among those who had other reasons for not wanting to change their legal gender marker, quite a few stated in their comments that they think legal gender should be abolished.

Ability to live according to one's gender identity

Far more trans men (75.6%) and trans women (70.9%) stated that they were able to always, or almost always, live according to their gender identities than did non-binary trans people, of which only 42.4% were able to. Only 3.5% of the non-binary respondents stated that they can always live according to their gender identity.

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Figure 45. Living according to gender identity, by gender identity (%)



Question: Computed variable on the following survey question: q0015: At the present time, how often are you able to live according to your gender identity?

Note: * Cases with fewer than 30 respondents.

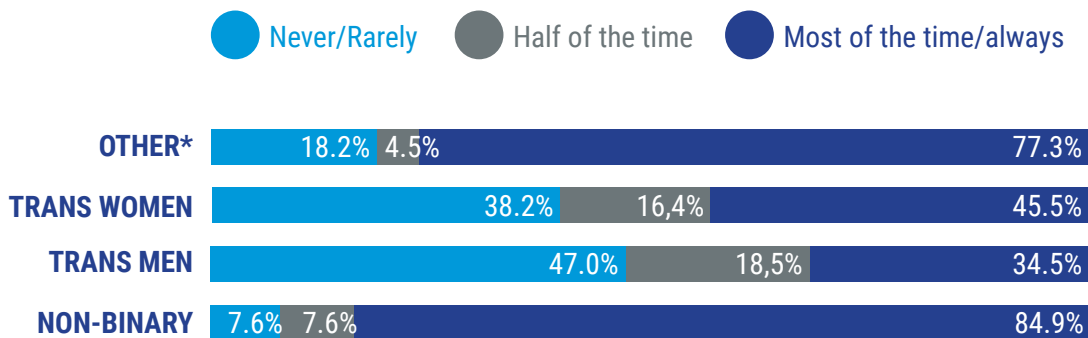
Source: Swedish trans respondents in the TGEU survey (n=472).

Base: TGEU HCU survey, 2017.

The three main reasons that people aren't able to live according to their gender identity are general reactions from society (80.8%), fear of discrimination (78.0%) and parent's reactions (51.4%).

Being read as someone of the gender you were assigned at birth by strangers, here translated roughly to misgendering, is a problem for many of the respondents in this survey where 45.5% of the trans women, 34.5% of the trans men and 84.9% of the non-binary people say misgendering by strangers happens always or most of the time. Some trans men (27.4%) and trans women (13.6%) state that they are never read as someone of the sex they were assigned at birth. 2.3% of the non-binary people experienced this.

Figure 46. Being addressed as sex assigned at birth, by gender identity (%)



Question: Computed variable on the following survey question: q0020: At the present time, how often do strangers (shop assistants, people on the street, etc.) address you as someone of the sex assigned at birth?

Note: * Cases with fewer than 30 respondent.

Source: Swedish trans respondents in the TGEU survey (n=472).

Base: TGEU HCU survey, 2017.

Self-reported health

We asked about general health, where 60.9% of the respondents stated that they are in good health, and 39.1% said that their health is bad. The differences in health between people with different trans identities are significant, with non-binary respondents reporting bad health more often ($p=.009$), as shown in Figure 47 below.

Figure 47. Health, by gender identity (%)

	GOOD	BAD
OTHER*	69.2%	30.8%
TRANS WOMEN	70.1%	29.9%
TRANS MEN	66.7%	33.3%
NON-BINARY	49.2%	50.8%

Question: Computed variable on the following survey question: q0024: In the next section, we would like to ask you a few questions about your health. In general, would you say your health is...

Note: * Cases with fewer than 30 respondents.

Source: Swedish trans respondents in the TGEU survey ($n=312$).

Base: HCU TGEU survey, 2017.

66% have support from their close family, while 34% do not. By close family we mean parents, siblings, partners and children. There is no significant difference in family support between the different gender identity groups. Our results show that trans people with supportive families have significantly better health. 50% of people who did not have their family's support stated having bad health, which is a significantly higher percentage than those who did have family support (31.7%, $p=.003$). People who experience misgendering always or most of the time have significantly ($p<0.001$) poorer health (46.2%) than people not experiencing this (20.7%). People who feel that they cannot live according to their gender identity have significantly poorer health, with 56% reporting bad health, compared to people who can, where 24.1% report bad health ($p<0.001$). Thus family support, and being able to live according to one's gender identity, are important factors for health among the trans people in this study.

Suicidal ideation and suicide attempts

The respondents were asked questions about suicide attempts and suicidal ideation. 79.2% of all respondents report having had thoughts about ending their own life, with 54% reporting having had these thoughts in the last year. 24.8% of all respondents report having attempted suicide at least once during their lifetime, 9.7% of all respondents had attempted suicide within the 12 months preceding the survey. There were no significant differences in the identity groups for lifetime suicidal thoughts or attempts. We also asked about where people turned for help, and 58.6% responded that they didn't seek any help at all. 36.4% sought help from friends, peers or family. 47.9% responded that they had sought professional help through mental health services. Factors like family support, experiences of misgendering or being able to live according to one's gender identity did not result in significant differences in experiencing suicidal ideation or suicide attempts. This report provides a second body of

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evidence indicating the that same issue is still impacting Sweden: that a significant proportion of many trans people have had serious thoughts of ending their own lives during the previous 12 months (37% in a previous study⁴⁸, 54.0% of all respondents in this study). In addition, both studies highlight that young trans people are struggling more than older trans people.

