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HEALTHCARE PROVISION OF SEXUAL AND GENDER MINORITIES IN SLOVENIA

Legal Regulations and Hospital Practices

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The article provides an overview of the legal regulation of the right to health and medical procedures in Slovenia for people of diverse sexual orientations, gender identities/expressions, or sex characteristics. It also presents hospital practices and the perceived relationship between patients and medical staff. Three objectives are pursued: to provide a comprehensive overview of Slovenian gender and sexual orientation legislation and hospital policies; to investigate how legal norms and hospital policies are implemented in clinical practice; and to highlight the ethical challenges perceived by healthcare workers and patients as a result of social diversity. Several types of data were reviewed: relevant legislation, internal documents from Slovenian general hospitals, documents from the Advocate of the Principles of Equality and the Human Rights Ombudsman, medical literature, and literature from non-governmental organizations. The reviewed and analyzed data indicate that some hospital staff lack the necessary skills to work with vulnerable groups, despite the fact that discrimination is prohibited by law and that cultural competency training is occasionally provided to healthcare professionals.

Keywords: professional ethics, sexual and gender minorities, vulnerable populations, public hospitals, medical anthropology, Slovenia

Introduction

The 2021 Guidelines for Psychological Practice with Sexual Minority Persons (American Psychological Association 2021) defines the term “sexual minority” as “a group of individuals whose sexual and affectual orientation, romantic attraction, or sexual characteristics differ from that of heterosexuals. Sexual minority persons are inclusive of lesbian, gay, bi+ (e.g., bisexual, pansexual, queer, fluid), and asexual identified individuals” (American Psychological Association 2021: 3, 57). More general dictionary definition defines the term “sexual minority” as “a member or members of the LGBTQ+ community, used especially in the context of discrimination against or advocacy for a minoritized sexual orientation, gender identity, or gender expression” (Sexual minority 2023). For most people, gender identity is congruent with the sex assigned at birth; for transgender and gender nonbinary individuals, gender identity differs in varying degrees from the sex assigned at birth. Sex is typically categorized as male, female, or intersex (i.e., sexual anatomy that combines or is atypical of male and female characteristics) (American Psychological Association 2021:

57). The term “sexual minority” was first recorded in 1975–1980 (Sexual minority 2023). It has not always been accepted by the LGBTQ+ community because it evokes unequal social status or because it refers specifically to sex when it should refer to gender, such as in transgender, transsexual, and asexual people. Nevertheless, it has become an umbrella term for a variety of groups whose sexual identity, orientation, or practices differ from the majority, as well as for intersex people.

Several studies have noted the existence of implicit bias in medicine, specifically prejudice, stigmatization, and discrimination against sexual minorities (Fallin-Bennett 2015; Baptiste-Roberts et al. 2016; Kamen et al. 2019; Logie et al. 2019; Waryold et al. 2020; Guerrero-Hall et al. 2021; Casanova-Perez et al. 2021; Apodaca et al. 2022; Hall et al. 2022; Russell et al. 2022; van Heesewijk et al. 2022; Khaleghi et al. 2023). Sexual minorities respond to discrimination and unfair treatment in a variety of ways: they fight back, flee, apologize, or circumvent prejudice. Long-term consequences reflect several types of coping: delaying or avoiding care, switching healthcare providers, self-prescribing, covering up behaviors, experiencing health complications, and distrusting healthcare providers (Apodaca et al. 2022). At the same time, physicians, particularly those in gynecology and obstetrics, acknowledge that they feel inadequately prepared to meet the medical needs of sexual minorities (Guerrero-Hall et al. 2021) and that cultural competency training is required to boost their self-assurance and ability to treat transgender and gender-diverse patients (Kreines et al. 2022). By citing this example, it becomes clearer why it is important to address sexual minorities in the context of healthcare. This can strengthen advocacy for their rights related to their sexual orientation, gender identity, or gender expression and help identify, understand, and reduce discrimination against them.

The research was conducted as a part of the HERA 2019–2022 project, “Health as a Public Space: Social Integration and Social Diversity in the Context of Access to Health in Europe.” The project looked at the ethical concerns surrounding diversity in healthcare at the level of European and Slovenian legislation, hospital policies, and individual perceptions of access to healthcare, discrimination, and prejudice against vulnerable groups in clinical practice by public hospital managers, health professionals, and patients.

The data collection took place in four phases.

a) The topic of anti-discrimination of sexual minorities in healthcare was searched in the portal of the Legal Information System of the Republic of Slovenia (PISRS) for all applicable Slovenian laws and other public documents issued by state bodies and public authorities in the Republic of Slovenia, as well as by the institutions of the European Union and the Council of Europe. To find relevant legal acts, search terms such as “health,” “healthcare,” “minority,” “gender,” “sex,” “vulnerable,” “discrimination,” and “equal opportunity” were used.

b) The grey literature review included the annual and special reports of the Advocate of the Principles of Equality of Republic Slovenia and the Human Rights Ombudsman, as well as those of Slovenian civil society organizations advocating for social and systemic change based on respect for sexual orientation, gender identity,

and/or gender expression, such as Legebitra and TransAkcija) In 2020, internal records were collected from both the two (2) university clinical centers and the twenty-three (23) general hospitals in Slovenia. The sample did not include privately owned hospitals or hospitals with partial concessions. The two methods for obtaining hospital policy documents were an email request to the director and administration of the hospital or online access.

d) Eighteen (18) semi-structured interviews were conducted from July 2021 to March 2022 with Slovenian healthcare professionals and patients from vulnerable groups. The purpose of the interviews was to learn more about the subjective viewpoints of healthcare workers and patients on the subject of discrimination in healthcare. The medical professionals, some of whom were also middle managers in the hospitals, were physicians specializing in gynecology, surgery, dentistry, palliative care, psychiatry, and psychology (N=10), as well as a nurse (N=1), a social worker (N=1), and a language interpreter (N=1). Among the respondents belonging to sexual minorities were homosexuals (N=3) and a transsexual (N=1). One respondent (N=1) belonged to another vulnerable group (highly qualified foreign workers). Due to the coronavirus epidemic, five (5) interviews were conducted in person, and the rest (13) were conducted remotely (online). One interview with a medical interpreter was conducted in both English and Slovenian; one interview with a foreign worker was conducted in English; the rest of the interviews were conducted in Slovenian only. The interviews, which lasted approximately 120 minutes each, focused on ethical issues arising from the problem of diversity in everyday healthcare practice, specifically on the following issues: a) awareness of and experience with discrimination in accessing healthcare, b) systemic and cultural barriers to accessing healthcare, c) knowledge of legal and institutional norms related to discrimination, and d) suggestions for improving the situation. Respondents were also asked about their experiences with possible multiple forms of discrimination in healthcare due to various personal circumstances. Members of sexual minorities and other above-mentioned members of vulnerable groups were asked about discrimination due to their personal circumstances in healthcare, as well as positive experiences and satisfactory treatment. They were asked to describe what made them feel good about receiving healthcare. Similarly, health professionals were asked to report on culturally sensitive treatment approaches and the lack of systemic support in treating vulnerable groups. All respondents gave their informed consent before participating in the study and had the option to decline to answer any questions, to stop at any time without repercussions, and to request that the personal information gathered be destroyed; however, none of them chose to do so. The researcher who conducted all of the interviews – the author of this paper – transcribed them as soon as they were finished.

