

Article

The Rights to Health and Health Care of Vulnerable Populations: Reducing the Existing Barriers to Health Equity Experienced by Transgender People in Ireland

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Abstract

The aims of this article are to analyse the existing barriers that Irish transgender people encounter while accessing medical care and to identify potential measures to minimize their negative impact. Although transgender populations may be subject to higher rates of health issues and often have specific health needs, they experience health inequalities due to social stigma, and professional and institutional discrimination. The article assesses governments' and health care providers' compliance with their responsibilities as defined in the Yogyakarta Principles (2007), in Ireland in particular. It identifies and discusses the key factors that limit transgender people's access to care and the standard of that care; these factors are: unequal access to health care, limited availability of trans-specific services, discrimination, lack of specific training and expertise, lack of information, and, crucially, non-respect for transgender patient autonomy. The article asserts that these inequalities infringe on the right to health of transgender individuals and should be tackled by means of ensuring that health sciences education, professional codes, standards of practice, and health policy are inclusive of gender variance. Furthermore, the author argues that for these measures to be effective, health care providers and policymakers must first acknowledge transgender identities, respect the rights of transgender individuals, and recognize the legitimacy of their health needs. Finally, they should actively promote transgender people's right to self-determination and thus enable them to make choices regarding their health. The author concludes that these coordinated efforts will contribute to the fulfilment of transgender people's right to the highest attainable standard of health.

Keywords: autonomy; discrimination; gender variance; health disparities; health policy; self-determination

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Introduction

Transgender people worldwide endure social stigma, discrimination, and violence in everyday life, which can determine their health status and contribute to their experiences of health inequities.¹ The provision of health care to transgender people is further fraught with controversy, not least because of the lack of consensus among health care professionals with regard to the legitimacy of gender variance phenomena and their corresponding gender-affirming treatments, often seen as ‘elective’ and ‘of choice’, rather than medically necessary.² Yet by being marginalized and vulnerable to discrimination, transgender people are a population at risk and have valid health needs that reach beyond the scope of routine care. Though research is scarce, there can be no doubt that as a group transgender people are inadequately represented and underserved by health care delivery systems oriented to binary gender representations and often experience unequal access to medical care, or a lower standard of medical care, as a result of many systemic barriers.

This article will analyse these barriers and explore how they manifest in the context of access to and the provision of trans-specific and general health care in Ireland. The analysis will focus on governments’ responsibilities to fulfil transgender people’s right to the highest attainable standard of health as specified in the Yogyakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity (2007)—a universal guide agreed by human rights experts aiming at affirmation of the human rights of sexual and gender minorities and setting their corresponding international standards in law, policymaking, and human rights practice.³

- 1 The World Health Organization (WHO 2015) defines *social determinants of health* (SDH) as ‘the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources.’ SDH that may adversely impact on human health are, for example, poverty, social isolation, and various forms of discrimination, such as racism, sexism, classism, ageism, ableism, homophobia, transphobia, etc. *Transgender* or *trans* is an umbrella term for individuals whose gender identity, gender expression, or behaviour does not conform to that typically associated with the sex to which they were assigned at birth (Drescher et al. 2012: Supplementary Material). In this article the term *transgender* is used in reference to members of this group in general.
- 2 *Gender variance* or *gender variant* is a non-pathologizing way to describe individuals with gender atypical behaviour or self-presentations (Drescher et al. 2012: Supplementary Material). *Gender-affirming treatments* involve certain types of surgeries or hormone therapy, or both, as well as other treatments aiming at either feminizing or masculinizing the physical characteristics of the person in transition. Examples of these treatments are provided in this article in the section entitled ‘Transgender health needs’.
- 3 Led by the International Service for Human Rights and the International Commission of Jurists, a group of academics, judges, UN experts, and representatives of NGOs met in Yogyakarta, Indonesia, in 2006, to address the lack of explicit application of human rights law to sexual and gender minorities. Announced in 2007, the Principles do not assert new rights, but provide a coherent and comprehensive identification of governments’ responsibilities under existing international human rights law to respect, protect, and fulfil the rights of all people regardless of their sexual orientation or gender identity. Although they are not legally binding, they have been acknowledged by

The author will argue that the conditions that transgender people must often fulfil to avail themselves of vital medical care infringe on their rights to health and health care, and that promotion of transgender patients' autonomy is a key component to the realization of these rights.⁴ To achieve this, health care providers should make coordinated efforts to minimize existing social and institutional barriers, which restrict transgender people's choice in making routine or life-changing decisions regarding their health.

The discourse in this article is focused primarily on the health care system in Ireland, in particular the Health Service Executive (HSE) and the professional and regulatory bodies there which shape policy, standards, and delivery of care. Although Irish transgender people are experiencing a historic moment following the passage of the [Gender Recognition Act \(2015\)](#), they still cannot avail themselves of culturally sensitive care or an agreed treatment pathway. Therefore, the principal aims of this article are to provide an overview of the causes of health inequality experienced by this group and to identify possible ways to tackle them.

Research on transgender issues in Ireland is very scarce. Therefore, this article includes numerous comparisons with the USA and Europe, where appropriate, thereby providing a source of relevant scholarship, and helping to situate Ireland within the wider political, cultural, economic and legal context.

The author will begin by discussing transgender health issues and their sources, followed by an overview of health needs, both trans-specific and general. Further, he will analyse the barriers which transgender people encounter within health care delivery systems in the context of compliance with the recommendations of the Yogyakarta Principles in the following order: provision of equal access to health care; provision of the required services; implementation of policies of non-discrimination; education and training of health care professionals; provision of information; and, finally, promotion of patient autonomy that is not limited to health-related decision-making but transcends a wider notion of the *ability to choose*.⁵

many Western and Latin American governments like those of New Zealand, Canada, the Netherlands, Brazil, Uruguay, and notably Argentina, where, although not cited, they appear to underpin the Gender Identity Law (2012), considered to be the most progressive of its kind (Köhler et al. 2013). They have also been referred to by agencies of the United Nations (UNDP 2013) and by numerous NGOs in advocating the rights of sexual and gender minorities.

- 4 General Comment No. 14 of the UN Committee on Economic, Social and Cultural Rights (CESCR) (2000) states that 'the right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.'
- 5 Yogyakarta Principle 17 confirms the right to health and calls upon governments to fulfil this right through legislation, equal access to health care, adequate facilities, policies of non-discrimination, promotion of autonomy, information, and health care professionals' education in transgender matters. Principle 18 calls for protection against harmful medical practices based on sexual orientation or gender identity, including on the basis of stereotypes, whether derived from culture or otherwise, regarding conduct, physical appearance or perceived gender norms. This principle also forbids treating sexual orientation and gender identity as intrinsic disorders to be treated, cured or suppressed (Yogyakarta Principles 2007).

