

Accessing Health: the Context and the Challenges for LGBT People in Central and Eastern Europe



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Note on terminology

ILGA-Europe uses the umbrella term transgender for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. The term may include, but it is not limited to: transsexuals, inter-sex persons, cross-dressers, and other gender variant people. ILGA-Europe is aware that the issues relating to inter-sex people can be significantly different and need to be addressed separately where relevant.

Gender identity refers to a person's sense of conformity between their biological and psychological gender. This is the individual's gender concept of self, which does not necessarily depend on the sex they were assigned at birth. Gender expression relates to the expression of oneself in external presentation and/or appearance through behaviour, clothing, hair-cut, voice, body characteristics, etc. Sexual orientation, in turn, is used to denote a person's sexual and emotional attraction to people of the same and/or different sex.

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The report is the result of a project, coordinated by ILGA-Europe in 2004 – 2006. The project coordinators throughout this period were Don Bisson, Miha Lobnik and Maxim Anmeghichean (currently Programmes Director).

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Introduction

ILGA-Europe is the European Region of the International Lesbian and Gay Association (ILGA). A Non-Governmental Organisation (NGO), ILGA-Europe is an umbrella organisation which represents its members, principally organisations of lesbian, gay, bisexual and transgender persons, at the European level. The organisation has acquired substantial knowledge of the Lesbian, Gay, Bisexual and Transgender (LGBT) movement in Eastern Europe through its wide membership in that region, and through the involvement of these members in conferences, projects, seminars and campaigns initiated by ILGA-Europe.

Two projects in particular, both funded by OSI-Budapest, have enabled us to understand the working terrain. The first resulted in a report entitled "Equality for Lesbians and Gay Men – a Relevant Issue in the EU Accession Process", and was based on a survey of the situation of lesbians and gays in the 13 EU accession countries. The second was a survey on sexual orientation discrimination in Romania, Slovenia, Hungary and Poland. A further phase of this project allowed us to extend the research in the Czech Republic, Estonia, Latvia, Lithuania, Malta, and Slovakia.

ILGA-Europe used the results of the research to lobby the EU Commission for the repeal of all laws discriminating on the basis of sexual orientation as a condition of accession to the Union. As of August 2005, only one out of the 13 newly acceded countries – Bulgaria – continues to have such laws.

Current Project

This report documents the process and findings of ILGA-Europe's first initiative in the field of health. Funded by Open Society Institute, the project involved research in five countries in Central and Eastern Europe. Working in partnership with LGBT organisations in those countries, the focus of the research was on capturing baseline data on:

- Issues relating to access to health care for LGBT people
- A range of issues regarding the relationship between LGBT people and health care professionals
- How the experience of discrimination impacts on access to health care
- The status of equality and human rights legislation and policy, including health policy, in each partner country.

Rationale for a Research Project



In our funding application we made reference to the need for sustained programmes of research and advocacy in the countries of Central and Eastern Europe. The approach of beginning our work in the area of LGBT health with a research project was necessary and strategic; necessary because of the lack of any research or baseline data in the five countries; and strategic because of our objective of promoting research as a prerequisite to changing both public policy and public opinion. In the first instance, a vital function of research is to bring the issues to public consciousness and in particular to the consciousness of all relevant stakeholders in the field of health care policy and provision.

The importance of research cannot be underestimated in the context of a strategy to achieve equality and equity for LGBT people in relation to health care provision. In the face of inadequate services, NGOs and community-based organisations have, for the most part, directed their resources to direct service provision. While such work is vital, it can be no substitute for capacity building within mainstream health care providers, and research is fundamental to capacity building. Furthermore, research of this nature needs to be a collaborative exercise involving all relevant stakeholders – public health officials, health policy makers, the full range of health care professionals, funders, advocacy groups and representatives from the LGBT community – if it is to make the necessary contribution to change.

Whilst a substantial body of research literature on gay and lesbian health concerns exists – most of which comes out of the USA and Canada – it is minimal when compared to what is available on the health concerns of other minority populations.¹ Much of the research has been carried out by LGBT organisations, often with limited resources, sometimes with the assistance of academic institutions but, most often with limited co-operation from health-related agencies. We can point to excellent innovative projects that have been carried out by public health authorities, where the commitment in terms of resources and expertise is of the highest standard. Alas, these are few and far between. The general picture remains one of institutional reluctance – fuelled by institutional homophobia – to recognise the legitimacy of the specific health care needs of the LGBT community. For many, the HIV/AIDS epidemic is viewed as the only specific health concern for LGBT people. One effect of this view has meant that most of the literature on LGBT health is focussed on HIV/AIDS.