The data obtained were analyzed step by step and separately at each stage. First, an analysis of European and Slovenian legislation was conducted (2019 and 2020), then the hospitals' internal documents related to discrimination were classified and reviewed (2020 and 2021), and finally, a qualitative content and narrative analysis of previously anonymized and coded interviews was conducted (2022).

The results, presented in the following main part of the article, consist of five chapters: the general presentation of “Access to the healthcare system and discrimination against sexual and gender minorities in Slovenia,” “National legislation and access to healthcare in relation to gender-specific circumstances,” “Gender reassignment procedures in the Slovenian healthcare system,” and, additionally, “The story of a transgender person and her experience with the Slovenian healthcare system,” “Intersex individuals in medical procedures,” and “Healthcare of homosexual men who are infected with HIV or have AIDS.”

Access to the healthcare system and discrimination for sexual and gender minorities in Slovenia: general findings

The overview of the current situation regarding access to the healthcare system and discrimination against sexual and gender minorities in Slovenia shows that while the legal framework and general access to healthcare are sufficient, there are some systemic barriers, individual biases of healthcare personnel, and sporadic cultural incompetence that occasionally occur. The needs of sexual minorities are rarely specifically addressed or mentioned in hospital policy documents; rather, these needs are typically covered by general legal prohibitions against discrimination based on personal circumstances.

The majority of interviewed medical personnel did not perceive direct systemic exclusion or discrimination against sexual minorities. The medical professionals who took care of patients with their psychosocial needs (for example, social workers and psychologists) and also focused on their specific complaints about what they consider to be discriminatory treatment were the most receptive to this issue.

The issue of which hospital room a trans person “belongs” in was raised in discussions with two physicians (a palliative care physician and an abdominal surgeon) who have not yet treated transgender people, or at least none who identified as such while receiving treatment. By asking the patient whether they would prefer to be in the men’s or women’s ward or room, the doctors would address this issue in accordance with bed availability. Some physicians (including an abdominal surgeon and a dentist) considered the treatment of sexual minorities unproblematic because, in their opinion, the body parts they treated were not directly related to their particular personal circumstances.

On the other hand, the sexual minority respondents reported, albeit in small numbers, direct homophobia, inappropriate communication, stigmatization, prejudice, and other individual discriminatory behaviors and attitudes. In response to questions about their experiences receiving medical care in hospitals, individuals from sexual minorities have expressed a variety of discomfort culminating with the refusal of care by medical personnel. Cases reported to the Advocate of the Principles of Equality, an independent and autonomous state body tasked with combat-

ing discrimination established in 2016 and operating on the basis of the Protection Against Discrimination Act (PADA), and the Human Rights Ombudsman, as well as publications by LGBTQ+ groups, also indicate discrimination by medical staff, although prohibited by legislation and the hospital's internal documents.

National legislation and access to healthcare in relation to gender-specific circumstances

Slovenian law includes provisions on equal treatment and the elimination of discrimination that take gender-specific circumstances into account. The principle of equal treatment is anchored in the Slovenian legal system and thus also in the healthcare system.

First, equal human rights and fundamental freedoms are guaranteed to all people, regardless of their national origin, race, *sex*,¹ language, religion, political opinion, material situation, birth, education, social status, or other personal circumstances, according to Article 14 of the Constitution of the Republic of Slovenia. All people in Slovenia are equal before the law according to the Constitution (The Constitution of the Republic of Slovenia 1991).

In 2016, the Protection Against Discrimination Act was adopted, and a new autonomous, independent state body, the Advocate of the Principle of Equality, was established to deal with discrimination. The general provision in Article 1 of the Protection Against Discrimination Act broadens the range of personal circumstances in determining the protection of every individual against discrimination irrespective of their *gender*, nationality, race or ethnic origin, language, religion or belief, disability, age, *sexual orientation*, *gender identity* and *gender expression*,² social status, economic status, education or any other personal circumstance in various areas of social life when enforcing human rights and fundamental freedoms, exercising rights and obligations, and in other legal relationships in political, economic, social, cultural, civil, or other fields (The Protection Against Discrimination Act 2016).

Discrimination is expressly forbidden in the healthcare system by law, and procedures are regulated to minimize it. In the Health Services Act, Article 45 (The Health Services Act 2005) determines that healthcare and allied professionals shall provide healthcare services in accordance with accepted medical doctrine and within the code of medical deontology or within other professional and ethical codes. In performing their work, they must treat everybody under the same conditions and in the same way and respect their constitutional and legal rights. The only measure of priority is the urgency of the medical procedure.

In addition, Article 7 of the Patients' Rights Act, which follows the diction of the Constitution, prohibits discrimination and mandates the right to equal medical

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treatment for all patients regardless of *sex*, nationality, racial or ethnic origin, religion or belief, disability, age, *sexual orientation*,³ or other personal circumstances. Article 3 of the Patients' Rights Act sets out the principles for the exercise of patients' rights. Those principles are respect for physical and mental integrity and safety; protection of the greatest health benefit for the patient, especially children; respect for autonomy in making decisions about treatment; and respect for personality and dignity in such a way that no one is socially affected by his or her state of health and the causes, consequences, and circumstances of that state or the resulting medical treatment (The Patients' Rights Act 2008).

Further, Article 12 of the Patients' Rights Act deals with the right to a medical procedure or treatment. This act states that a patient is entitled to a medical procedure or treatment carried out at the expense of public funds when, according to the rules of the medical profession and modern medical doctrine, it is necessary to expect, with good reason, that it will be beneficial for the patient and that the expected benefits for the patient will outweigh the risks and burdens (The Patients' Rights Act 2008). Article 8 of the Patients' Rights Act on the protection of children and other vulnerable groups stipulates in paragraph 3, the second indent, that medical treatment of children shall be appropriate for the age and state of health of the child, without unnecessary medical interventions and actions that could cause physical or mental suffering for the child (The Patients' Rights Act 2008).

Gender reassignment procedures in Slovenian healthcare system

According to Grm et al. (2019), gender affirmation or medical transition is a complex process during which a person makes the transition from one gender attributed to him or her at birth to another gender he or she feels like his or her own. The purpose of the transition is to affirm one's own sexual identity. Medical confirmation of gender identity or medical transition includes psychological/psychiatric assessment, hormone therapy, upgrading or building of secondary sexual characteristics, and gender affirmation surgery. It depends on the individual transgender person which of the following procedures he/she wants to perform during the medical transition process. The process of medical transition during gender identity confirmation in Slovenia includes treatment in various health fields. The treatment in psychiatry and clinical psychology is mandatory in the Center for Mental Health, Dispensary for Sexual Health at the University Psychiatric Clinic in Ljubljana, while other areas come into consideration according to the needs and goals that a transgender person wants to achieve through the medical transition. Obtaining a diagnosis of a gender identity disorder, transsexualism – F64.0 (ICD-10) – is necessary to continue the process of confirming gender identity in Slovenia (Grm et al. 2019: 26,

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27). Transsexualism is a medical classification listed by the World Health Organization in the “Mental, Behavioral and Neurodevelopmental Disorders” section under the category “F64.0” or “Gender Identity Disorders.” Transsexualism is defined as a desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one’s anatomic sex and a wish to have surgery and hormonal treatment to make one’s body as congruent as possible with one’s preferred sex (ICD-10, F64.0, 2016: 327). The other gender identity disorders from the same classification are dual-role transvestism (F64.1), gender identity disorder of childhood (F64.2), other gender identity disorders (F64.8), and unspecified gender identity disorder (F64.9) (ICD-10, F64.0, 2016: 327–328).