Transgender health and well-being—key issues

Transgender people's health and well-being issues can be derived from five principal sources: (1) social stigma, discrimination, and transphobia; (2) mental health issues; (3) self-perception and self-determination of identity; (4) the process of transitioning to one's authentic gender; and (5) general health issues.

The impact of social stigma and discrimination

As Lombardi (2001) noted, there is within societies a pervasive pattern of discrimination and prejudice against transgender people. Therefore, social stigma and discrimination are universally recognized as the main contributors to the prevalence of mental health and poor well-being issues among transgender people (Bockting et al. 2013). The majority of reports and articles cited in this article highlighted social isolation, stigma, rejection, and violence as being directly responsible for the widespread anxiety, substance misuse, self-harm, and even suicide, as well as the higher rates of HIV/AIDS, that affect many transgender individuals worldwide.

Discrimination and harassment can occur in almost every social setting. This constant feeling of threat and rejection may lead to physical and mental health issues. In Ireland, the recent report of the Transgender Equality Network Ireland (TENI 2014) revealed that 36 per cent of respondents experienced physical intimidation and threats or sexual harassment, and 16 per cent were physically assaulted because of their gender identity.⁶ The US National Transgender Discrimination Survey (Grant et al. 2011) revealed that 55 per cent of respondents lost their job due to gender bias, 51 per cent were harassed or bullied at school, 61 per cent were victims of physical assault, and 64 per cent of sexual assault. Globally, the Trans Murder Monitoring Project (TvT Project 2014) reported 1,612 killings of transgender people in 62 countries between January 2008 and November 2014—with 226 cases of killings reported in 2014 alone. There is no conclusive data illustrating the level of transphobia, discrimination, and violence against transgender people around the world. The situation varies greatly from one country to another and may be influenced by the political system, the level of legislative protection, social attitudes informed by religious and cultural tradition, and the strength of transgender-led social movements. However, all existing literature points to dramatic social and economic marginalization of transgender people across cultures and societies with negative consequences for their health and well-being. The rates quoted above are indicative of the dangers that transgender people must deal with on a daily basis and help explain the higher rates of mental health issues within this community.

Mental health issues

The main mental health issues identified by the Irish study's respondents (McNeil et al. 2013) were stress (83 per cent), depression (82 per cent), and anxiety (73 per cent). Moreover, 44 per cent admitted to self-harming at some point in life and six per cent admitted to currently self-harming. In the UK these rates were slightly higher at 53 per cent and 11 per cent respectively (McNeil et al. 2012). Furthermore, almost 80 per cent of the Irish respondents had considered suicide in the past. The Trans EuroStudy (Whittle et al. 2008)

6 The Yogyakarta Principles (2007) define *gender identity* as 'each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth'.

revealed that 29 per cent of transgender people within the EU had attempted suicide at some point in their lives. Another Irish study (Mayock et al. 2009) placed that figure at 26 per cent. These alarming figures serve as evidence that, regardless of the cause, transgender people are at a higher risk of developing mental health needs than the general population.

Self-perception as being transgender

Regarding mental health issues associated with being transgender, the available data is not conclusive. In the aforementioned Irish study (McNeil et al. 2013) 27 per cent of respondents felt that being transgender was detrimental to their mental health and 12 per cent felt it was beneficial. Interestingly, 46 per cent felt that being transgender had both a positive and negative impact on their mental health. On a wider European level 14 per cent of Trans EuroStudy respondents reported that they see being transgender as a disability (Whittle et al. 2008). These results suggest that the experience of being transgender in terms of being beneficial or detrimental to mental health and well-being is very complex. Given the widespread marginalization and violence reported in the larger studies (Grant et al. 2011; TENI 2014; TvT Project 2014), it follows that transgender people's negative opinions about themselves stem from negative public perceptions and from experiences of discrimination and transphobia. However, more research is needed to allow for a better understanding of the complexity of transgender identities and issues associated with self-actualization. Although the figures cited above indicate that some individuals do see being transgender as detrimental to their mental health, the existing studies from Ireland (McNeil et al. 2013) and the UK (McNeil et al. 2012) suggest that transitioning to one's affirmed or authentic gender alleviates discomfort.

The process of transitioning

The process of transitioning can be demanding and burdensome with potentially adverse health consequences. However, the end results appear to have predominantly positive outcomes. In Ireland, 81 per cent of those who have undergone some sort of gender-affirming treatments were more satisfied with their lives post-transition, while only five per cent declared dissatisfaction (McNeil et al. 2013). Nonetheless, some treatments like surgeries and prolonged hormone therapy do entail a potential risk of unwanted side effects that may have either temporary or long-term negative consequences on physical and mental health. Unfortunately, knowledge of the extent and severity of these effects is not conclusive due to the small number of large-scale, longitudinal studies available, and therefore the long-term health effects of transgender endocrine therapy, for example, remain uncertain (Feldman and Goldberg 2006). Furthermore, the transitioning process can place additional strain on family relationships as many family members and partners struggle to cope with this immense change, thus compromising further the health and well-being of some transgender people.

General health issues

Transgender general health issues resemble those of the rest of the population and depending on the stage of transition can be either male- or female-specific, or encompass both sexes. Feldman and Goldberg (2006) highlighted specific health issues which health care professionals should be aware of when assessing the health of their transgender patients. These may include risk of cancers (breast, cervical, endometrial, prostate), cardiovascular

diseases, diabetes, HIV and hepatitis B and C, osteoporosis, and sexually transmitted infections (STIs). These risks are common to the general population, although some like HIV are known to strike higher rates among transgender individuals. For instance, in the USA the estimated HIV prevalence in *male-to-female* (MTF) transgender individuals (or trans women) is 27 per cent (Herbst et al. 2008)—with overall HIV prevalence amongst the US transgender population four times the national average (Grant et al. 2011). These higher US rates are mainly associated with social marginalization of trans women, who often become sex workers and can be more exposed to the risk of contracting HIV. Given the higher rates of poverty and discrimination by health care providers reported in the larger studies, many transgender people resort to the use of non-prescribed hormones, self-performed surgeries (Grant et al. 2011; Rotondi et al. 2013), and self-injected silicone fillers with shared needles (UNDP 2013), all of which are extremely dangerous to health and possibly life-threatening.

The above examples illustrate that transgender people, although sharing common health issues with the rest of the population, are nonetheless more vulnerable to health risks due to stigma, discrimination, economic marginalization and, for at least some individuals, due to the potential side effects of gender-affirming treatments.