¹ There is even less literature on the health concerns of transgender and transsexual people, and this is, regrettably, reflected in this report.

The Research

Introduction



This research project represents the first time that a study of this size and scope has been carried out among the LGBT community in any of the five participating countries. As such, the initiative is of groundbreaking importance and the data collected will serve to inform ongoing advocacy and policy work. In addition, it has become apparent, having completed the initial analysis, that there is more scope for further interrogation of the data. On one level, there is an exercise to be completed in comparing the data with that of similar surveys within the mainstream populations, to the extent that this is possible. At another level, questions arising from the initial analysis will serve to inform the structure of future studies. This will involve refining questions as well as conducting more limited and yet more targeted and focused surveys on issues that have been highlighted in this initial research. Qualitative studies will also be important, particularly for those sections of the LGBT community that are most difficult to reach. It will also be important to explore the potential of some of the well established survey instruments which have the potential of yielding data on specific health issues, as well as enabling comparisons with many other studies.

Methodology



The research had two distinct components; 1) a quantitative survey of the health concerns of the LGBT community, and 2) a review of the legislative and policy background to the protection of human rights, including the right to health care. This section of the report is concerned with the methodology used in the quantitative survey. The second part of the research was achieved mainly through desk research by the partner organizations. To some extent, and particularly in Moldova, there was consultation with relevant health care professionals and policy makers.

Selection of Partners



ILGA-Europe sent out an invitation-to-tender proposal to over thirty organizations in Central and Eastern Europe. Applicants were asked to complete a questionnaire, and their selection was based on the

following criteria:

- clear evidence of capacity to carry out the work, as demonstrated both by the resources available to the organization and also the track record in executing other similar projects;
- experience of working on health policy issues and the organization's plans for future work;
- expertise available to the organization, through staff and board members, in the field.

Nine organizations submitted a proposal, from which five were chosen.

Literature Review

The purpose of the literature review was to gain a broad overall understanding of the health concerns of LGBT people, and of the focus and scope of research in this area. As such our study of the literature was preliminary, rather than extensive. What became evident was that there is considerable commonality across the literature, both in terms of findings and also in terms of the challenges to research itself. The overview gained informed the design and adaptation of the questionnaire and also served to support the implementation of the project, particularly when we encountered some of the challenges which the literature discussed.

Questionnaire Design

In a trawl of recent research, ILGA-Europe acquired a template for the questionnaire, which had been used, in one form or another, in a number of research projects. We were able to talk in some detail with Stonewall Scotland and, based on those discussions, modify the questionnaire. The intention was to have the partner organizations work to further adapt the template to suit local situations. Because this was the first time quantitative research had been carried out in the participating countries, a goal in the design of the questionnaire was to develop an instrument that would capture baseline information. This meant a questionnaire that was comprehensive which in turn, necessarily, meant that it was long.

Development of Toolkit

ILGA-Europe put together a toolkit, which included the questionnaire, to serve the partner organizations as an aid to their work in the field. The other elements of the toolkit were:

- a document outlining the rationale and objectives of the research as well as background information on the importance of health issues for the LGBT community and for LGBT NGOs;
- a document detailing questions and guidelines aimed at identifying: i) public health policy in the respective countries and opportunities to influence policy development in relation to LGBT needs; and ii) the structure of health services, and specifically, where lobbying activities might be used to best advantage.

Presentation of Toolkit



The project was launched at a two-day workshop in Bucharest. During the workshop, which brought together all five partners, the toolkit was presented and elaborated. A big part of the workshop was training on the technical aspects of the administration of the questionnaire, and on how to identify the sample of respondents. This was also when the time frame for the research was set and outcomes and outputs established.

Administration of Questionnaire



Each partner organisation was responsible for the administration of the questionnaire which involved a number of distinct tasks:

- Translation and adaptation of the questionnaire
- Sourcing and mapping the target group
- Training of volunteers to administer the questionnaire
- Conducting interviews with respondents and facilitating the completion of the questionnaires

Data Management & Analysis



When the questionnaires had been completed, ILGA-Europe conducted a 2-day workshop in Budapest during which the five partner organizations were given guidance on how to manage and analyse the data. It was decided at this workshop to invest in SPSS, the statistical management software, and also in the expertise of sociologists in each country. As is noted elsewhere in this report, one element of data analysis was the expert interpretation brought by the partner organisations. No other agency comes close to matching their knowledge, their empathy, their experience nor their skill in this regard.