A survey on the lives of transgender persons in Slovenia was conducted in 2019 by Koletnik et al. The survey included 113 transgender persons between the ages of 14 and 50, with the majority of participants, 83% overall, falling into the 14–30 age range. The survey reveals that the vast majority of persons (63%) were uncomfortable receiving a diagnosis of a mental health disorder. Nevertheless, they prefer to have this diagnosis and be in the process of medical transition and/or have personal documents in order rather than nothing. 19% of the participants did not care about receiving the diagnosis, 13% wanted the diagnosis and 6% were very uncomfortable receiving the diagnosis, respectively (Koletnik et al. 2019: 6, 23, 24, 27). The process of medical transition and legal recognition of a “new” gender is thus not separate. Then the transgender person obtains the necessary referrals for specialists or a letter of recommendation from a psychiatrist and personal doctor. With those documents and referrals, they can go to specialists, including endocrinologists and plastic surgeons (Grm et al. 2019: 27).

In general, and according to a survey from 2019 (Koletnik et al.), the experience of transgender people in medical treatment shows various forms of discrimination or unpleasant experiences due to their gender identity and/or sexual expressions, such as the use of incorrect pronouns (50%), ignorance of basic information on transgender issues (48%), invasive and inappropriate personal issues (37%), pronounced lack of knowledge about transsexuals in the relevant professional field of healthcare (36%), use of the wrong name (35%), inappropriate comments about the body/parts of the body (27%), unprofessional interest in the person and his/her body (23%), refusal to use correct pronouns (22%), ridicule and insults (16%), and 5% of persons also experienced a call for a genital examination, although this was not medically necessary. Thus, 5% of persons experienced sexual harassment during medical treatment. Transgender people, just like LGBTQ+ people, very often experience in healthcare that their problems, which led to them seeking medical help or information, are understood in the perspective of transgenderism, i.e., they acquire a negative connotation even if a particular health issue is not related to their gender identity. At the same time, medical staff very rarely have a positive attitude toward transgender people, and they also lack the knowledge and skills that would enable them to receive professional treatment from transgender people, regardless of the reason for their visit (Koletnik et al. 2019: 27–28).

Another research from Perger in 2021 points out that Slovenian transgender persons' experiences with the healthcare system outside the period of the COVID-19 epidemic, especially with healthcare services related to medical transition, are mostly positive (Perger 2021: 72). The primary healthcare level is the one with most positive experiences for transgender individuals. In general, positive experience is characterized by healthcare professionals being perceived as engaged, showing interest if not knowledgeable about the field of transgenderism, and at the same time approaching the treatment of transgender persons sensitively, with awareness and consideration for the discomfort that a gynecological exam may bring. Respect for gender identity is also reflected in the use of appropriate names and pronouns by some of the medical staff (Perger 2021: 72).

Further, the research highlights that transgender people often have low expectations of treatment in the context of healthcare: Frequently, not having a "horrible" experience is enough for the experience to be right or "positive." Transgender persons also have ambivalent experiences in healthcare. The range of these experiences is from "correct" to "negative." The negative experiences are those that contain too much discomfort and unease to be considered right. It is not necessarily that such an experience includes transphobia, even if it borders on it. In short, it is a borderline experience that includes, for example, "well-intentioned practices" and situations that are particularly uncomfortable (e.g., gynecological exams for transgender men or sexually non-binary people) (Perger 2021: 73). In the context of negative experiences, transgender people often experience transphobia. This can include exoticization, where transgender people are addressed as "rare trophies" and as such are a source of special "pride" for healthcare workers, which does not always translate into accurate and respectful interactions; pathologizing, misuse of names and pronouns (sometimes despite repeated warnings), to situations of forced disclosure of transgender identity and invasions of privacy. Negative experiences also include a lack of knowledge on the part of medical professionals (e.g., ignorance of the difference between intersex and transgender people), which often forces transgender people into educational tasks that they experience as stressful. Transgender people avoid experiencing transphobia in three ways. First, through practices aimed at avoiding or minimizing contact with the public health system, at least in part (e.g., through the use of self-paid services), through the avoidance of health services, and through the practice of confrontation (e.g., through formal complaint procedures). Avoidance of health services and anticipation of transphobia are the most problematic experiences of transphobia for transgender people. However, some people also report actively caring for their own health regardless of transphobia, with various support networks playing an important role (e.g., friendships and their support) (Perger 2021: 73, 75).

Concerning medical transition, transgender individuals point to the following positive aspects: the existence of the possibility to perform medical transition within the public health system, legislation that supports transgender identity, and the for-

malization of an interdisciplinary Council. Among the negative aspects, they highlight the other features or weaknesses of the Slovenian health system. In relation to specific health services, they emphasize the ambiguity of medical transition procedures, where they are exposed (Perger 2021: 73) to different timetables and successive steps of medical transition or insufficiently standardized procedures, including difficult access to information about the medical transition process and the lack of information and inconsistency of medical professionals. In this context, they point to the absence of various options in the course of the medical transition, namely the absence of the possibility of an appeal procedure (which refers to the period before the formalization of the Council), the absence of the possibility of obtaining a second opinion and of choosing between different but equally qualified medical professionals (Perger 2021: 74).

An important negative feature of the medical transition is also the length of procedures, including the cancellation of already scheduled appointments for medical treatment. The long procedure is also reflected in irregular but necessary endocrinological examinations. The length of the procedure contributes to the constant pressure from transgender individuals on medical staff to get things done in the foreseeable future, but these tasks can be quite stressful for a transgender person in the face of anticipated transphobia. The more important element of the negative aspects of medical transition is represented by the “psychiatrization and psychologization” of medical transition. This part is the most burdensome and refers to various practices of judging the legitimacy of transgenderism based on criteria that are not perceived as justified or appropriate (e.g., criteria of age, sexual normativity, presence of concomitant diseases, etc.), as well as other practices including lack of adequate psychological support. With such practices by health professionals, it is difficult for a transgender person to establish a sufficient level of trust and sense of safety for psychological and/or psychiatric treatment to be truly supportive (Perger 2021: 74). According to Perger (2021), at the time of the epidemic COVID-19, transgender individuals experienced some difficulties in accessing secondary health services [the secondary level includes specialist outpatient and hospital activity; added by the author]. At the primary level, there was no failure of health services as health workers responded appropriately. However, at the secondary level, transgender persons experienced cancellations of elective (non-essential) health services (in line with epidemic-related measures), including cancellations or irregular provision of mental health services. Healthcare workers’ unresponsiveness and delayed appointments were the factors that have led to a specific form of uncertainty for transgender persons, especially those in the early stages of medical transition, as the “end result” of transition has been pushed into the unpredictable future. Transgender individuals who had largely completed the process of medical transition and only needed services to “maintain” the situation did not perceive major changes in their ability to access the healthcare system (Perger 2021: 74).

The story of a transgender person and her experiences with Slovenian healthcare

For illustrative purposes, a transgender woman's experiences and her perceptions of discrimination in the healthcare system are presented separately in this chapter. The interviewee I spoke with in September 2021 gave me three specific instances of disrespectful communication based on her gender and appearance, and these examples perfectly capture the complexity of the problem at the center of this study. Her story represents a subjective experience while providing insight into other people's perceptions and opinions. The narrative is used here to examine the transgender patient's perspective on illness, the role of the doctor, and the importance of the doctor-patient relationship. It also serves as an ethical case study. The information presented in this narrative coincides with research conducted by LGBT and other institutions in Slovenia also mentioned in this study.