Experiences of general healthcare

In total, 62.1% of all Swedish respondents (n=446) report to have delayed going to a general healthcare practitioner – ranging from sometimes to all the time. A significant difference in the gender identity groups was found, with trans men delaying going to a general healthcare practitioner more frequently when compared to other identity groups.

Figure 48. Ever delayed going to the doctor for general healthcare (% Yes)



Question: Computed variable on the following survey question: q0065: Have you ever delayed going to the doctor for general healthcare because of your gender identity?

Note: * Cases with fewer than 30 respondents.

Source: Swedish trans respondents in the TGEU survey (N=446).

Base: HCU TGEU survey, 2017.

23.2% of the respondents state having experienced discrimination because of their gender identity or gender expression from a healthcare provider in the last 12 months. Those who experienced this reported a higher likelihood of having delayed going to a general healthcare practitioner (92.2%) than those without discriminatory experiences (52.5%).

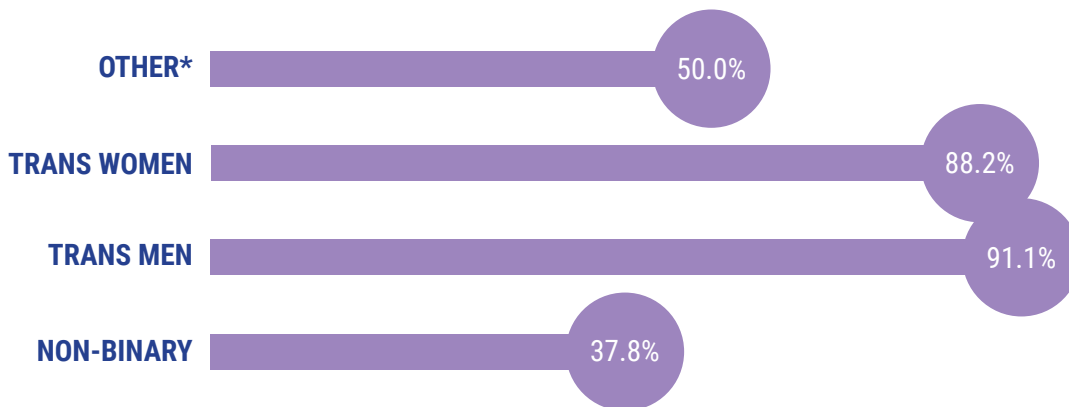
91.2% of our respondents think it would improve access to general healthcare if all staff members underwent mandatory and regular education on trans issues. 82.6% also think it would be good to have LGBTI- or trans-specific healthcare clinics. 89.6% stated that a list of trans friendly doctors or clinics would also improve access to healthcare for trans people. It is clear that practitioners in general healthcare need to have more knowledge about trans identities and experiences in order to be able to treat trans people properly, both when it comes to interpersonal relations and actual medical treatment.

Experiences of trans related healthcare

Of all Swedish respondents, 69.1% have sought psychological or medical help for being trans, with the group of trans men and trans women reporting the highest levels of seeking trans specific help.

⁴⁸ Zeluf et al., 2017.