Overview of Findings

This section presents a review of some of the principal findings of the research. It is to be remembered that each partner organisation has, or in the case of Phase 2 partners will, publish the full findings of the research. For ILGA-Europe's purposes, we have chosen to focus on those findings which relate our health advocacy strategy. That strategy, primarily focused on Central and Eastern Europe, is concerned with influencing all relevant stakeholders, including governmental and inter-governmental agencies, regionally-focused NGOs and funders, whose remit is to support LGBT health.

The findings are presented under the following headings:

- Demographics of Population Surveyed
- Identity and Degree of Outness
- Relationship with Healthcare Provider
- Medical Testing
- Mental Health
- Experience of Discrimination (include public opinion)
- Legal and Institutional Environment

Demographics of Population Surveyed

Table 1 shows the number of people surveyed in each country and the breakdown by sex and age. It is apparent that in all countries the population is largely young and male. In BiH and Macedonia women make up 35% of the overall target group, while in Romania women represent only 15.6% of respondents. In Moldova all of the women respondents are aged 30 or below; none is aged over 30. In terms of age, the vast majority of those surveyed are aged thirty or under, with this grouping making up over 86% in BiH, almost 80% in Moldova, over 75% in Romania and 62.5% in Hungary. If we look at those over 50 years of age, we see that in Romania this grouping make up only 2% of the total target group. The country with the highest percentage of over 40s is Macedonia with 8%.

Table 1 Respondents – number, and by female/male

	No. of Respondents	% Female	% Male
Bosnia & Herzegovina	183	35.5	61.7
Macedonia	100	35	65
Hungary	146	24.7	62.5
Romania	392	15.6	81.4
Moldova	147	30.5	69.5

There is considerable variation between countries in relation to the level of education attained by those surveyed as well as their current employment and student status. What stands out is that a considerably higher number of those surveyed are in employment in Hungary, Romania and Moldova than in BiH. Conversely, the percentage of unemployed in BiH, at 13.7%, far exceeds the percentages in the other three countries, with the lowest in Hungary at 2.7%. In terms of education, 14.2% of those surveyed in BiH attained to a University education, while in Hungary a full 50% attended university, and close to that (47.6%) in Moldova.

In terms of the geographic spread of the surveyed population in each country, in BiH and Macedonia close to two-thirds of respondents are from the respective capital cities, with the remaining one-third coming from the other major cities spread throughout the country. In Moldova all those surveyed live in the capital, Chisinau.

Identity and Degree of Outness

Not surprisingly given the dominance of men in the populations surveyed, gay men represent the largest grouping in each country. While the figures in Table 2 indicate that both BiH and Moldova report in the region of 36% as gay (compared to from between 50% and 65% in the other countries), there are local situations which can be taken into account. In the case of BiH, Organisation Q, which has a strong focus on identity politics, offered a wider range of choice to those completing the survey. This resulted in over 20% in BiH choosing an option that was not available to respondents in the other countries. In Moldova those identifying as bisexual is considerably higher than in the other countries and it is worth noting that in Moldova men make up 66.3% of all those who identify as bisexual.

Table 2 Categories of Identification

	Bosnia Herezgovina	Macedonia	Hungary	Romania	Moldova
Gay	31.1	50	65.1	57.2	36.7
Lesbian	17.5	28	20.5	6.9	15.6
Bisexual	20.8	22	18.5	29.5	42.9
Transgender	2.7	0	0.7	3.6	0
Heterosexual	2.7	0	0.7	0	1.4
Transsexual	n/a	0	2.1	3.1	0
Other (please specify)	2.7	0	0	0.3	2
Unsure	7.1	0	0	1.8	0

(More than one response possible)

What is striking is the low representation of lesbians captured in the research. The percentage is highest in Hungary with lesbians representing 20.5% of the total, and the lowest is in Romania at only 6.9%. The percentage of those identifying as transgender or transsexual ranges from 0.7 to 3.6% and 2.1 to 3.1% respectively. None of the respondents in Macedonia identifies as transgender and none identifies as transsexual in BiH, Macedonia or Moldova.