First, she mentioned that as a transgender person, she's very afraid of going to the doctor and that for her, this is always a decision that she considers critically and carefully, weighing in advance whether she really needs a doctor: *"I avoid a doctor like a minefield. As a transgender person, I'm afraid to go to any doctor, not just the emergency room, because I've had bad experiences, and going to the doctor brings me more problems than benefits. I'd rather not go. For self-protection reasons, it's better for me to solve a lot of things myself than to go to the doctor."* She then referred to a case when she had to go to the ER for appendicitis and described the communication in detail. The doctor told her during an ultrasound, *"Yeah, the uterus is fine. Obviously, there is some bloating in there because I can't see that well, but it's fine."* And then my interviewee said to herself, as a transgender woman who has a penis, takes hormones, but hasn't had gender reassignment surgery, *"Yes, if my uterus is fine, then I'm very happy."* The doctor saw her as having a uterus that she didn't have just because she looked like a woman. She commented that from a doctor's point of view, anything else was impossible. The interviewee reported the shock and despair that this statement caused her, in addition to her health condition. The doctor, who was supposed to be an expert, had, in her opinion, no idea what he was doing, and the examination was a complete misunderstanding of her condition. And this was not the only case.

In another example, again involving the emergency room, she mentioned having gone in because she had peed blood, and *"that's a nightmare for a trans person. Something about the genitals of non-normative people is a situation where I can expect a clash, so I had a partner who is also queer, a non-binary person, speak for me because otherwise, I would hit someone. If I want to be treated, I'll be patient and take all those tests, but overall, I had a really bad experience. When I went to the clinic where these problems are treated, a young doctor examined me very quickly, laid me on my side, and asked if my kidneys hurt. I was not in pain; I was just peeing bright red. I read on the Internet that it's a bad sign when nothing hurts and you're peeing blood. It was so stressful for me to be naked for the exam, but because my pee was bloody, I had to undress. The doctor patted me down*

really quickly and then left. I had such a bad feeling, and I told it to my partner because I didn't know if my health file mentions I am a trans woman. Sometimes some doctors know I am trans, but most of the time they do not. I do not know where it's written or how they find out, maybe they know me from the media or they suspect it. I think they can tell from my medical records because it is medically relevant. But if it's not recorded, that's concerning because that information is health-related."

The interviewee also mentioned that she thinks it is important for people to know how to behave. "Because doctors still think that a person with a penis is a man and a person with a vulva is a woman. As long as that is the case in medical textbooks, it will be a disaster. It will be a disaster. They seriously believe that we, as we are, cannot really exist, given the concepts they have and the taboos with which they treat patients. We do not belong anywhere in such a binary system because it is so essentialist and reduced to a part of the body. That's why all my experiences with doctors have been like that. With this doctor, I wondered if he understood that I was trans or not. So, my partner walked down the hall, knocked on the doctor's door, and asked him, 'Excuse me, do you understand that my friend is a trans woman?' And the doctor replied, 'Yes, and no. But it does not matter anyway, because tomorrow you will go to a specialist for dermatovenerological diseases, and you will tell him everything there,' in the sense that he would want to say, 'I do not care.' And that's a common reaction, you know; they have some information that they cannot deal with, and they would rather avoid dealing with it. But when confronted with the facts, they give completely stupid answers, like 'Yes, and no.' What does 'yes, and no' mean? And that changes everything. The doctor came back ten minutes later, peeked in, and asked, 'Excuse me, stupid question, but do you have a penis? And you are a partner?' 'Yes, yes,' we tried to tell him for a long time. 'But, of course, yes'. And he says, 'Oh, but that changes everything because that's different bacteria.' Yes, of course, because I know that. But you know what I mean, you have to be two steps ahead of them and think about a possible flaw in the system because I am trans. And I know I am not going to get the same service as the others. Because all the knowledge they have is based on the idea that there are only cisgender people in the world. The fact that I am trans should be on the record; why should I disclose it to him? It is not up to me to tell him that I am a transgender woman. I did not tell him I was trans at the beginning of the examination because that would have put me in a situation where I had to reveal myself all the time. In a transphobic society, I have to face such situations with other people. Not just theoretically, but in every concrete situation."

The interviewee then goes on to describe additional instances in which she had to deal with doctors. "The fact that some transgender people are denied medical services is another issue. I haven't experienced that. However, I am aware of a transgender patient who, after undergoing gender reassignment surgery in Belgrade, went to the emergency room because something was seriously wrong; however, in Ljubljana, the staff refused to assist her. When the doctor realized the patient was transgender, he declared, 'I'm not going to do that, just go home.' [This person then sought help in a private clinic in Ljubljana.] Therefore, I don't out myself as trans right away for fear of getting into trouble. Because of the discrimination in the healthcare system, some people believe that only some people have rights and others do not. To put it simply, that is discrimination. I don't judge,

and nobody has bad intentions. When I discuss my experience, I do not judge this man; instead, I evaluate his attitude. I start to doubt whether I should have come at all in every instance where the doctor is uninformed. Why am I even here if this man doesn't know anything about me? I will then have to think for him. Anyone can read on the Internet that, regardless of how urgent it may be, peeing blood requires a visit to the emergency room. Despite the fact that I am aware that I will go through this, it still affects my psychological well-being because a week after the examination with such an attitude, I experience panic attacks. I picture a doctor in that situation asking his co-workers, 'Do you know what happened to me?' [Here, the interviewee caricatured the doctor in a silly voice.] I'm not referring to this specific doctor; rather, I'm saying this generally. The culture in healthcare is such that when a nurse sees a health card with a man's name on it but me looking like a woman, she may address me wrong. This is an illustration of how the nurse views me. People don't always have a binary appearance that corresponds to their gender identity or to their sex and sexual attractiveness. For instance, if I go alone, nobody even notices that I'm trans; they just address me as Mrs. But if I go with my partner, who is obviously queer, has different hair colors, etc., I am treated differently; they treat me more like a punk and immediately use a more intimate form of address. It is a completely different behavior simply because people judge others by appearance. They judge a lot by appearance. Doctors are such people who should not judge but should be available. We should not force people to be normative, either physically or with their lives, and judge because they think they are in the right. You can feel it.

So, the next day I went to the dermatovenerologist, who was cool. I explained to him that I am a sex worker and that it is possible, that it is risky, and that I had done a little research on the Internet. He did not force me to get checked out, and he asked me, 'Can we take a look?' I agreed, 'Yes, we can,' because I thought it was important that someone finally take a look at me. But then when I lifted my skirt, you know how he reacted! He exclaimed in amazement, 'O!' [The interviewee imitated the doctor in a high-pitched voice.] It was a remark about my body. His assistant, who was sitting behind him, stood up and looked over my shoulder at my genitals. I was lying down at the time. I thought: I am a sex worker; at least pay me if you are going to look at me like that. Ten euros if you look at me like that. The nurse was surprised by the doctor's 'O!', and, out of curiosity, she got up and looked. I didn't say anything. Why would I tell someone they were not acting professionally? I was there in the role of a patient and not in the role of an activist, but I am still constantly deprived of some rights. It was so shocking that I was at a loss for words, plus I did not expect this because the beginning of the examination was fine and correct. It was insulting, but they will never admit that their behavior is wrong. I must discern and know when it's worth saying something and arguing with someone and when it's not. I know if I react, I won't get anything out of it. Otherwise, I can fight all the time, but I don't want to, plus I don't have the strength every time I go to the examination. If you fight with them, they'll humiliate you even more. They're defensive. But that's how it was throughout the transition. When I left the dermatovenerology room, I went to the nurse who was going to make my next appointment. And she taught me not to come in when I've got my period because it's very important. I tell her that's not a problem because I don't have my period.