Transgender health needs

Transgender health needs can be divided into general and gender-affirming. Although all transgender people share general health needs with the rest of the population, including those concerning mental health, not all have trans-specific health needs since a small number of transgender people do not wish to alter their bodies by surgical or hormonal means (McNeil et al. 2013; McNeil et al. 2012).

Feldman and Goldberg (2006) postulated that the general health needs of transgender populations can be addressed in a primary care setting and usually comprise routine examinations, periodic screenings, general preventive care, HIV and STI preventive care, management of existing health problems, and provision of mental health care and counselling. More specialized care can include endocrine, gynaecologic, urologic, and reproductive health services (Coleman et al. 2012).

Gender-affirming treatments may involve certain types of surgeries or hormone therapy, or both, as well as other treatments aiming at either feminizing or masculinizing one's physical characteristics. Physical interventions may be fully reversible, such as a puberty-suppressing hormone therapy in adolescents; partially reversible, such as feminizing or masculinizing hormone therapy; and irreversible, such as genital and chest reconstruction surgeries (Coleman et al. 2012), henceforth referred to as *gender-affirming surgeries*.⁷ Other treatments include voice and communication therapy, electrolysis, other forms of

7 In this article, the term *gender-affirming surgeries* means irreversible surgical interventions aimed at affirming physical attributes of the sex associated with the authentic gender of a transgender individual in transition and usually, but not exclusively, may include penectomy (amputation of the penis) and vaginoplasty (creation of a vagina) in a male-to-female individual (or trans woman), and mastectomy (removal of breast tissue), phalloplasty (construction of a penis), and chest reconstruction surgery in a female-to-male individual (or trans man). Most medical professionals agree that these surgeries are reconstructive and do not include other types of aesthetic surgery, i.e. breast augmentation, facial feminization, etc. (Coleman et al. 2012).

hair removal, and laryngoplasty.⁸ There is also a range of cosmetic surgeries aiming at feminizing or masculinizing the individual's external features. However, cosmetic surgeries are generally not considered medically necessary by public health care providers and therefore fall outside the scope of this article.

The list of health needs that transgender people may have is long and suggests a higher utilization of medical care in comparison with that of the general population. Therefore, health care providers should meet these needs in order to fulfil transgender people's rights to health and health care in accordance with clinical evidence and international best practice.

Transgender health care based on human rights and international best practice

Yogyakarta Principles 17 and 18 stipulate the legislative, professional, and systemic requirements necessary for the fulfilment of the right to health of transgender people. This section will analyse these requirements and the level of compliance of the medical profession, policymakers, and health care delivery institutions, in Ireland in particular. The discussion will focus on seven themes of the Yogyakarta Principles' recommendations with regard to the realization of transgender individuals' right to health: (1) equal access to health care; (2) availability of adequate facilities and services; (3) policies of non-discrimination; (4) education and training of health care professionals; (5) access to information; and (6) promotion of autonomy.

Equal access to care

The many barriers hindering access to health care affecting transgender people in Ireland and other Western countries can be direct or indirect. Direct barriers systemically restrict access to certain services through eligibility requirements, medical necessity criteria, prohibitive cost, and restrictions on gender-specific medical services. Indirect barriers such as stigma and discrimination can obstruct or delay the provision of care or compromise its quality.

The following analysis will mainly focus on barriers that are intended to control access to transgender health services, in particular to gender-affirming treatments and their corresponding aftercare. Where applicable, the author will compare Ireland and the USA due to the political, economic, cultural, and legal similarities between the two countries. Also, given the lack of relevant Irish case law, this section will utilize selected examples from the USA and the European Court of Human Rights (ECtHR) due to their persuasive authority for the Irish courts.

This section will also briefly discuss the role of stigma and discrimination in denying medical care in general and the role that these barriers play in undermining equal access to the care many transgender people need.

Diagnosis

The issue of diagnosis as a precondition for access to gender-affirming treatments is highly controversial and has recently attracted a large volume of literature, due to the publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5),

8 *Electrolysis* refers to the use of shortwave electric currents to destroy the roots of hairs and so remove unwanted hair from the skin surface. *Laryngoplasty* refers to the plastic surgery operation to repair the larynx.

published by the American Psychiatric Association (APA 2013a), and the anticipated publication of the 11th Revision of the International Classification of Diseases (ICD–11) by the World Health Organization (WHO). There is disagreement among experts as to whether diagnosis can ease access to gender-affirming treatments by helping to justify their ‘medical necessity’. As Drescher (2010) pointed out, without diagnosis, these treatments may otherwise be seen as elective body modifications rather than corrective. Based on this argument, the APA retained the diagnosis of gender dysphoria in DSM–5 (APA 2013b).⁹ Furthermore, as Green et al. (2011) and Nichols (2008) rightly noted, there are some transgender people who genuinely suffer distress as a result of being gender variant or even see themselves as ‘disordered’. Therefore, appropriate diagnosis could assist them in accessing psychological support and care. And although transgender identification is not inherently dysfunctional or disabling, the potential lack of access to treatment could eventually lead to debilitating distress.

The counter-argument is largely based on the principle that gender variance is normal and does not require diagnosis, which has a social context rather than clinical and can be seen as a control tool (Drescher 2010). Therefore, Drescher et al. (2012) postulated that a psychiatrist’s involvement should be based on standards of care, clinical necessity, and health policies, rather than sustained by medical classification systems. In addition, there is an argument that rejecting a requirement of psychiatric diagnosis can, in some instances, remove a barrier to access to health care. For example, the removal of a diagnosis requirement for hormonal treatment may decrease the likelihood that potentially harmful ‘street’ hormones will be used (Winters 2005). However, it can be argued that diagnosis could help those who experience distress limited to being gender dysphoric, rather than those who have a strong, clear, and persistent gender identity and who only experience symptoms as society’s bias against transgender people or because of ongoing dysphoria due to persistent lack of treatment (Green et al. 2011).

Nevertheless, psychiatric diagnosis is traditionally derived from psychopathological notions regarding gender variance and can still be interpreted in those terms by physicians who control access to transitioning services. It also pertains to one ‘condition’ only, thus excluding other gender variances that may require some medical treatments but not all, and in so doing it reinforces inequalities in accessing these services. Presently, evidence of persistent and well documented gender dysphoria is still recommended by the World Professional Association for Transgender Health (WPATH), which is the leading authority on the care of transgender patients, as a precondition for hormone therapy and surgeries (Coleman et al. 2012).

Real-life experience

Currently the WPATH recommends 12 continuous months of living in a gender role that is congruent with the gender identity of a patient who wishes to undergo full genital surgery (Coleman et al. 2012).¹⁰ Although the WPATH argues that this particular requirement is based on expert clinical consensus, it does raise some concerns due to

9 The DSM–5 definition of *gender dysphoria* refers to the distress that may accompany the incongruence between an individual’s experienced or expressed gender and that individual’s gender assigned at birth (APA 2013a).