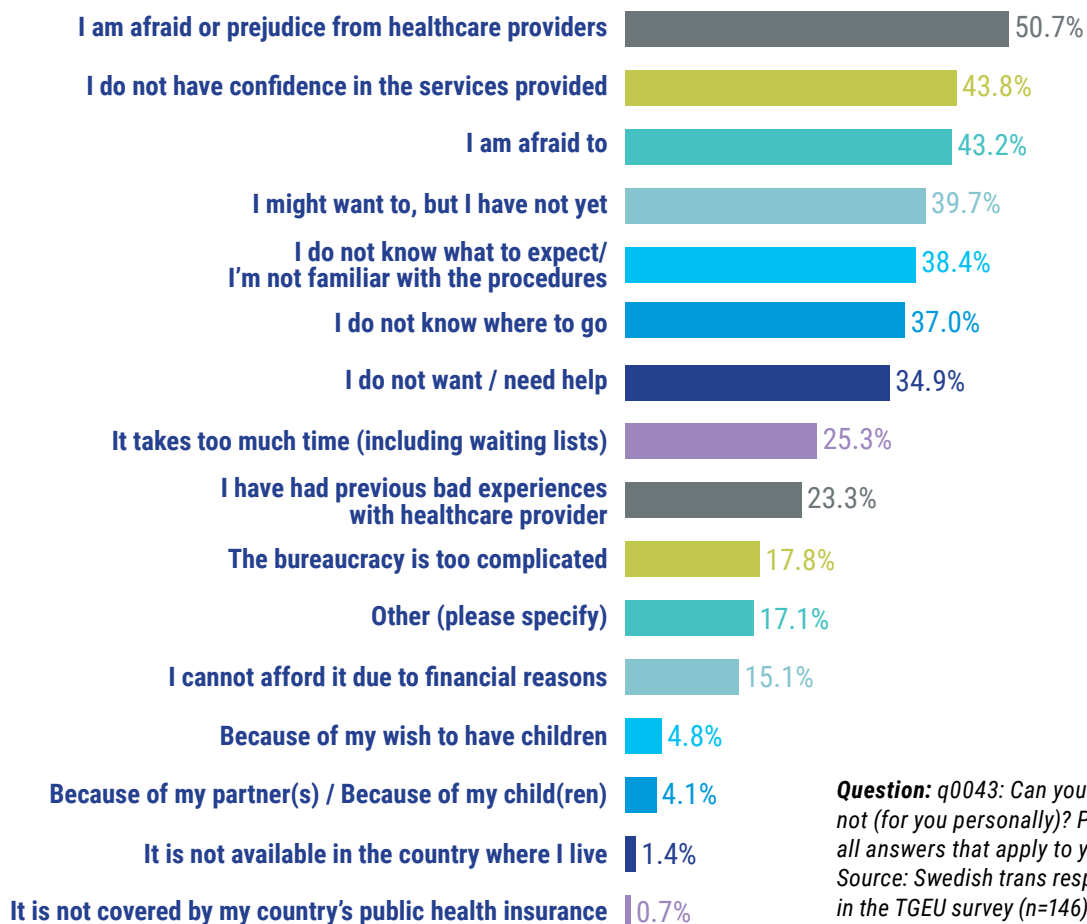
Figure 49. Seeking psychological or medical help (%Yes)



Question: q0042: Have you ever sought psychological or medical help for being trans?
Source: Swedish trans respondents in the TGEU survey (N=472).
Base: HCU TGEU survey, 2017.

The reasons for not seeking help vary, with the most common being fear of prejudice from healthcare providers (50.7%), lacking confidence in the services provided (43.8%) and being too afraid to seek help (43.2%).

Figure 50. Reasons for not seeking help (% of cases)



Question: q0043: Can you tell us why not (for you personally)? Please select all answers that apply to you.
Source: Swedish trans respondents in the TGEU survey (n=146).
Base: HCU TGEU survey, 2017.

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We asked an open question about experiences in trans related healthcare, and got 190 answers from our respondents. Many of them were waiting for a first visit to a gender dysphoria clinic after referral, or were in the process of trying to get a referral to one. There is a lot of frustration regarding waiting times and the amount of time that the assessment takes among the HCU respondents. Some respondents, however, were satisfied with the treatment and care they got from their clinic, while other respondents were very critical of their healthcare providers and have found the process humiliating, stereotypical or negative in other ways.

We asked about respondents' opinions of trans-specific healthcare. 38.3% said that, generally, they would rate the trans healthcare in Sweden as bad. 46.3% thought that it was fair and 18.1% thought that it was good. 96.6% thought it was common for people to feel that they have to prove that they are "trans enough" in order to receive treatment, and 95% say it is widespread in trans-specific healthcare that people feel forced into presenting as gender binary during the assessment period.

Figure 51. Occurrence in trans-specific healthcare (%)

	Rare	Widespread
People feel they must prove they are "trans enough" to receive treatment	3,4%	96,6%
People feel forced into the gender binary (the concept that there are only two gender, masculine and feminine)	5,0%	95,0%
People feel that healthcare professionals do not respect their gender identity or expression (for example being misgendered intentionally)	20,6%	79,4%
People experience transphobia or hatred in a healthcare setting	31,3%	68,7%
People are afraid or anxious to access healthcare	6,8%	93,2%

Question: Computed variable on the following survey question: q0059: In your opinion, how widespread are the following in trans-specific healthcare in the country in which you live.

Source: Swedish trans respondents in the TGEU survey (N=472).

Base: HCU TGEU survey, 2017.

90.8% of our respondents think that it is necessary to increase the number of healthcare providers in trans specific healthcare, and 94.6% think it is necessary to decrease waiting times for trans specific healthcare.

Non-binary people's health

In this study, we specifically reached out to many non-binary respondents, 172 people in total. Hence, it is possible to look at this group separately, which hasn't been done in a Swedish context before. It is clear from our results that non-binary people have worse self-reported health, more self-reported disability and are less happy with how society perceives them than the men and women in the study. The majority report having supportive families. However, as many as a fifth (18.0%) of the non-binary respondents state that they don't know yet if their close family will be supportive or not when they come out to them.

Misgendering is a big problem for non-binary people, where 84.9% state that this happens all the time or most of the time. Even the 2.3% who say that they are never read as someone of the gender they were assigned at birth are possibly misgendered, but as another gender. It is also clear from comments from our respondents that a great deal of the negative healthcare experiences are attributable to misgendering or healthcare staff not understanding, or wanting to understand, non-binary identities.