The process of coming out is a crucial act for LGBT people. For one thing, it represents a level of self realisation and development. Fear of negative reactions, such as being rejected and ostracised, is one of the factors that inhibit the coming out process. It is not only important to be able to feel comfortable with one's sexual identity with family and friends, but also at school and work, within the extended family and neighbourhood settings and when availing of public services, and in particular health services.

Respondents were asked two forms of questions in relation to whether they were out to family and friends. Firstly they were asked if they were out to their family and friends while the second form of question asked if the majority of their family and friends know about their sexual orientation or gender identity. Being out would generally entail a freedom and intimacy of relationship to talk, with varying degrees of openness, about one's life, including about sexual relationships. However, one's sexual orientation or gender identity being known by family and friends implies a more limited relationship where one does not experience the freedom to share openly. Responses to the first question are shown in Table 3.

Of those surveyed, the percentage who are out to their family ranges from just over 20% in BiH to just over 50% in Moldova. The numbers out to their parents is considerably lower in BiH and Macedonia (at 20.2% and 26% respectively) than in the other three countries. The same is true in relation to those among

the family who know about the sexual orientation or gender identity of the respondent. It is significant to note that in BiH less than 50% of respondents report that their sexual orientation and/or sexual identity is known about by their friends; in Romania it is two-thirds, while in the other three countries it ranges from 80% to 83%.

Table 3 Out to Family and Friends

	Bosnia Herezgovina	Macedonia	Hungary	Romania	Moldova
Do the majority of members of your family know about your sexual orientation and/or gender identity?	29.5	26	57.5	40.3	50.3
Are you out to the majority of the members of your family?	20.2	26	46.9	34.9	50.3
Do the majority of your friends know about your sexual orientation and/or gender identity?	44.8	80	82.8	66.1	83

A further question in this area asked respondents to choose from a list the people in their lives to whom they were out. Among family members, significantly more respondents report being out to their mother or a sibling than to their father. Clearly friends rank highest when it comes to being out about sexual orientation or sexual identity with this category being chosen by between 75.5% and 86.3% of respondents. As the author of the Moldova report notes, these findings would seem to confirm what is widely known about how it is easier to confide about one's sexual orientation with friends than with family. In relation to being out at work or at school, responses given range between 17% and just over 30%.

It was observed in the report on Hungary that the act of coming out for many of the respondents occurred during or after the major political climate change around 1989/90, a time of considerable attitudinal change in society at large. A further observation on Hungary is that the data shows that the coming out level of the sample is relatively high, and this is assumed to be because of the nature of the survey sample, i.e. employed, well-educated, white and urban. Romania's LGBT population, on the other hand, is described as being of "low visibility" and suggests that this is because of the existence of laws, until recently, criminalizing consenting same-sex acts, and of residual discrimination and stigma experienced by the community.

Age and Coming Out



The survey sought to determine the age at which respondents came out. It should be remembered that overall the target group is relatively young; taking an average of all five countries, almost 74% of the respondents are under 30, those aged between 31 and 40 make up 16.6% of the total, while the remaining 9.4% are aged 41 or over.

In BiH the majority of respondents, almost 74% came out between the ages of 12 and 20; here the oldest reported coming out age is 32. In Macedonia the majority (91%) came out between 18 and 33 years, with one person coming out before 18 years old. In Hungary, 83.2% of respondents came out by the time they were 23; of these, 48.2% came out between 19 and 23 years, while 5.8% of the total came out before they were 16 years old. In Moldova over one-third (35.1%) came out before they were 18 years old and almost 38% came out between ages 19 and 23.

In all countries surveyed, the vast majority of respondents frequent the formal gay social venues (bars and discos) to socialise. This is further confirmation that the survey reached a mostly young, confident, out and active population. Finally on the topic of being out, respondents were asked if the reactions of people to them coming out caused them difficulties. In Romania, just over one-third of respondents experienced some difficulty; in BiH, 20.2% report difficulties in this area, while in Moldova the percentage rises to 89%.

In Hungary the researchers, in an effort to better understand their data, constructed a schema whereby they sought to measure responses to a range of questions according to the degree of outness of the respondents. While acknowledging the limitations of their interpretive approach, they did report that the data suggested that coming out and mixing within a friendly environment are factors which contribute to a more positive and less fearful attitude to life. The primary focus of this exercise was to determine whether being out meant a more responsible and less risk-taking approach to health, and this is discussed later in this report.