I don't have any. But she was like, 'No, but, you know, it's not okay because then it destroys the tests. You have to be really careful to catch the date. If you suspect that the date isn't going to go well...' 'Ma'am, I don't have my period. You can give me the card and I'll go.' She just didn't let go because I looked like a woman, like a person who is cisgender. That hurts me a lot. She didn't mean any harm; she was just doing her job. She just doesn't know that there are people who don't necessarily have their periods. How can you tell at first glance? Who knows I'm trans? What if I was going through menopause? And I also don't know if the health card says I'm trans. Because if she saw that, she'd probably know how to act right. [A nurse cannot determine from the information on the health card whether a patient has changed sex. Only a number on the identity card contains the legal information regarding gender identification. Otherwise, this information is only available to doctors who are actively involved in the medical gender affirmation process.] Transgender people in healthcare are an outrage. I didn't want to explain to her that this was the second time I'd have to explain that I am transgender at the same examination; I just wanted a card, and then I left.

The story of this transgender person doesn't end there. The interviewee goes on to describe the mammogram and ultrasound examinations. *"When I came in for a mammogram as a person who was classified as male at birth, the radiologist said, 'Hey, what about you here? Why are you here?' I said I was here for a mammogram, and he said they couldn't do that. Then I told him that I was discharged from psychiatric treatment because I'm transgender, and he was surprised. 'Oh, you're trans? Really?'" [She mocked the doctor with a fake, happy, deep voice.] Finally, he didn't take a mammogram picture of me but just looked, and we talked for five minutes because he had never met a transgender person and I had to explain everything about myself to him. He expected me to tell him everything, he calmly asked me about my genitals, who I was, just everything. I taught him a lesson about what transgender people are. It wasn't a physical check-up; I didn't even get a mammogram. He groped me a little bit and asked, 'Why do you even need that? I don't even know what to look for.' [She imitated his calm voice.] This is what the doctor told me. And so, it was similar when I had to go in for an ultrasound of my abdomen because that's what you have to take before you get hormones, and everyone thought it was a mistake and just wanted to see my condition. The doctor scolded me, 'What hormones?!' 'Yes, hormones, because I told you I'm a transgender person and I'm going to have hormone therapy.' 'Really, or what?!' [She mocked his glee-surprised voice.] There was nothing on the electronic referral, I assume, because this psychiatrist of mine writes that it's like everyone knows what it's about, but really no one does. So transgender people are sent to health centers all over Slovenia, but nobody knows who a transgender person is or how to act toward them. So, they ask you for information they don't have. The doctors are asking you for information they don't have, and you have to be your own expert to make them understand why they're here and what they have to do, what their role is. That shouldn't be the patient's role. Absolutely not. The patient comes and gets a service. Period. Society doesn't want systemic change, so we're subject to transphobia. At the beginning of my transition, I explained a lot, I felt obligated to explain everything about myself, really everything. And I communicated a lot. But over time I've come to the point that I don't have*

the energy to explain anymore, and I don't think that's my role either." (Representative excerpts from an interview with a transgender person, recorded in September 2021)

We lack a better picture of how frequently patients with unique personal circumstances encounter similar situations in their interactions with the healthcare system, and we lack other qualitative information on how healthcare workers' attitudes affect the 60–70 or so outspoken transsexuals estimated to exist in Slovenia, and the 250–300, who, according to the interviewee, annually seek assistance from non-governmental organization. In any case, the data presented above attest to the blatantly unprofessional conduct of some health professionals and their lack of familiarity with this population's needs. This group of sexual minorities is therefore likely to have received paternalistic, insufficient, and generally subpar treatment and care, leaving medical facilities feeling humiliated and with their dignity damaged. In addition, no one systematically compiles data on other psychosocial factors, such as the impact of social, occupational, and family environments, that may affect treatment outcomes. For instance, in rural areas, openly identifying as transgender and going through the transition is more challenging and socially unaccepted than in urban areas.

Intersex individuals in medical procedures

According to the United Nations (UN), the number of newborns with sexual signs of intersex is between 0.05 and 1.7 percent of the total population, and in Slovenia, about 4–5 intersex children are born every year. The frequency of sexual development disorders in Slovenia is 1 in 4500 (Položaj interspolnih 2020a: 7).

In 2019 a group of non-governmental organizations gave the initiative to the Advocate of the Principle of Equality of the Republic of Slovenia to examine the position of intersex persons in relation to human rights violations or unequal treatment due to a personal circumstance of a sexual sign (Summary 2020). For the study, the Advocate sent 31 written enquiries to key healthcare institutions and competent state authorities (patients' rights representatives, the Ministry of Health, the National Medical Ethics Committee, the National Institute of Public Health, the Ljubljana Maternity Hospital, the Gynecology Clinic of the University Medical Center Ljubljana, the Clinic for Gynecology and Perinatology of the University Medical Center in Maribor and the Clinic for Pediatrics in Maribor). The results of the enquiry indicate, among other things, the unfamiliarity of stakeholders with cases of medical treatment of intersex persons; ambiguity and inconsistency of non-urgent medical interventions in the sexual signs of intersex persons and reliance on a subjective judgment of "social acceptability" as a criterion for deciding on medically non-essential sex adjustment operations (Summary 2020: 38).

In Slovenia, as in other countries, a few intersex children are born every year. These are newborns with physical characteristics where their sex cannot be defined as female or male because they may have underdeveloped or atypically developed

sexual organs, disorders in the development of the gonads or a chromosomal and hormonal structure that differs from the majority. Those children may be subject to various forms of human rights violations from birth, because they were born with such physical characteristics that – according to established medical and/or societal norms – their sex cannot be defined as female or male. This was also noted by the European Parliament and the Parliamentary Assembly of the Council of Europe, which adopted specific resolutions on protection against discrimination and the human rights of intersexual persons (Promoting human rights 2017; European Parliament resolution 2019). The resolutions also contain guidelines and recommendations to ensure the protection of human rights and the right to equal treatment of intersex people, including in the field of healthcare for intersex people.

Based on analysis, the Advocate of the Principle of Equality prepared a special report on how the protection of human rights and the right to equal treatment of intersex people in medical treatment procedures are ensured in Slovenia.

The Advocate of the Principle of Equality noted, among other things, that several Slovenian healthcare institutions are unaware of the meaning of the term “intersex,” which in his opinion calls into question the understanding of intersex people’s rights to equal medical treatment as required by the Patient Rights Act (Položaj interspolnih 2020b). Instead, medical institutions use the medical terms: “disorders of sex development” (DSDs), “newborns with unclear sex,” “same-sex persons,” “children with changes in sexual development,” “intersex persons,” “children with ambivalent sexual organs” (Položaj interspolnih 2020b). The Medical classification uses the term “indeterminate sex and pseudohermaphroditism.” The Advocate of the Principle of Equality follows the opinion of the Council of Europe (Agius 2015), the European Parliament (European Parliament resolution 2019) and the European Union Agency for Fundamental Rights (The Fundamental Rights Situation 2015), which have called for a review of medical classifications which unnecessarily medicate intersex traits. The medical term is controversial because it affects people’s experience and impacts the choice and use of healthcare providers. “Intersex” is used as an umbrella term to denote the number of different variations in a person’s bodily characteristics that do not match strict medical definitions of male or female. These characteristics may be chromosomal, hormonal and/or anatomical and may be present to differing degrees. Many variants of sex characteristics are immediately detected at birth or even before. Sometimes these variants become evident only at later stages in life, often during puberty. While most intersex people are healthy, a very small percentage may have medical conditions that might be life-threatening if not treated promptly. In medical terms, some of these variants are grouped under “disorders of sexual development.” However, this is rejected by many, including activists and intersex people themselves, who perceive it to be stigmatizing and pathologizing. It should also be noted that some intersex people may not wish to identify as such (The Fundamental Rights Situation 2015: 2).