Only 3.5% of non-binary respondents state that they can always live according to their gender identity, which is not unusual in a society that is still very caught up in the idea of the gender binary. The current Swedish law makes it impossible for non-binary people to have their legal gender recognised, since there are only two legal genders, male and female. It is impossible to know for sure if the frequent misgendering and inability to live according to one's gender identity leads directly to bad health. The theory and research about minority stress⁴⁹ does, however, imply that environment is the main cause of ill-health among sexual- and gender minorities and our research indicates that these factors do play an important role for trans people's health. Previous research has also shown that non-binary people in Sweden have worse self-reported health than other trans people⁵⁰, and the body of evidence on this is growing.

There are no significant differences between people of different gender identities when it comes to suicidal ideation and suicide attempts. Non-binary people think about ending their lives and attempt suicide as often as other trans people. It is clear that this group also needs specific guidelines included in suicide prevention interventions for trans people.

C. Recommendations

Legal gender recognition

The Swedish Government must take action to make the process around legal gender recognition easier, separating it from medical procedures and letting young people, under 18 years old, have their gender recognised. These are key legal changes required to improve the living conditions for trans people in Sweden. RFSL also recommends the Swedish Government to make the Swedish personal identity numbers gender neutral in order to simplify legal gender recognition. For non-binary people, legal gender recognition is currently impossible, as Sweden does not recognise more than the two binary genders. The Government should consider introducing a third legal gender or completely abolishing legal gender in order to make legal gender recognition available to everyone.

Training of general healthcare staff

Experiences of discriminatory treatment in healthcare settings prevents trans people from seeking care and having their right to healthcare met. All employers within the healthcare sector should make sure that all staff in general healthcare get compulsory training on trans awareness and trans healthcare, as part of their continuous professional development training. The Universities need to ensure that all healthcare students get this training at university level.

⁴⁹ Meyer, 2003.

⁵⁰ Zeluf et al., 2016.

Improvement of, and access to, gender identity clinics

Many of the gender identity clinics need to improve their interpersonal treatment of their clients and adapt more to the Swedish protocols for trans healthcare. Landstingen (local governments for healthcare) need to make sure that the gender clinics get increased funding in order to take on more clients, and to reduce waiting times. More Landsting should consider forming gender identity teams, as there is a need for more gender identity clinics, particularly ones that are explicitly open to non-binary people and young clients.

Access to mental health services

Trans people who have mental health problems or suicidal thoughts need help. They need to know that there is trans-inclusive healthcare available, without having to explain or defend their gender identity when seeking help for life-threatening mental health conditions. It is their right to get this help from mental health services. Landstingen need to ensure this improves, as much improvement is required. Suicide prevention interventions that reach trans people of all genders are also desperately needed. The Public Health Agency and the Swedish Government are responsible for improving the suicide preventive measures taken in Sweden.

Chapter 5

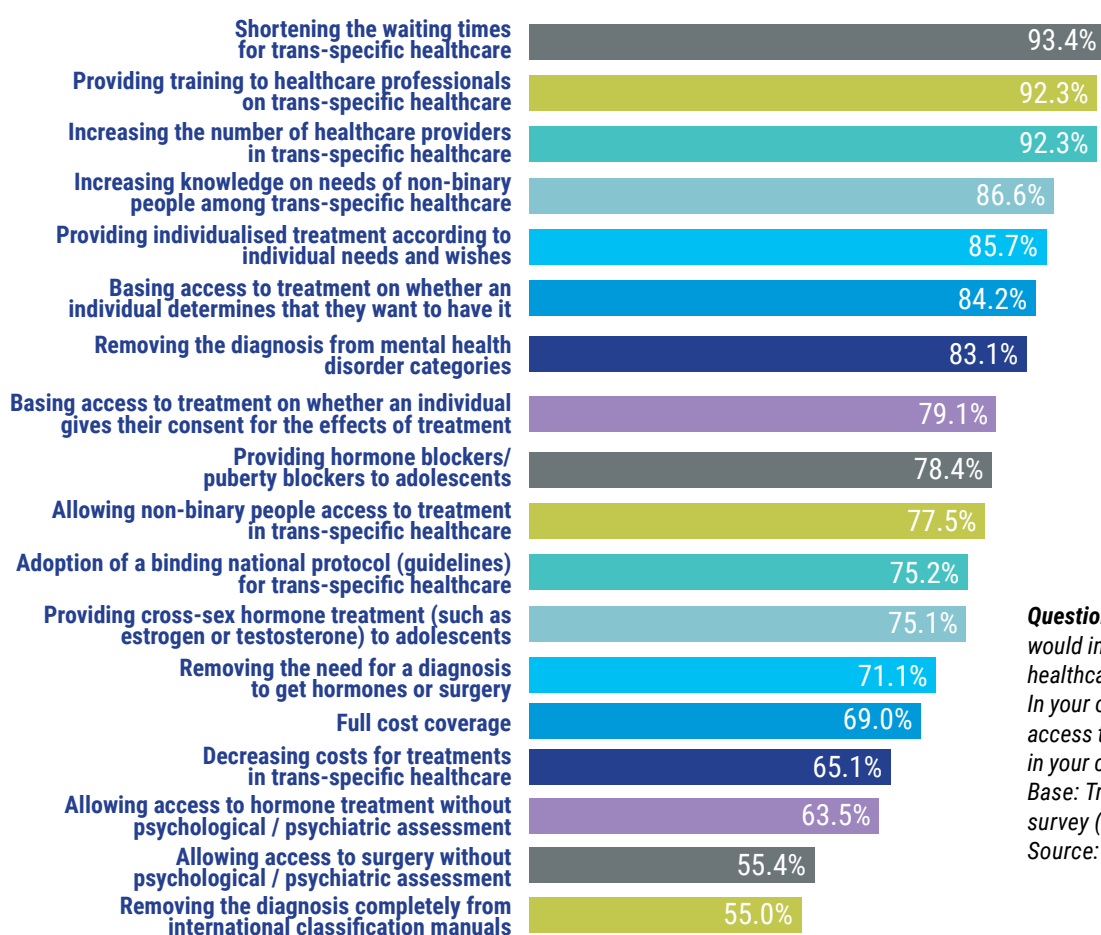
Improving access to general and trans specific healthcare