10 *Gender role* refers to the outward behaviours and dress that distinguish one as male or female (Drescher et al. 2012: Supplementary Material).

ambiguities regarding duration, lack of proper monitoring, and documentation of the process (Levine 2009). Moreover, the objective of the real-life experience may also be problematic in that it requires engagement in life either as a woman or a man and in so doing it implies a strictly binary concept of gender roles that may not be consistent with some transgender people's sense of gender identity. Moreover, this requirement also fails to account for the economic vulnerability of transgender people as they transition and may foreclose the possibility of affording transitioning care by potentially threatening secure employment.

Furthermore, evidence from Ireland and the UK (McNeil et al. 2013; McNeil et al. 2012) shows that only a very small number of transgender people are unsure about physical interventions and that the vast majority had made or wanted to make physical changes to their bodies. This indicates that the margin of uncertainty is very narrow and suggests that those who decide to undergo genital surgery do it consciously and out of necessity. Therefore the real-life experience test may be perceived to be just another hurdle that transgender people must overcome to access treatments necessary for leading fulfilling lives.

Prohibitive cost

In principle, the Irish, like the Americans, are expected to cover the cost of their own health care (Amnesty International 2011). The vast majority of transgender people who need access to gender-affirming treatments rely either on public or private health insurance cover, which is subject to strict eligibility criteria. In Ireland, treatments such as laser or voice therapy are generally available in private health care facilities only, which require private insurance cover (McNeil et al. 2013). The results of the only Irish study to date on access to health services for transsexual people (Collins and Sheehan 2004) revealed that other treatments, such as gender-affirming surgeries, also had to be funded from private resources.¹¹ The referral and funding for treatments not available in Ireland, such as gender-affirming surgeries, were possible under the Treatment Abroad Scheme (TAS) and considered on an ad hoc basis. There is no available data detailing how many such applications the HSE receives per year. However, figures obtained under freedom of information legislation revealed that between 1999 and 2014 the HSE provided funding for gender-affirming surgeries under TAS to 49 patients only (McDonald 2014). Collins and Sheehan (2004) found that other treatments, such as cosmetic surgeries, electrolysis, and body hair removal, were paid in full by the patients, with a very small number of cases funded by either a local health board or a private health insurer.

In the USA, the Patient Protection and Affordable Care Act (2010) provides the American transgender community with access to a more affordable and fairer health insurance market. The Act prohibits denial of cover by insurance companies in receipt of federal funding on the basis of pre-existing conditions, such as gender dysphoria. However, the Act covers broad categories of benefits and in many US states insurers uphold exclusions regarding some trans-related treatments on the basis of their not meeting the medical necessity test. In Ireland, Collins and Sheehan (2004) found that the

11 Collins and Sheehan's (2004) report concerned transsexual people only. *Transsexual* is a term used to describe an individual who has undergone or intends to undergo gender-affirming surgery, either *male-to-female* (MTF) or *female-to-male* (FTM) (Drescher et al. 2012: Supplementary Material).

principal reason for the refusal of funding was that these treatments were not considered medically necessary.

Medical necessity review

The argument of medical necessity can be a powerful tool in granting or withholding access to transitioning treatments. The WPATH (Coleman et al. 2012) firmly defended the view that these treatments are necessary for many transgender people to lead normal and fulfilling lives, and has been cited by US courts in granting access to them, like in the case of *Kosilek v. Spencer* (2014). The clinical evidence also confirms that gender-affirming treatments are effective in treating gender dysphoria (Smith et al. 2005). Nonetheless, many Western health care providers and private insurers still use the medical necessity review for the purpose of denying insurance coverage for these treatments.

In the USA, most states have restricted funding coverage to at least some interventions (mainly gender-affirming surgeries) on medical necessity grounds, and private insurance companies follow suit (Khan 2011). Historically, the negative decisions of US state authorities regarding the funding of these treatments were legally challenged with mixed results. In *Doe v. Minnesota Department of Public Welfare* (1977) the Minnesota Supreme Court found that total exclusion of 'transsexual surgery' from eligibility for state funding was void because the ban was directly related to the treatment involved rather than to the evaluation of medical necessity of the intervention. However, in the more recent case of *Smith v. Rasmussen* (2001) the court upheld the refusal to fund, stating that although surgery may be necessary in some cases, it is permitted to refuse funding if other treatment options are available or if there is a lack of consensus in the medical community. This ruling is an example of legally condoning the arbitrary powers of the authorities and insurers to decide which treatment pathway is appropriate and which is not. Nonetheless, since the US Department of Health and Human Services (2014) lifted the federal ban on the Medicare funding of gender-affirming surgeries, a growing number of US states have now introduced bans on trans-related treatment exclusions in health insurance plans (USA, NCTE 2015), and it seems that the Patient Protection and Affordable Care Act (Government of USA 2010) has accelerated this process.¹²

In Europe, although selected trans-related treatments are funded by the EU member states (Whittle et al. 2008) many transgender people rely on private health insurance. However, the European health insurers also use the medical necessity review in determining eligibility for the cost of these treatments to be covered. This policy has been challenged in the European Court of Human Rights in *Van Kück v. Germany* (2003). In its judgment the court stated that the requirement to prove the medical necessity of gender-affirming treatment for insurance purposes was unreasonable, and in so doing provided a robust human rights argument against this policy across Europe, including Ireland.

Khan (2011) considered claims of the high cost of transitioning treatments and their selective applicability to gender variant people to be the principal reasons that authorities and insurers alike refer to the medical necessity review, and highlighted the need for a policy recognizing the diversity of health needs among transgender individuals. As for the consequences for transgender people, the recent US study (Grant et al. 2011) revealed that 48 per

12 According to the National Center for Transgender Equality (USA, NCTE 2015), ten states and the District of Columbia (DC) banned trans-related exclusions by July 2015: California, Colorado, Connecticut, Illinois, Massachusetts, New York, Oregon, Vermont, Washington State, and Nevada.

cent of respondents postponed care because they could not afford it. Many turn to cheaper but unsafe methods, such as unregulated use of hormones, which can be very harmful (Lombardi 2001; UNDP 2013). Therefore it can be concluded that questioning the medical necessity of gender-affirming treatments for the purpose of not providing funding is one of the principal barriers to equal access to transgender health care.