It is clear from the 2019 medical institutions’ responses to the Advocate of the Principle of Equality that they perceive intersexuality as a pathology, as a disease that

must be treated. The Advocate of the Principle of Equality pointed out the tendency of the medical profession to classify intersex persons as male or female as soon as possible, which is also a consequence of the requirement in the Civil Register Act (2011) according to which the birth and sex of a child must be reported to the competent administrative unit within 15 days.

In Slovenia, intersex children and adolescents may also undergo non-essential and unhealthy surgical procedures that attempt to make their sexual characteristics as similar as possible to those that are considered normal for male or female bodies in society. This can lead to a variety of health and psychological problems (e.g., persistent infertility, pain, incontinence, loss of sexual desire, and various forms of psychological stress) (Položaj interspolnih 2020b). When asked about diagnostics, surgical procedures and their necessity, the answer was given by the Pediatric Clinic of the University Medical Center Ljubljana and the Clinical Department of Perinatology of the University Medical Center Ljubljana, where medical treatment is performed for all Slovenian hospitals due to the rarity of this pathology and the need for a multidisciplinary approach. The Pediatric Clinic of the University Medical Center Ljubljana and the Clinical Department of Perinatology of the University Medical Center Ljubljana replied that surgical procedures are performed in childhood or adolescence. At the Pediatric Clinic of the University Medical Center Ljubljana, they decide on surgery and possible hormonal treatment or other treatment according to international guidelines and point out that the timing of the procedure may be important for maintaining fertility and/or significantly reducing the risk of malignancy. The Clinical Department of Perinatology stated that in Slovenia, we have an agreement that the sex of a child is determined within two days after birth based on an examination, a genetic test, or on the basis of the diagnosis made. Surgical interventions are not necessary, but in some cases, it is necessary and recommended (Položaj interspolnih 2020b: 25, 26).

The key findings from the analysis of the responses received from healthcare institutions indicate: ignorance of the term intersex among some stakeholders, including patients' rights representatives; ignorance of stakeholders with cases of medical treatment of intersex people; surgical procedures are performed in childhood or adolescence; the sex of the child is determined within a few days after birth based on an examination, genetic testing and diagnosis; the decisions of the competent departments of healthcare institutions are based on current medical guidelines, while there is a lack of adherence to an approach that would ensure comprehensive protection of human rights (human rights-based approach); surgical interventions are also performed for the sake of "social acceptability", although they are not necessary to ensure the health of the baby or child or even survival; some planned ways of informing parents of intersex children indicate that intersexuality may be stigmatized and pathologized; protocols for decision-making on medical interventions for intersex persons, which are not necessary, are unclear and inconsistent (Položaj interspolnih 2020b: 6).

In line with resolutions of the European Parliament and the Parliamentary Assembly of the Council of Europe, the Advocate of the Principle of Equality, there-

fore, recommended that healthcare institutions should refrain from performing non-essential medical procedures on the sexual characteristics of intersexual children if such procedures can be postponed until the person's consent. The Advocate of the Principle of Equality called on them to ensure that intersex children and their parents or guardians are adequately informed about the course of these procedures, about all possible consequences and the possibilities of psychosocial and psychological counseling before medical intervention in their bodies. Among other things, the Advocate of the Principle of Equality advised them to adhere strictly to the definitions and terms relating to intersex, based on respect for the human rights of intersex persons (Položaj interspolnih 2020b).

The Advocate of the Principle of Equality also made several recommendations to the Ministries of Health, Education, and the Interior. In his Special Report, the Advocate underlined the importance of introducing a uniform protocol for the treatment of intersex people, which should be brought in line with modern medical guidelines and practices, including international human rights standards for intersex people. He suggested that consideration be given to the legal regulation of flexible procedures for birth registration or legal recognition of sex based on self-determination, as regulated in some European countries and as proposed by the European Parliament and Parliamentary Assembly of the Council of Europe. For the Advocate of the Principle of Equality, an important measure to ensure the appropriate treatment of intersex persons is also the updating of general educational material with content about intersex and protection against discrimination against intersexual people. The Ministries of Health and Education, in cooperation with the professional and civil society, should also inform the staff of healthcare institutions at all levels of healthcare (Položaj interspolnih 2020b: 7).

Healthcare of homosexual men who are infected with HIV or have AIDS

Slovenia is among the 30 countries in the European Union/European Economic Area with the lowest rates of people diagnosed with HIV. Sex between men remains the predominant mode of HIV transmission. It accounted for more than 60% of new HIV diagnoses (HIV/AIDS surveillance in Europe 2020: 2). In Slovenia, according to the annual report of the National Institute of Public Health from 2019 (Okužba s HIV v Sloveniji 2020), the incidence of HIV infection, AIDS and deaths due to AIDS between 2010 and 2019 was the highest in 2014 and 2016, especially among men who have sex with men (MSM). In this period, one case of infection was in a transgender person. Among MSM, the number of new diagnoses of HIV infection was highest in men aged 30–39 years in 2019 and in the period 2010–2019. Among women, most infections in 2010–2019 were due to sex with infected men or heterosexual sex with men for whom there was no information on their infection or

risky behavior, followed by infections in women from countries with a high proportion of infected populations; infections in women who had sex with bisexual men; infections in women who had sex with men from countries with a high proportion of infected populations. One woman probably had sex with a person who injected drugs. One woman got infected through sex with an infected hemophiliac. At the end of 2019, there were 704 people living in Slovenia with diagnosed HIV infection, of whom 92% were receiving antiretroviral drugs and 96% had a viral load of <40 copies / mL of plasma [which means that the virus is no longer transmittable during sexual activity and that the infected person is undetectable]. Among the 23 people who did not yet have such a low viral load were those for whom treatment had only recently been introduced. Thus, most people living with HIV in Slovenia cannot infect others because of successful treatment (Okužba s HIV v Sloveniji 2020: 1, 5, 6). The estimate is that there are probably another 100 people living in Slovenia who are infected with the HIV virus and about whom we do not yet know anything (Tomažič 2017: 452).

In the group of men who have sex with men, the proportion of infected persons remains below 5% (Tomažič et al. 2016: 47). The relatively low number of new HIV diagnoses among MSM and the decline in the number of late diagnoses can be attributed to the successes of combined prevention, particularly the availability of testing and the change in testing culture among MSM, as well as a prompt treatment after a diagnosis of infection (Okužba s HIV v Sloveniji 2020: 1).