5.1. OPINIONS REGARDING POSITIVE DRIVERS FOR TRANS-SPECIFIC HEALTHCARE

According to trans respondents, the aspects of trans-specific healthcare that need improvement, taking into account the current country situation, are shorter waiting times, training for healthcare professionals, and an increase in the number of healthcare providers in trans specific healthcare, these being listed by nine out of ten trans respondents. Topics that are seen as less important for change include allowing access to surgery without psychological/psychiatric assessment (55.4% want this to be improved) and allowing access to hormone treatment without psychological/psychiatric assessment (63.5% want this to be improved). Only half of healthcare users agreed that removing the diagnosis completely would improve access to trans-specific healthcare, which is understandable as there is a realistic fear that removing the diagnosis from diagnostic manuals will prevent trans people from accessing healthcare services⁵¹. 83.1% did agree that removing the diagnosis from mental health disorder categories would improve access to trans-specific healthcare.

Figure 52.

What would improve access to trans-specific healthcare (% improvement is necessary)



Question: q0063: In your opinion, what would improve access to trans-specific healthcare in your country? q0064: In your opinion, what would improve access to trans-specific healthcare in your country (continued)?
Base: Trans respondents in the TGEU survey (n=810).
Source: TGEU HCU survey, 2017.

⁵¹ See for example European Union Agency for Fundamental Rights (2016)

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Some interesting results within this area of research were found. Significantly more non-binary people (89.7%) in comparison with the other identity groups (between 67.1% and 79.3% respectively) agreed that improvement is necessary when it comes to allowing non-binary people access to treatment in trans-specific healthcare.

Ensuring training for all staff members is mandatory and occurs regular is the most important aspect for change in general healthcare, according to 91.9% of trans respondents in the survey. Also *having a binding protocol (guidelines) for how to address trans people* and *having lists of trans-friendly doctors or clinics* are seen as very necessary improvements (90.5% and 90.1% respectively). On the other hand, 11% indicated that the situation is fine as it is with regards to *having peer mentoring and support groups* to contact, as well as 10.7% in regard to having allies or peers to accompany trans people to the doctor.

Figure 53.

What would improve access to general healthcare (% improvement is necessary)



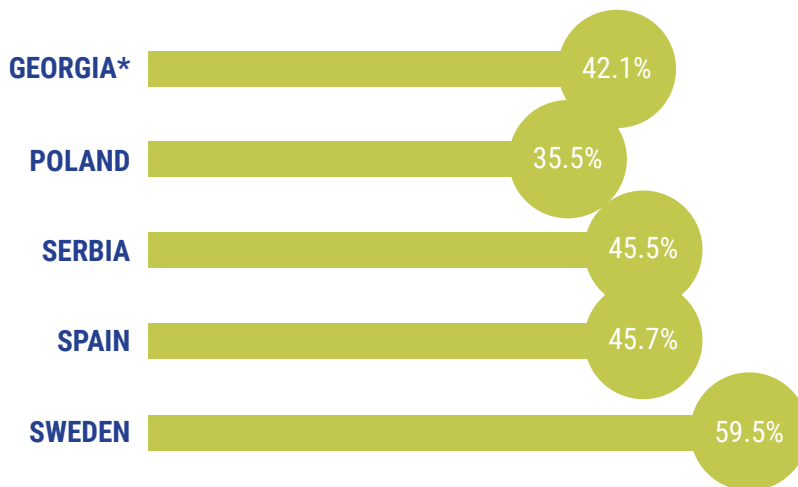
Question: q0073: In your opinion, what would improve access to general healthcare for trans people in your country?
Base: Trans respondents in the TGEU survey (N=776).
Source: TGEU HCU survey, 2017.

5.2. SUGGESTIONS FOR IMPROVEMENTS FROM THE PERSPECTIVE OF TRANS HEALTHCARE PROVIDERS

A. Why is training meaningful for healthcare providers?

Half of all healthcare providers reported that they had, at some point, received training on trans issues (52.1%). Only in Sweden (59.5%) was there a small majority of HCP who had ever received training, with only one in three HCU's in Poland ever receiving training (35.5%). The fact that the percentages are this disparate is possibly due to the sampling method - since taking part in a survey organised by trans organisations might be an indication of a positive stance towards the topic.