To address the problem the WPATH (2008) issued clarification on the medical necessity of gender-affirming treatments and insurance coverage in the USA, which, given the international reputability of this organization, can be applied to other Western jurisdictions. The WPATH reaffirmed its professional opinion regarding the benefits and effectiveness of these treatments based on decades of clinical evidence. It also stressed that the differences in treatment needs must be determined on an individual, not 'one-size-fits-all', basis. The WPATH once again stressed that gender-affirming treatments are not 'cosmetic', 'experimental', or 'elective'. Finally, the organization urged health insurers and health care providers to eliminate transgender exclusions to ensure that transgender care is equally accessible.

Restrictions on gender-specific medical services

As some care is gender-specific, many transgender individuals who are transitioning or have undergone transition to their authentic gender may still require medical care specific to their sex assigned at birth. For instance, trans men (*female-to-male* transgender) may develop ovarian cancer and trans women can develop prostate cancer (Feldman and Goldberg 2006). Therefore, medical services restricted to sex assigned at birth need to be accessible to transgender people, both in and post-transition.

Although there is no reliable data concerning post-transition access to gender-specific medical care, it is very likely that some health care providers, in particular those which are community based, may not be comfortable, for example, to provide gynaecological care, like cervical smears and so on, to trans women. Therefore gender-specific health care providers should be inclusive of individuals who do not fit easily within the sex-segregated categories (UNDP 2013). The need for this inclusion is best illustrated by the case of an American trans man who died of ovarian cancer after he was denied access to such services. This case prompted the Feminist Women's Health Center in Atlanta to extend its services to trans men by setting up its Trans Health Initiative, which serves as a good example of trans-inclusive health services (Bader 2009).

Stigma and discrimination

Last but not least, stigma and discrimination are among the greatest barriers to transgender people's equal access to medical care. This problem manifests itself in many forms of discrimination, and the ways to combat it will be discussed in a subsequent section. However, it is important to highlight here the issue of the outright denial of care. This problem appears to affect general care in particular, where some ill-informed and prejudiced physicians simply do not want to treat their transgender patients. In the USA around 20 per cent of transgender people were refused care at least once due to their being transgender (Grant et al. 2011; Kosenko et al. 2013). The refusal rates for Ireland and the UK are 11 per cent and 12 per cent respectively (McNeil et al. 2013; McNeil et al. 2012). These examples represent the unacceptably high level of violation of the fundamental moral, ethical, and professional duty of every physician—that is, to provide adequate care to patients who seek it, regardless of who they are, how they look, or what lives they lead.

Availability of services

Availability of medical services plays a crucial role in the delivery of equal health care and access to these services usually depends on resources and demand, which in turn determine the range of services provided. This includes specialized treatment pathways, the availability of professional knowledge and expertise at hand, and their geographical proximity.

Services and treatment pathways

As previously shown, the health needs of transgender people may be of the general and gender-affirming type. General health care should be readily available to everyone and respectful of social diversity. The provision of specialized care is more challenging as it requires more stringent justification and is largely dependent on the existence of professional expertise and adequate resources. Gender-affirming treatments fall within the categories of specialized care, therefore their availability is limited. The lack of recognition of the need for transgender health care on the part of policymakers and the medical establishment further impedes its availability.

The only Irish report to date examining the issues surrounding transgender people's access to health care compiled by *Collins and Sheehan (2004)* found that the majority of transgender care treatments were available in Ireland with the exception of gender-affirming surgeries. The former Irish health boards provided treatments within the scope of in-house expertise or through referrals abroad.¹³ What was lacking then was a clear treatment pathway, encompassing mental health and endocrine services, operating on a national level. Almost ten years later *McNeil et al. (2013)* found that the range of services available to Irish transgender people had not changed since 2004, and despite the recent HSE-led initiative to fill this gap (*Government of Ireland 2013*), as of 2015 the transitioning treatment pathway is yet to be developed.

Professional knowledge and expertise

The availability and the standard of care are also determined by the knowledge and expertise of health care professionals. However, studies confirm that there are huge levels of ignorance and a severe lack of experience in transgender health among health care professionals. In the USA a staggering 50 per cent of the National Transgender Discrimination Survey respondents reported having to teach their medical providers about transgender care (*Grant et al. 2011*). In Ireland, expertise in transgender care is severely limited. According to the support website of the Transgender Equality Network Ireland (*TENI 2015*) there were only four endocrinologists in the country with expertise in hormone therapy for transgender patients, and only a handful of psychologists working with transgender people. The *McNeil et al. (2013)* study also found that there was no gender dysphoria specialist in the Republic of Ireland. *Mayock et al. (2009)* also noted the lack of dedicated service providers while pointing out that those who possessed some level of the necessary expertise did not have a primary responsibility to transgender patients. The *HSE (2009)*, in its only report on lesbian, gay, bisexual, and transgender (LGBT) health care issues to date, has identified the absence of a designated gender specialist, as well as a limited provision of psychological support and gender-affirming treatments. These reports confirm

13 Irish regional health boards were replaced by the centralized Health Service Executive (HSE)—a government agency established in 2004 for the provision of public health care nationwide.

that this situation is the result of the absence of transgender care from national policy and planning and from the education and training curricula.

With regard to the provision of general care, many writers suggested that existing expertise can be adapted to the needs of transgender patients. [Feldman and Goldberg \(2006\)](#) provided a comprehensive set of guidelines for primary care physicians concerning a range of transgender health issues and their corresponding standards of care. They range from health assessment, prevention, screenings, and management of existing conditions, to feminizing or masculinizing medical interventions. The authors highlighted the importance of evidence-based decision-making, such as applying knowledge from non-trans settings to transgender patients as relevant to the clinical context. For example, the knowledge of hormone therapy for post-menopausal females may be relevant to over 50-year-old trans women who are taking similar hormones. [Roberts and Fantz \(2014\)](#) have also agreed that primary care providers should be able to deal with co-morbidities associated with long-term hormone use as this falls within the scope of primary care.

Geographic location

Access to transgender health care may also be restricted by its geographical location. The previously cited Irish studies ([Collins and Sheehan 2004](#); [Mayock et al. 2009](#); [HSE 2009](#); [McNeil et al. 2013](#)) all highlighted that the vast majority of trans-related care is concentrated in the Dublin metropolitan area, leaving the rest of the country virtually devoid of any transgender services. Again, this situation is common in other countries, where transgender health care services are sparse and usually located in large urban centres ([UNDP 2013](#)).

Although the author acknowledges that it is not feasible to provide the same level of access to transgender care locally, there are ways to make it more accessible. The health care professionals who took part in [Collins and Sheehan's \(2004\)](#) study emphasized the need to develop a single specialized care team, which could establish relationships with community-based physicians and coordinate the provision of transgender care as well as taking referrals from the rest of Ireland. This model has been implemented in other small European countries, such as Latvia, where a single team coordinates treatments for all of its citizens ([Fundamental Rights Agency \(FRA\) 2010](#)).