Among the causes of the high number of infections among MSM, the increased number of new infections is the most important; it is also partly a reflection of the increased volume of testing in the health sector and especially in the MSM communities (the activity of non-governmental organizations). Mainly due to certain changes in society and modern technological possibilities, MSM have an easier way to meet their partner(s) and arrange sexual contact. Such simplified arrangements for sexual intercourse are enabled by many specialized apps or special social networks for MSM. Increasingly common, for example, are “Chemsex parties” (lasting one or more days), where more or less anonymous people arrange to have sex with each other via online or mobile applications. The use of various recreational or social drugs significantly decreases the ability to make clear judgments while significantly increasing sexual arousal and prolonging sexual desire. Therefore, after a short period of time, participants in such meetings abandon the use of condoms and indulge in risky sexual behavior. Unfortunately, stigma still has a great influence. People are afraid that they will be diagnosed with HIV, that they will be stigmatized in their community and beyond, and that their bi- or homosexuality will become known. All of this discourages people from getting tested for HIV and other sexually transmitted diseases and from participating in health surveillance. These underlying causes make prevention increasingly difficult and increase the incidence of other sexually transmitted diseases that, without treatment, further increase the possibility of HIV transmission (Tomažič et al. 2016: 47).

In the prevention of HIV and other sexually transmitted diseases, the health system addresses all citizens (young and old, men and women, etc.), with the main message of responsible and safe sex, including the correct and consistent use of condoms and lubricants. This includes educating the partner(s) with important information about their current status regarding HIV infection (as well as other sexually transmitted diseases), which is made very difficult because of the influence of stigma. This is important in the case of unprotected receptive anal intercourse, which is the main cause of the increased spread of the infection in Slovenia. One of the main problems is how to bring “preventive” information to those most at risk: these are men who have sex with men, aged between 17 and 60. It is important that young men who are sexually attracted to men and are just entering a sexually active stage of life receive preventive information before their first sexual experience (Tomažič et al. 2016: 48).

Tomažič et al. (2016) state that early detection of HIV-infected individuals (through frequent, regular testing of those most at risk, especially men who have sex with men) and early treatment of infected individuals (as soon as possible after diagnosis) are priorities in the fight against HIV/AIDS, as is the promotion of more responsible and safer sexual behavior. Treatment is an excellent and highly effective prevention: for people who are successfully treated, the risk of transmitting the infection to a sexual partner decreases by more than 90%. The Slovenian health system promotes HIV testing and treatment for all infected persons, and these measures significantly reduce the population's exposure to the virus. NGOs play an important role in informing, counseling, and persuading people to get tested for HIV in the group of men who have sex with men. To facilitate access, destigmatize, and increase testing for HIV and sexually transmitted diseases in the community of men who have sex with men, the main NGO Legebitra from Ljubljana has been conducting prevention for men who have sex with men since 1999. Since 2009, it has been testing the MSM community for HIV in its premises and social facilities. In addition to HIV, they are also tested for hepatitis B and C virus infections, syphilis, and gonorrhea (through oral and anal swabs). Since 2015, the MSM community has also been tested in six other cities (Koper, Radovljica, Novo Mesto, Celje, Maribor, Murska Sobota), which is also supported by University Clinical Center Ljubljana and the Faculty of Medicine in Ljubljana. Slovenia also implements a four-week Postexposure Prophylaxis (PEP) for persons who have had unprotected sexual intercourse with an HIV-positive person or with a person who is very likely to be infected with HIV. A very important epidemiological measure is also that persons who need post-exposure prophylaxis (PEP) also inform the potential source of infection so that they can be tested as soon as possible. Protection with medicines based on health or epidemiological indications against HIV/AIDS is also implemented in the Slovenian National program for vaccination and protection with medicines. Slovenian infectiologists estimate that HIV infection is present and still undiagnosed in approx. 30% of people with risky sexual behavior. Therefore, they are working to strengthen the network and improve access to outpatient clinics for sexually transmitted diseases.

es, more comprehensive treatment, better staffing, easier and free access (without referral) to outpatient clinics across Slovenia, and the inclusion of MSM, for whom stereotypes and prejudices against homosexuality are an additional barrier alongside the usual stigma around sexually transmitted diseases and bisexuality (Tomažič et al., 2016: 48–49). In Slovenia, any general practitioner, emergency physician, infectiousologist or other specialist may propose to routinely test a patient for HIV infection if he or she observes known epidemiological circumstances. Such circumstances are risky behavior, especially in men in the sexually active period; so-called indicator diseases for HIV infection (group B diseases according to the CDC classification) and sexually transmitted infections; as well as diseases defining AIDS. The HIV test is voluntary, the person gives verbal consent to it, while the doctor explains the test results before and after the test (Tomažič 2017: 456).

People with symptoms and signs of sexually transmitted infections are usually treated by specialists in outpatient clinics for sexually transmitted infections, where they are referred by an elected general practitioner, and the costs of examination, diagnosis, and treatment are covered by The Health Insurance Institute of Slovenia, which provides the compulsory health insurance. These clinics exist in various regions of Slovenia. HIV testing in health facilities can be done anonymously, with a referral or at the patient's own expense, and requires an identification document, except for anonymous testing. Testing is also done in communities of men who have sex with men. This is an approach where all staff involved in the test are part of the community, and everyone at the test site understands and fully accepts the sexual orientation of the test subject. There is also the opportunity to talk about experiences and learn about sexuality in complete confidence and free of charge. Community testing is only for men who have sex with men. In Slovenia, HIV testing is done at 16 sites in all major cities. Testing sites for men who have sex with men are also available in some saunas and clubs.

In 2019, out of a total of 66 men who had sex with men who reported being tested for HIV, only ten reported being tested by their chosen doctor. None reported testing themselves with a test purchased online (Okužba s HIV v Sloveniji 2020: 19).

In Slovenia, healthcare workers who meet more frequently with people living with HIV also strive to destigmatize them and deal with them in a professionally appropriate and respectful manner in the healthcare system, thus contributing to the reduction of internal stigma among people living with HIV. They point to the need to ensure compliance with the provisions of the Patients' Rights Act (2008), such as the right to access healthcare and the provision of preventive services, the right to equal access and treatment in healthcare, the right to privacy and the protection of personal data, etc. At the same time, they point to the problem of rejection of people with HIV by many dentists, which is absurd considering that today all people in Slovenia who are treated for a recognized HIV infection have undetectable levels of the virus in their bodily fluids, not to mention universal precautions (such as wearing gloves). In doing so, they invoke the Patients' Rights Act, which states that

the physician and healthcare provider chosen by the patient, unless it is emergency medical care, may refuse the patient's choice only in especially justified cases when the treatment is likely to be less successful or impossible, or when provided for by law. The healthcare provider shall propose to the patient the choice of another physician and shall explain the reasons for the refusal in writing within eight days after the patient has expressed his choice. Dentists who do not refuse to treat people with HIV (who disclose their disease to them) often make an appointment with them at the end of working hours, which is pointless since services must be made available to all people at any available time (regardless of what disease is recognized or perhaps not recognized in patients). For infections that can be transmitted through contact with infected blood or body fluids, universal precautions should be taken to prevent transmission of infections. Healthcare professionals should be aware that patients who know about their HIV infection or AIDS and are being treated are much less likely to transmit the virus than patients who do not yet know about their infection and may have very high levels of the virus in their blood. Therefore, to prevent transmission of infections transmitted through contact with infected blood or body fluids, universal precautions should be taken in all patients (Tomazič et al. 2015: 17).