Figure 54.
Having had training about trans people / transsexualism / gender dysphoria, by country (%)



Question: q0013: Have you ever had training about trans people / transsexualism / gender dysphoria? (The term "transsexualism" is one of the diagnoses in the ICD-10 for trans people. The term "gender dysphoria" is the term for the diagnosis in the DSM-5.)

Note: *Cases with fewer than 30 respondents.

Base: Healthcare providers in the TGEU survey (n=888).

Source: TGEU HCP survey, 2017.

Those who did receive training reported markedly less extreme attitudes towards of gender norms⁵² compared to those who had not receive training. In other words, training on trans issues led to a broader understanding of what gender can mean to individuals, and how gender identity and gender expression can differ amongst humans.

Providers who had received training also reported significantly greater awareness of protocols such as knowing where to refer onwards, and knowledge of the existence of trans care protocols: 62.8% of those who had received training would know where to refer a client to when this person wants to access trans-specific healthcare which they themselves do not offer, in comparison with 27.7% of those without training. They also reported significantly more knowledge (62.7% versus 28.4%) regarding where to refer a trans service user / client / patient looking to contact a trans support group. Those without training had significantly less knowledge of the existence of a national protocol in their country or region (29.6%) versus those who did receive training (52.5%).

In short, receiving training leads to:

- » Less stereotypical gender assumptions / more nuanced understandings of gender
- » More knowledge when it comes to referring a client who wants to access trans-specific healthcare
- » More knowledge when it comes to referring a client to trans support groups
- » More knowledge on existing trans specific healthcare protocols

⁵² Measured with the Beliefs about Gender Scale, Tee and Hegarty (2006). In this survey, the scale had an acceptable reliability (Cronbach's $\alpha = 0,716$).

There was no significant difference in regards to perceptions of the prevalence of discrimination between those who did receive training and those who did not, but there was a significant difference between the figures in this survey and the Special Eurobarometer on discrimination in the European Union (European Commission, 2008). The report from the European Commission in 2008 reported lower percentages of respondents stating that discrimination on the ground of gender is widespread (36%) in comparison to this survey (88,3%).

Figure 55. Comparison of discrimination ratings of healthcare providers and the Special Eurobarometer 296 (% Widespread)⁵³

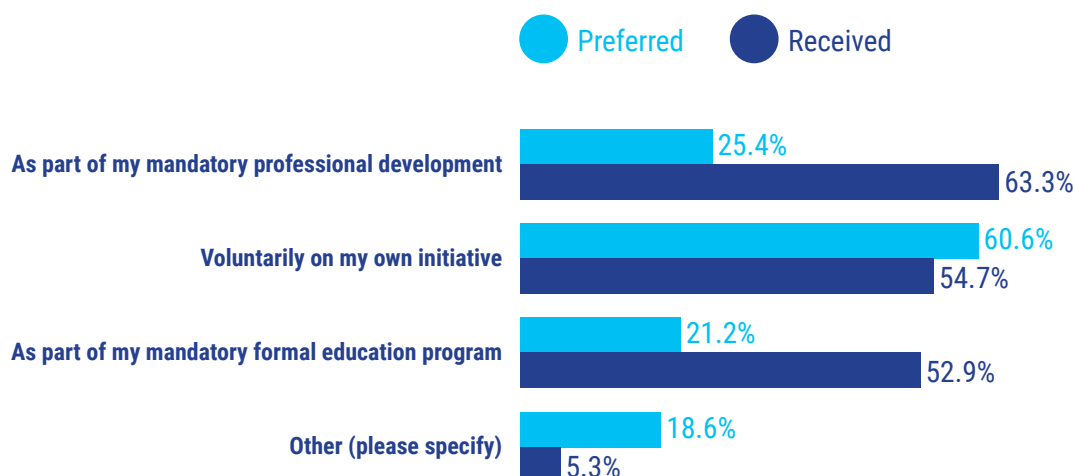
	SPECIAL EUROBAROMETER 296, 2008	TGEU HCP SURVEY, 2017
POLAND	25%	90,9%
SPAIN	54%	87,2%
SWEDEN	50%	87,9%

B. What do healthcare providers want their training to look like?

The HCP survey contained questions for healthcare providers (HCP) on the training they had received, including details on who provided this training, the format this training was provided in and so on. The HCP survey also questioned HCP's on what type of training they would find helpful in order to increase their level of competence in working with trans users / clients / patients, and by whom this training should be provided. The comparison of the received training and the preferred training reveals interesting conclusions, which are briefly presented here.

The majority of those who had received training did so on their own initiative and on a voluntary basis (60.6% of cases). However, when questioned on the format through which they would prefer to receive training, a majority of HCP would prefer to receive training on trans issues as part of their mandatory formal educational program (52.9%) and/or as part of their mandatory professional development (63.3%).

⁵³ Georgia and Serbia were not included in the Special Eurobarometer 296 report, so percentages are not available.