Relationship with Health Care Provider



In attempting to take a measure of the type of relationship respondents report having with their health care providers, we look at whether they have chosen a family doctor and how often they visit a gynaecologist or urologist, in addition to a range of issues in relationship to the degree of comfort, trust and fear experienced in accessing health care.

The percentage of respondents who have a family doctor ranges from just over 31% in BiH to 80% in both Macedonia and Romania, while the percentage of these who visit their doctor regularly ranges from almost 40% in Hungary to 90% in Macedonia. When it comes to visiting a gynaecologist or urologist the findings show a lower attendance rate overall. In Hungary, for example, only 11% of the women respondents make a visit every six months and a further 38.9% once a year. The writer of the country report from Hungary notes that to a large extent lesbians lack trust in gynaecologists, one factor being that most gynaecologists in Hungary are men. One woman in BiH reported a harrowing experience when the gynaecologist tried to break her hymen, because, according to the woman, the gynaecologist perceived her to be a lesbian.

In Moldova, almost 45% of the women surveyed make twice yearly visits to a gynaecologists, while a further one third visit once a year. In BiH 58.5% of the women visit a gynaecologist at least once a year, while over 40% did not report any visit to a gynaecologist. For the women surveyed in Macedonia only 35% visit at least once a year, leaving 65% who did not report any specialist visit.

It is clear from the findings, presented in Table 4, that men are even less likely than women to attend a specialist regularly. In Macedonia none of the 50 men surveyed report attending an urologist at all, while the same is the case for 58.4% of the men surveyed in BiH². The author of the report on BiH indicated that respondents felt that they did not attend a specialist because they had no need to do so, and this can perhaps be explained by the young cohort which was surveyed.

Table 4 Relationship with Health Care Providers

	Bosnia Herezgovina		Macedonia		Hungary		Romania		Moldova	
Chosen Family Doctor	31.1		80		72.6		80		64.6	
Visit Doctor Regularly	63.2		90		39.6		n/a		65.2	
Visit Specialist	M	F	M	F	M	F	M	F	M	F
Every Year	29.2	23.1	0	12	n/a	38.9	n/a	n/a	n/a	33.3
Every 6 months	12.4	35.4	0	23	n/a	11.1	n/a	n/a	n/a	44.4

When asked if they would feel comfortable revealing their sexual orientation, gender identity or same-sex practices with a health care provider, the percentage of those who responded positively ranged from 2%

²The question re visiting a specialist was not asked of the men surveyed in Phase 1 of this project, i.e. those in Hungary, Moldova and Romania.

in Macedonia to 55.5% in Moldova. Those percentages increase when asked if they would reveal the information if it was necessary for proper medical care. In these circumstances, the positive responses range from 56.8% in BiH to 96.6% in Hungary. While these findings are encouraging, one has to wonder, however, how decisions are made as to when information about sexuality is necessary for proper medical care. LGBT people who are in the position to make this decision, outside of the facility of a full discussion with their health care provider, face an undue pressure. What, it must be asked, are the health implications for those large numbers of LGBT people, who, for whatever reasons, do not feel comfortable talking openly about their sexuality or gender identity?

Respondents were asked if they considered health care providers to be sensitive to the health needs of LGBT people. What is perhaps most telling in the findings is the numbers of respondents whose answer was that they did not know. The results show that in Moldova, 56% of respondents did not know; in Macedonia the percentage was 64%, in Hungary 70.8% and in BiH 80.8%³. The most likely explanation for this lack of knowledge is because they lack the confidence in the first place to reveal their sexual orientation or gender identity.

Respondents were asked about their knowledge of actual different or unequal treatment of LGBT people. In response to one question which asked if they had experienced any problems because someone in the doctor's practice knew or presumed to know about their sexual orientation or gender identity, the percentage of respondents who answered in the affirmative ranged from 1.6% in Moldova to 10.5% in Romania. In response to a second question as to whether they felt that they had been treated worse because of their perceived sexual orientation or gender identity, a significantly greater number of respondents answered yes, with the range between 8.2% in BiH and 19% in Moldova.

Table 5 for Hungary Relationship with Health Care Providers

	Yes	No	DK
Would you feel comfortable revealing your sexual orientation, gender identity or sexual practices with people of the same sex, to your health care provider?	45.2	53.8	
Would you reveal sexual orientation, gender identity or sexual practices with people of the same sex if it was necessary for proper medical care?	95.9	3.4	
Are the medical care providers you have met sensitive to the different health needs of lesbian, gay, bisexual, intersex and transgender persons?	10.4	18.8	70.8
Can you discuss your health related needs with your doctor in an open and honest fashion?	51.5	40.1	n/a

³ Figures are not available in the Romania report for this question.