Policies of non-discrimination

Most writers agree that stigma and discrimination are the most formidable barriers to equal access to health care for transgender people. In the USA many transgender people experience gender insensitivity, displays of discomfort, verbal abuse, and even demands of forced psychiatric care ([Kosenko et al. 2013](#)). The Irish ([McNeil et al. 2013](#)) and UK ([McNeil et al. 2012](#)) studies also revealed that the vast majority of respondents suffered discrimination while seeking medical care.

Institutional discrimination

[Poteat et al. \(2013\)](#) confirmed that structural and institutional discrimination restrict opportunities of stigmatized people and ensure that transgender experiences are virtually absent from the education and training of physicians, leading to ambivalence and substandard care. Moreover, patients' experiences of discrimination can compound or exacerbate mental health problems leading to their postponing seeking medical care or not doing so at all.

In Ireland 40 per cent avoided seeking urgent mental health care due to previous negative experiences (McNeil et al. 2013). In the USA 33 per cent of transgender people postponed preventive care due to discrimination and disrespect (Stroumsa 2014). This widespread mistreatment of transgender people calls for strict non-discrimination policies in accordance with national legislation based on human rights obligations.

Legislation and professional codes

Despite all governments' responsibility to enact non-discrimination legislation inclusive of gender identity, the [Employment Equality Act \(1998\)](#), [Equal Status Act \(2000\)](#), and [Equality Act \(2004\)](#), which are the principal anti-discrimination laws in Ireland, do not explicitly mention gender identity under prohibited grounds for discrimination. By extension, the existing institutional policies and professional codes also seem to omit gender identity from their scope.

Although the [HSE \(2009\)](#) acknowledged that stigma and discrimination are key transgender health issues, it failed to acknowledge the problem of potential discrimination on the part of its staff. The [HSE National Healthcare Charter \(2012\)](#)—a statement of commitment describing what patients can expect when using health services in Ireland—does not include gender identity under 'respect and dignity'. Likewise, the codes of professional conduct and ethics of the two main professional groups—medical practitioners, and nurses and midwives—do not explicitly mention gender identity. The latest version of the Medical Practitioner's Code (Ireland, [Medical Council 2009](#)) is very general in stating in Section 5.1 that all patients must be treated with respect for their dignity, and in Section 9.1 that care must never be refused on the basis of personal discrimination. The new code for nurses and midwives (Ireland, [NMBI 2014](#)) also fails to explicitly mention gender identity. This is contrary to the recommendations given by Collins and Sheehan in their 2004 report, which called on the HSE and regulatory and professional bodies to introduce policies based on non-discrimination—a document that the [HSE \(2009\)](#) itself later recommended for immediate implementation, but to no avail.

It must be stressed that discrimination against patients on any grounds violates the core principles in biomedical ethics as it harms the patient and therefore should be subject to disciplinary procedures. Many writers like [Lombardi \(2001\)](#) and [Shaffer \(2005\)](#) highlighted the importance of non-bias in the provision of care to transgender patients and called on health care providers, institutions, and practitioners alike to promote zero-tolerance for discrimination and denial of care. Therefore, to be effective, any non-discrimination legislation, institutional policy, and professional codes must be inclusive of gender identity.

Education and training of health care professionals

The majority of writers agree that awareness of transgender issues plays a key role in the delivery of care. Respondents to recent studies in Ireland ([McNeil et al. 2013](#)), the UK ([McNeil et al. 2012](#)), and the USA ([Grant et al. 2011](#); [Kosenko et al. 2013](#)) all confirmed that the lack of knowledge and expertise of health care providers in dealing with transgender patients is one of the main causes of those patients' negative experiences while seeking medical care. [Poteat et al. \(2013\)](#) also claimed that physicians' ignorance about trans issues makes them ambivalent about transgender care and undermines their medical authority in public perception, which reinforces their negative opinions about transgender health.

In Ireland, McNeil *et al.* (2013) confirmed cases of disrespect, insensitivity, and incompetence. However, the most crucial issue this study highlighted is that of physicians not recognizing the gender identity of their patients. The numbers are staggering: 37 per cent of respondents experienced their gender identity treated as a symptom of mental illness; 19 per cent were told they were not really transgender; 26 per cent were discouraged from exploring their gender; 16 per cent experienced hurtful or insulting language; and 19 per cent said that their primary physicians refused to discuss or address trans-related health concerns. The report concluded that although these results expose the discrimination which exists, they also reveal a simple lack of understanding due to inadequate knowledge of trans issues and lack of professional experience. These results also highlighted two target areas that need addressing: the content of educational curricula, and awareness of trans issues among professionals.

Including trans issues in education curricula

In Ireland, it is the responsibility of third-level educators and professional and regulatory bodies to define the scope and content of health sciences teaching and training programmes. Therefore, the current system of programme accreditation should at a minimum actively promote inclusion of gender identity as part of cultural competence modules. Collins and Sheehan (2004) placed a particular burden on professional bodies in driving this change due to their accrediting powers. Despite this, however, the current accreditation standards for medical (Ireland, Medical Council 2010) and nursing (Ireland, NMBI 2005) postgraduate curricula do not explicitly require inclusion of any LGBT-related content.

As recent research in the USA suggests, exposing medical students to LGBT health needs is particularly important in tackling the existing bias against LGBT patients. Burke *et al.* (2015) reported that over 45 per cent of self-identified heterosexual medical student respondents expressed at least some explicit bias, and over 81 per cent at least some implicit bias, against gay and lesbian people. In Ireland, there is very little research on the level of awareness of LGBT health needs among students and qualified practitioners. A small survey of specialist registrars (Donohue 2011) found that the majority of its respondents had no specific undergraduate or postgraduate training in equality and diversity matters in general. Another small-scale case study (Spencer 2014) revealed a striking lack of recognition of the value of cultural competence and a very low awareness of it among undergraduate students. Both of these studies were concerned with diversity only in the context of ethnicity, nationality, religion, and cultural background, and did not include sexual orientation or gender identity in their scope.

For the purpose of this article, the author examined publicly available online listings of medical and nursing modules in five major Irish medical schools and found a complete lack of explicit reference to LGBT matters and that separate cultural competence/sensitivity modules were rare.¹⁴ Although it is possible that LGBT-related topics form part of clinical and cultural competence training nonetheless, it is impossible to be conclusive due to lack of publicly available policy documents and an in-depth research examining the content of medical and nursing curricula in Ireland, which could confirm this.