Figure 56. How the training was/should be provided (% of cases)

Questions: q0014: Can you tell us more about how this training was provided? Please select all answers that apply. q0019: What type of training would you find helpful to increase your level of competence in working with trans users / clients / patients? Please select all answers that apply. Base: Healthcare providers in the TGEU survey, both respondents who have received training before (experienced n=452) versus all respondents (preferred n=780). Source: TGEU HCP survey, 2017.

In most cases, the training was presented as a topic in a workshop, seminar, or conference (59.4%).

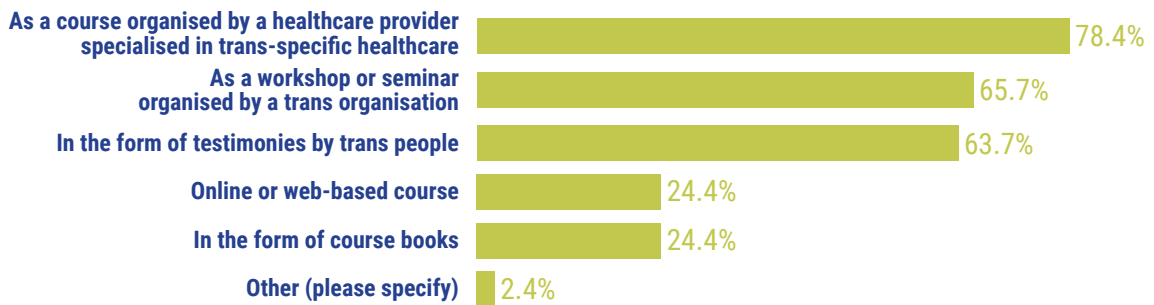
Figure 57. In what format did you receive this training? (% of cases)

Question: q0016: In what format did you receive this training? Please select all answers that apply. Base: Healthcare providers in the TGEU survey. Respondents who have received training before (N=448). Source: TGEU HCP survey, 2017.

The question about the preferred format ranged from a course organised by a healthcare provider specialised in trans-specific healthcare (78.4%) to a workshop or seminar organised by a trans organisation (65.7%). Testimonies by trans people were also much preferred (63.7%). Of those who chose the 'other' category (2.4%), most indicated that they would prefer a combination of the given possibilities, a more profession-specific training or a training in cooperation with a specialised organisation.

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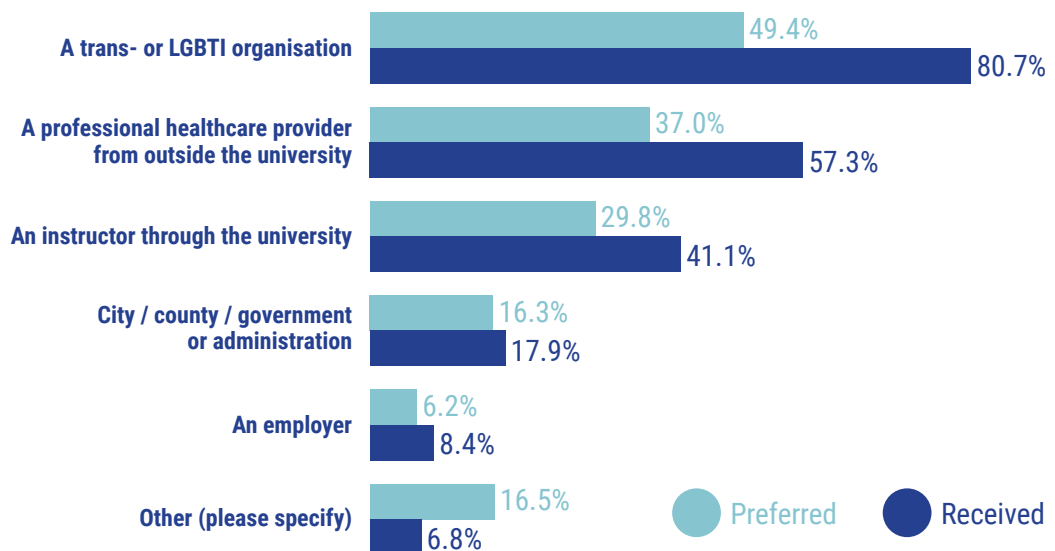
Figure 58. In what format would you prefer to receive training? (% of cases)



Question: q0021: In what format would you prefer to receive training?
Please select all answers that apply.
Base: respondents in the TGEU survey (n=779).
Source: TGEU HCP survey, 2017.

When questioned about by whom they would like to receive this training, again a large discrepancy was noted between training which had been provided and how respondents would prefer to receive training. The vast majority of HCP would prefer to receive this training from a trans- or LGBTI organisation (80.7%), whereas only 49.4% of HCP who received training reported that this was the case in their training. Furthermore, 41.1% to 57.3% would prefer this to be delivered by an instructor through the university, or a professional healthcare provider from outside the university respectively.

Figure 59. By whom would you like to receive this training? (% of cases)



Question: q0015: Who provided this training? Please select all answers that apply. q0020: By whom would you like to receive this training?
Please select all answers that apply.
Base: Healthcare providers in the TGEU survey, both respondents who have received training before (experienced n=449) versus all respondents (preferred n=778).
Source: TGEU HCP survey, 2017.