The number of cases of stigma/discrimination against people living with HIV in healthcare settings is poorly researched, as only recently have more people been encouraged to report them. However, they do not only occur in dental care but also in other medical settings. Patients testified about indiscretion, stigma, or discrimination against people living with HIV/AIDS, and those are the reasons why they do not want to disclose their HIV status driven by fear of being denied treatment for their additional health problem (e.g., a doctor disclosed HIV-positive status by writing it on medical folder with red pen; the patient had to put his pajamas in a special bag in the hospital and was always last in line for therapy; the patient was forced to disclose his HIV status when he was admitted to the emergency room for an injury; the nurse at the hospital wrote HIV on the hospitalization list which could be seen by that all other medical staff used abusive language with moralized tone in a discussion with the patient; medical staff unnecessarily asked the patient questions about how and why he got infected, etc.). Infectious disease specialists advise any newly discovered HIV-infected person to appropriately disclose their HIV status to healthcare workers while maintaining their integrity, as this is important for further medical care. However, they are not required to disclose their status to healthcare workers for the reason of protection of healthcare workers, as they must follow universal precautions anyway. Patients are taught that it is their moral obligation to inform them. Infectious disease specialists strive for equal treatment of people with HIV in healthcare and social institutions, as their HIV status does not pose a risk to other protégés or employees of these institutions. Unfortunately, there are still many prejudices in this regard in Slovenia. There are also known and inadmissible cases where a doctor refused to provide emergency medical care to a person with HIV when they needed it and was in imminent danger of death, which is a legally prohibited and serious ethical offense (Tomazič et al. 2015: 17–19).

Conclusion

The legal basis for the protection of equal rights and against discrimination in Slovenia is regulated by various laws. However, only a few of them explicitly mention sexual minorities. The Patients' Rights Act prohibits discrimination and ensures that all patients, regardless of sex or sexual orientation, receive equal treatment. Sexual minorities in Slovenia experience some systemic discrimination due to a lack of medical staff; however, this problem affects other people with access to health insurance as well, so it is not unique to their particular circumstances. For example, there is only one interdisciplinary gender identity confirmation council in the entire state, which acts as a gatekeeper, and some gender affirmation surgeries are not available in the public system because they are not covered by insurance. As a result, many transgender individuals choose to seek surgical and psychiatric services abroad or in private clinics in Slovenia at their own expense. They also buy hormones on their own on the Internet and are generally dissatisfied with the legal and medical transition process, finding it too lengthy and humiliating. Another issue is the lack of public accessibility of the guidelines for procedures for medical confirmation of gender identity and the vague presentation of the instructions for the medical procedures for gender reassignment.

Although the process of medical transition is regulated, there are significant deficiencies in the legal regulation. It is problematic that gender affirmation procedures in Slovenia require the identification of a person within the binary gender order. In this way, non-binary gender identities are pathologized. Apart from the problems related to the procedure preceding the medical procedure of gender affirmation and its cost recovery, another important issue up to October 2022 was the registration of gender in personal documents. From October 2022 transgender individuals in Slovenia are able to apply to any administrative units to change the gender information on their identity documents, reducing the possibility of involuntary disclosure of their transgender status, which could subsequently lead to stigma and discrimination. Up until then, only certain administrative units took measures to ensure the confidentiality of gender affirmation procedures.

In addition to the necessary changes to existing legislation, the focus on people with multiple minority identities (e.g., ethnic and sexual) has been recognized. Nevertheless, those people are not sufficiently recognized and can be presumed to face more difficulties in accessing healthcare, as it has been already identified.

The main recommendation for improvement of treatment of intersex people in Slovenia is a standardized treatment protocol harmonized with international human rights standards for intersex people, including self-determination of the person in care.

Nevertheless, positive aspects of the Slovenian situation are the mere existence of the possibility of performing medical transition within the public health system and legislation that allows transsexualism.

Both Slovenian law and hospital regulations prohibit discrimination based on personal circumstances, including sexual orientation and gender identity or expres-

sion. Some sexual minorities, however, reported systemic discrimination as well as individual cases of unequal treatment, inappropriate communication, and discriminatory attitudes based on their sexual orientation. Some members of sexual minorities find medical treatment traumatizing, particularly when gender affirmation surgery is performed or inappropriate communication occurs. They believe that medical staff should be more cautious about how they address them in front of other patients or in the outpatient clinic because they find medical procedures and constant explanations and disclosures of their condition offensive and humiliating. To make matters worse, the system makes medical transition difficult and exhausting. On the other hand, the medical personnel who treat these people for other diseases report that they do not care about their sex, sexual orientation and gender identity. They just want to treat the diseases that patients have. This discrepancy gives the space and opportunity to improve communication on both sides. Interviews with health professionals revealed that when individuals from sexual minorities are disclosed to them during the treatment process, they communicate and act with patients according to their past experiences. The interviewed medical professionals are aware that they do not receive adequate training in how to interact with vulnerable groups and that such training is rare and not readily available to all, but that they do not intentionally exclude or discriminate against anyone.

Limitations

The results of this study must be considered in light of its limitations. Contact with hospitals and patients occurred during the COVID-19 pandemic when healthcare workers and administrative staff in hospitals were under extreme stress and time pressure. Also, because the quantity of documents given by hospitals varied, it was necessary to investigate additional sources, including hospital websites. Because fieldwork was hampered by the COVID-19 regulations and most interviews had to be conducted remotely, the interview sample collected by one researcher (the author of this article) is also modest. To more fully investigate the connections between healthcare policies and practices and patients' feelings of discrimination based on sexual orientation, gender identity/expression, or gender traits, a study with a bigger sample size is needed.

Conflict of interest

The author declares no conflicts of interest. The funders had no role in the design of the study, in the collection, analyses, or interpretation of data, in the writing of the manuscript, or in the decision to publish the results. The results in this article are published as an additional output of the HERA project.

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Ethical approval

The study was conducted in accordance with the Declaration of Helsinki and approved by The Institutional Review Board (or Ethics Committee) of The Human Research Ethics Committee at the University of Ljubljana (July 5, 2021).

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Zdravstvena skrb za seksualne i rodne manjine u Sloveniji. Zakonodavstvo i bolničke prakse

U radu se predstavlja pregled zakonodavstva o pravu na zdravstvene postupke za osobe različitih seksualnih orijentacija, rodnih identiteta/ekspresije ili seksualnih karakteristika u Sloveniji. Navode se i bolničke prakse i percipirani odnos između pacijenata i medicinskog osoblja. Rad ima tri cilja: pružiti sveobuhvatan pregled slovenskog zakonodavstva o rodu i seksualnoj orijentaciji te bolničkih politika; istražiti kako se pravne norme i bolničke politike provode u kliničkoj praksi; prepoznati etičke izazove koje percipiraju zdravstveni radnici i pacijenti kao posljedicu društvene raznolikosti. Analizirano je nekoliko vrsta podataka: relevantno zakonodavstvo, interni dokumenti općih bolnica u Sloveniji, dokumenti zagovornika načela jednakosti i pučkog pravobranitelja za ljudska prava, medicinska literatura i literatura iz nevladinih organizacija. Pregledani i analizirani podaci ukazuju na to da dio bolničkog osoblja ne posjeduje vještine potrebne za rad s ranjivim skupinama, unatoč činjenici da je diskriminacija zakonom zabranjena i da se zdravstvenim djelatnicima povremeno pruža obuka u području kulturne kompetencije.

Ključne riječi: profesionalna etika, seksualne i rodne manjine, ranjiva populacija, javne bolnice, medicinska antropologija, Slovenija