14 Online module listings containing module titles, descriptions and their learning outcomes were examined in the following medical and nursing colleges: University College Dublin; University College Cork; University of Limerick; National University of Ireland, Galway; and Royal College of Surgeons in Ireland.

In the USA as in Ireland, there is no specific requirement to include LGBT matters in medical curricula. Nonetheless, a recent large survey (Obedin-Maliver et al. 2011) revealed that the majority of medical schools in the USA and Canada did teach LGBT topics, with over 30 per cent reporting teaching about gender transitioning and nearly 35 per cent about gender-affirming surgeries. In addition, some educators established centres of excellence for LGBT health, like the University of California, San Francisco, and the Fenway Institute, serving as sources of information and expertise available to transgender patients, medical care providers, and educators alike.

There is no doubt that establishing at least one educational centre specialized in LGBT patient care by one of the major Irish third-level educators would advance the knowledge of LGBT health in Ireland. However, given the lack of evidence of institutional initiative, this article asserts that the accrediting bodies should include an explicit requirement for the inclusion of LGBT care in the content of medical and nursing curricula—thus setting a national standard.

Training of general practitioners

A separate issue is that of general practitioners (GPs), who in many countries, including Ireland, act as the first point of contact and control access to specialized medical care. Therefore they should be aware of trans health issues and be prepared to deal with transgender patients in their practice in a knowledgeable and sensitive manner. Yet the only two guides for GPs endorsed by the Irish College of General Practitioners (Allen 2013; Psychological Society of Ireland 2015) omit transgender patients from their scope. Furthermore, there is no evidence of specific training being offered to Irish GPs.

Literature from the USA provides examples of specialized training frameworks. Goldberg (2006) suggested employing a three-tier approach to transgender care and clinical education, which includes basic, intermediate, and advanced core competencies. The basic care requires very general competencies applicable across disciplines; therefore mandatory training should involve building transgender sensitivity and awareness with the use of gender competency models used in health care education. Intermediate training entails not just awareness but also knowledge and skill and can help GPs to understand specific health needs and coordinate referrals. Advanced training could be open to physicians with substantial experience in working with transgender patients and may include endocrine therapy in its scope. Those who complete this level can help in forming the network of GPs specialized in transgender care.

In a different approach, Ahmadi et al. (2013) proposed two-step interdisciplinary short-term courses focusing on the social determinants of the health problems of marginalized populations, which could provide more in-depth understanding of the special health needs of transgender people. This model could be incorporated into the continuous professional development (CPD) of all medical practitioners.

Regardless of these proposals, specialized training cannot be implemented without the required local expertise necessary for its delivery, which in turn, cannot be achieved without including transgender care issues in education and training curricula in the first instance.

Promoting professional and institutional awareness

Collins and Sheehan (2004) called on the Irish Department of Health, the HSE, and professional bodies, to develop and implement transgender care training and awareness

programmes. The HSE (2009) pledged to implement these recommendations and to distribute and promote LGBT good practice guidelines. However, the 2012 survey of HSE-employed health care professionals which was led by the Transgender Equality Network Ireland (TENI) and HSE (Government of Ireland 2013) found that although 90 per cent of respondents had not had specific training in providing services to transgender people, 32 per cent knowingly provided such services, while only 19 per cent declared themselves to have a 'good (or expert) knowledge of trans issues'. Interestingly, the vast majority acknowledged the need for better awareness of transgender care, as 74 per cent wanted training and 75 per cent wanted further information on trans issues. These results indicate that more needs to be done professionally and institutionally to end transgender invisibility in the provision of medical care in Ireland.

Literature from the USA, although mainly in the context of HIV/AIDS care, suggests that nurses can become agents of change. Keiswetter and Brotemarkle (2010) proposed that where policymakers are slow to act, a head nurse could coordinate sensitive care and staff education on a ward or unit level. They also suggested the use of information pamphlets from which other staff could learn how to provide gender competent care. Shaffer (2005) also highlighted the importance of educating staff from the front desk all the way up to executive directors. Nonetheless, all of these efforts require institutional goodwill and professional competency of the coordinator. Therefore it is crucial that the profession's new entrants acknowledge the legitimacy of transgender issues and are trained in the provision of gender sensitive care. Furthermore, health care providers should identify staff with relevant knowledge and expertise who could share it with their colleagues, and in so doing raise their awareness of trans issues and promote good practice on an institutional level.

Access to information

Awareness requires information; therefore, in order to facilitate transgender people's access to health care and to raise awareness of trans issues amongst health care professionals, information must be readily accessible for both groups. However, many physicians struggle to find a reliable source of information regarding transgender care or where to refer their patients even in countries where transgender care pathways do exist, as exemplified in the recent study from Canada (Snelgrove et al. 2012). The aforementioned 2012 TENI–HSE survey results (Government of Ireland 2013) strongly suggest that Irish physicians are also left in the dark.

As for the patients, Yogyakarta Principles 13 and 17 call upon the state and its agencies, such as the Irish HSE, to provide information regarding treatments and their corresponding cost-cover options. Collins and Sheehan (2004) recommended that health service providers should implement information strategies on gender variance phenomena, available services, and how these can be accessed. They also stressed that these strategies should include provisions for transgender people's families and friends. To date, the HSE (2014) has included gender dysphoria, with its symptoms, diagnosis, and available treatments, in its online Health A–Z database. Yet its presentation is not as accessible and user-friendly and does not include corresponding guidelines like its UK counterpart (NHS 2014), which provided the content for the HSE webpage.¹⁵

Furthermore, the author of this article suggests that HSE information should also include a directory of local general practitioners (GPs) with experience in working with transgender people, and that the TENI website could serve as a good template (TENI 2015).

The above discussion confirms that more needs to be done to ensure that transgender people are informed about medical services that are available and how to access them. Physicians should also be able to quickly find information on transgender health needs and their corresponding treatment options.

Promotion of patient autonomy

The previous analysis focused on practical means of minimizing the existing barriers hindering access to and delivery of care for transgender people. However, this cannot be achieved without respecting and effectively promoting the autonomy of transgender patients through respecting their fundamental human rights, observing ethical principles, recognizing trans experiences, and contextualizing transgender patients' autonomy.

Respecting human rights

International human rights law situates promotion of patient autonomy at the centre of the delivery of health care. Yogyakarta Principles 17 and 18 safeguard transgender people's rights in a health care setting and aim at protecting them from unnecessary, degrading, or forced treatments by means of enumerating governments and their agents' responsibilities to make coordinated efforts to promote respect for patient autonomy. Furthermore, international human rights experts clearly oppose all requirements for the purpose of recognizing transgender people's gender identity that violate their rights to privacy, family life, and bodily integrity (Council of Europe Commissioner for Human Rights 2009).