Conclusions and Recommendations

A BAD STATE OF HEALTH AND WELLBEING

Trans people score significantly worse in health status (Fig. 14) and wellbeing (Fig. 16). More than half of all trans respondents (55.8%) reported having delayed going to the doctor for general healthcare because of their gender identity (sometimes, regularly, or all the time). The most common reasons (cited by four out of ten respondents) was fear of prejudice from healthcare providers (44.1%) and not having confidence in the services provided (41.1%).

Public health authorities should critically review healthcare services and adopt measures for a improved access for all trans people. Besides trans-specific care, general healthcare provisions, such as suicide prevention measures, need to be rethought and drastically reformed to make them relevant for, and inclusive of, trans people.

INTERSECTING IDENTITIES AND MULTIPLE DISCRIMINATIONS

Every third trans person (Fig. 2) identifies outside the gender binary, thus forming a considerable part of the trans community. Non-binary trans people face specific barriers in the health sector, as only four out of ten sought psychological or medical support. Service providers, both community-driven and in the healthcare sector, need to ask themselves if they are open-minded enough to consider narratives beyond those traditionally given, in order to avoid reinforcing a narrow understanding of trans experiences, thus excluding a large portion of the trans community.

Respondents belonging to disability minority groups, young people, and poor respondents experienced discrimination significantly more often because of their gender identity or expression from healthcare providers in general healthcare. Multiple grounds for discrimination intersect in trans people's experiences of the health sector, and require specific attention. Further, the fact that those trans respondents (7.0%) who engaged in sex-work were significantly more likely to have experienced discrimination from healthcare providers points towards another field for educating HCP.

DEPATHOLOGISATION IN PRACTICE

A clear majority of trans people and healthcare providers agree that being trans is not a psychiatric disorder, that a psychiatric diagnosis has a stigmatizing effect on a person, and that a medical non-psychiatric diagnosis would be a better option for trans people (Fig. 23). Nevertheless, healthcare providers are still more likely to express support for a gatekeeping model, in which a mental health practitioner decides when a person is ready to start hormone-replacement treatment or to undergo surgery (Fig. 25). It is worrying that healthcare providers are less likely to support an informed consent model in which trans people are supported in making an informed decision on their choice and timing of transition-related treatment options. National public health authorities should ensure that trans people are not considered sick due to their gender identity or gender expression, and to remove the requirement to obtain a disorder diagnosis in order to access gender affirming healthcare services. This has to translate into national catalogues and trans-specific healthcare-protocols that centre on the informed consent of the person

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concerned and limit gatekeeping powers of health providers, particularly those of mental health professionals. No two trans people's health needs are alike, and healthcare protocols should ensure that trans people with non-binary gender identities and those experiencing discrimination related to their sexual orientation, ethnicity, disability, young age or low income have equitable access. The envisioned de-psychopathologisation of trans identities in the WHO ICD-11 presents health authorities with a unique opportunity to review existing, or to develop new, protocols.

THE IMPACT OF LEGAL GENDER RECOGNITION ON HEALTH

In all countries surveyed, individuals have to undergo certain types of medical treatment in order to obtain legal recognition of their gender. Besides the problematic human rights aspects - mandatory medical treatment undermines an individual's right to physical integrity - the intermingling of administrative and healthcare restrictions negatively affects quality, availability and accessibility of care for trans people. Trans-specific healthcare provision is often linked to requirements of legal gender recognition procedures. Scarce resources in the healthcare sector should not be used as an excuse to impose outdated and rigid administrative practices, but rather focus on the individual's needs. To this end, legal gender recognition should be completely de-medicalised and reformed into quick, accessible and transparent procedures that are based on self-determination.

HOW TO IMPROVE THE HEALTHCARE SERVICE EXPERIENCE

When asked where improvements were necessary, healthcare users found improvements in most areas of healthcare fields were important. Shorter waiting times, more and better trained healthcare professionals, greater awareness for non-binary trans experiences, individualised treatment paths and basing access to treatment on an individual's self-determination are the top priorities (Fig. 52). Health authorities and healthcare providers, together with local trans groups, have to urgently review classification catalogues and decision-making procedures, increase resources dedicated to trans-specific healthcare, and aim to develop and implement quality, readily-available and accessible gender affirming care models based on informed consent.

TRAINING FOR HEALTHCARE PROVIDERS

The majority of healthcare providers would prefer trans issues to be part of their mandatory formal training program. However, most healthcare providers who had received training did so on their own initiative and on a voluntary basis (Fig 56). The preferred format could range from a course organised by a specialised healthcare provider, to a workshop or seminar organised by a trans organisation.

Given the high importance HCPs place on the involvement of trans- or LGBTI organisations (80.7%) and trans testimonies (63.7) in such trainings, public resources need to be invested in trans community structures to ensure sustainable and quality contributions. Education ministries, universities, and other professional training providers need to ensure that the healthcare needs of trans people and the most up-to-date information on service provision are integrated in curricula and made broadly available for health service providers.

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Biographies

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