Observing ethical principles

Principles of biomedical ethics forbid physicians to act against the wishes of their patients or to inflict harm. Advocates of the so-called principlism in biomedical ethics such as Gillon (2003) believe that the principle of respect for autonomy should be 'first among equals', not least because it is a necessary component of aspects of the other three: beneficence, non-maleficence, and justice.¹⁶ Consequently, this article asserts that it is unethical for any health care professional to demand or engage in the provision of medical interventions, such as forced sterilization or psychiatric evaluation, which are contrary to the wishes of their transgender patients. In light of clinical evidence (WPATH 2008) it is also unethical not to recognize transgender people's self-determined identities and their corresponding health needs, or to deny the medical necessity of treatments that aim at alleviating the life-impeding incongruence between the body and the gender identity of a transgender patient.

15 The National Health Service (NHS) Health A–Z database also includes a 'Real Stories' section, containing videos of transgender people sharing their experiences of gender dysphoria and their encounters with health care professionals.

16 Beauchamp and Childress (2013:106–10) defined the respect for autonomy as an acknowledgement of 'people's right to hold views, to make choices, and to take actions based on their personal values and beliefs'. In regard to medical care such respect 'involves acknowledging the value and decision-making rights of persons and enabling them to act autonomously'. Therefore the principle of respect for autonomy is correlative to the patient's 'right to choose' and, consequently, its observance and fostering is a 'professional obligation' of health care providers.

Furthermore, it is unethical to discriminate against transgender patients based on personal prejudices or social stigma associated with gender variance phenomena, since institutional discrimination restricts their opportunities and choices (Poteat et al. 2013).

Recognizing trans experiences

In order to effectively promote transgender patient autonomy, health care providers must first acknowledge a patient's gender identity and legitimate health needs. Therefore this article contends that the lack of such recognition is the underlying cause of transgender people's inability to avail themselves of transition-related medical treatments or general care without the risk of discrimination. To promote patient autonomy the health care professionals must feel confident, not ambivalent, about providing medical care to a member of any marginalized group.

Contextualizing transgender patient autonomy

Entwistle et al. (2010) highlighted the importance of relational accounts of autonomy that consider the patient's autonomy in situations beyond decision-making and acknowledge ideas that individuals are always located within a broader social context. Therefore, for example, dismissive and judgmental comments may impair autonomy and signify disrespect. This wider concept of autonomy entails having a choice and an opportunity to have one's health needs recognized. Although many physicians rightly oppose the notion that patients should be able to 'request' any medical treatment, the idea that they should be allowed to make voluntary choices is extremely important (Entwistle et al. 2010). In the context of respecting transgender patient autonomy, the crux of the problem is not to *allow* the transgender person to choose whatever treatment they like, but to *enable* choice by recognizing their gender identities as legitimate and their health needs as medically necessary.

Therefore this article postulates that the effective promotion of transgender people's autonomy must include three essential components. First is the recognition of self-determined transgender identities and a patient's corresponding health needs, which can empower transgender patients to make appropriate health choices and raise awareness of their needs amongst health care providers. Second is enabling choice by making services available, providing information about them, and ensuring equal access to them. Third is responding to transgender people's health needs by always providing care of the highest possible standard, which is inclusive, respectful, gender sensitive, and not compromised by any bias (Maguen et al. 2005).

Conclusions

As demonstrated, transgender people worldwide are a vulnerable population due to stigma, transphobia, discrimination, and economic marginalization; therefore they display higher rates of mental health needs than the general population. Also, for many, the process of transitioning to their authentic gender is physically, emotionally, and economically demanding, which leads to a high need for medical care. Therefore, the many health needs of transgender people require unhindered access to health care.

The Yogyakarta Principles (2007) call upon governments to provide equitable health care to their transgender citizens who often experience ignorance, incompetence, and discrimination while seeking medical care. Furthermore, they must overcome many systemic

barriers including restricted access to trans-related services, or outright denial of any care due to prejudice and bias of the health care providers.

In Ireland, the availability of trans-related medical services, adequate knowledge and expertise, and gender sensitive care in general are limited and to date there is no agreed transgender treatment pathway. Therefore, following Collins and Sheehan's (2004) recommendations and examples in other European countries, the Health Service Executive (HSE) should establish a single specialized team to coordinate transgender health care nationally by creating networks of general practitioners and local specialists and taking referrals from them.

The problem of stigma and institutional discrimination should be tackled by means of implementing zero-tolerance policies and their corresponding disciplinary procedures, while professional codes of practice should explicitly confirm that discrimination on the basis of gender identity is a violation of the core principles of biomedical ethics.

To address the matter of inadequate knowledge of trans issues and the lack of professional expertise, education and training programmes' accrediting bodies and educators should include gender diversity as a mandatory requirement in health sciences curricula. This is particularly important in relation to general practitioners, who act as the first point of contact and gatekeepers of specialized care.

In parallel, policymakers and institutional and individual health care providers should actively promote awareness of trans issues and the best standards of care. They should also provide information to health care professionals and to the transgender community and their families and friends regarding issues, support, and available treatments, in an easily accessible and user-friendly manner.

Health care providers must recognize transgender people and their corresponding health needs as legitimate and in so doing empower them and enable their choice to make health decisions according to their needs. Finally, medical professionals should respond to these needs by means of ensuring equal access and the highest standard of care that is evidence-based, competent, non-biased, and gender-sensitive.

Furthermore, despite the much-deserved emphasis on the issues of discrimination and violence against LGBT people in the work of key human rights organizations, more effort is needed to help 'mainstream' transgender health needs. Although recent publications by Amnesty International (2014) and Human Rights Watch (McLemore 2015) advocate for the right to health of transgender people in Europe and the USA in the context of gender recognition or HIV/AIDS prevention policy, the scope of human rights campaigns should encompass all barriers limiting transgender people's right to health analysed in this article.

Moreover, human rights organizations should closely cooperate with transgender advocacy and support groups to ensure wider impact on policy and law reform as well as societal attitudes towards transgender health needs. Due regard should be given to exposing human rights activists to issues concerning social determinants of transgender people's health, and the recent publications by UN Development Programme (UNDP 2013) and ILGA Europe (2015) can serve as good sources of information.

Finally, more research is needed to ensure comprehensive and reliable reporting on transgender health concerns. Therefore human rights organizations should actively promote, support, and engage in research concerning transgender matters, thereby helping to generate much needed data and boosting awareness among the academic community, health care providers, and society generally.

These coordinated efforts of all aforementioned agents will minimize systemic barriers to equal access to medical care and will directly contribute to the promotion of a wider autonomy of transgender patients. Only then can the rights to health and health care of transgender people be truly realized.

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