Table 5 for BiH Relationship with Health Care Providers

	Yes	No	DK
Would you feel comfortable revealing your sexual orientation, gender identity or sexual practices with people of the same sex, to your health care provider?	29.5	24	15.3
Would you reveal sexual orientation, gender identity or sexual practices with people of the same sex if it was necessary for proper medical care?	56.8	4.9	6
Are the medical care providers you have met sensitive to the different health needs of lesbian, gay, bisexual, intersex and transgender persons?	8.2	10.9	80.8
Can you discuss your health related needs with your doctor in an open and honest fashion?	36.6	27.3	36.1

Table 5 for Macedonia Relationship with Health Care Providers

	Yes	No	DK
Would you feel comfortable revealing your sexual orientation, gender identity or sexual practices with people of the same sex, to your health care provider?	2	66	12
Would you reveal sexual orientation, gender identity or sexual practices with people of the same sex if it was necessary for proper medical care?	63	1	14
Are the medical care providers you have met sensitive to the different health needs of lesbian, gay, bisexual, intersex and transgender persons?	5	33	64
Can you discuss your health related needs with your doctor in an open and honest fashion?	18	33	49

Table 5 for Macedonia Relationship with Health Care Providers

	Yes	No	DK
Would you feel comfortable revealing your sexual orientation, gender identity or sexual practices with people of the same sex, to your health care provider?	39.3	56.9	n/a
Would you reveal sexual orientation, gender identity or sexual practices with people of the same sex if it was necessary for proper medical care?	76	17.9	n/a
Are the medical care providers you have met sensitive to the different health needs of lesbian, gay, bisexual, intersex and transgender persons?	21.4	15.8	61.5
Can you discuss your health related needs with your doctor in an open and honest fashion?	51.5	40.1	n/a

Table 5 for Moldova Relationship with Health Care Providers

	Yes	No	DK
Would you feel comfortable revealing your sexual orientation, gender identity or sexual practices with people of the same sex, to your health care provider?	55.5	44.5	n/a
Would you reveal sexual orientation, gender identity or sexual practices with people of the same sex if it was necessary for proper medical care?	85.7	14.3	n/a
Are the medical care providers you have met sensitive to the different health needs of lesbian, gay, bisexual, intersex and transgender persons?	34	10	56
Can you discuss your health related needs with your doctor in an open and honest fashion?	56	40.1	n/a

In a related question, significant numbers of respondents in all countries report that they have not attended a doctor or other health service because of a fear that they would have to reveal their sexual orientation or gender identity. Table 5 presents the findings which range from 6.2% in Hungary to 41% in Macedonia. Another question on this topic asked if respondents delayed seeking medical care because of a fear that their medical records would be revealed to a third party. Answers in the affirmative to this question range from 8.8% in Moldova to 40% in Macedonia.

In terms of overall levels of satisfaction with medical services, Table 6 presents the findings. Those who reported being dissatisfied range from 17.7% of the respondents in Moldova, to 52% in Macedonia. The numbers who report being very dissatisfied are considerably smaller. However, those who report being neither satisfied nor unsatisfied range from 24% to 49%. This means that between almost one quarter and one half of the respondents are ambivalent about the quality of health care service available to them. Clearly while it is not possible, given the parameters of this research project, to identify the factors which contribute to this ambivalence, it is a matter for concern.

Table 6 Level of Satisfaction with Medical Care Services

	Bosnia Herezgovina	Macedonia	Hungary	Romania	Moldova
Very Unsatisfied	5.5	n/a	2.7	9.7	4.1
Unsatisfied	19.7	n/a	21.2	23	17.7
Neither Satisfied or Unsatisfied	39.3	n/a	48.6	31.9	49
Satisfied	29	n/a	24	26.8	4.8
Very Satisfied	5.5	n/a	3.4	6.6	4.8
Average	3.1	n/a	3.4	3	3.1

The final aspect of the relationship with the health care service is to gauge how respondents react to the concept of a LGBT-specific health care provider. In Moldova, 81% say that they would use a LGBT-specific provider, if it existed; in Hungary 70%, in Romania 85.2%, 63% in Macedonia and 48.1% in BiH.

As noted by the author of the Hungary report, comparative data which reflects mainstream satisfaction levels are needed in order to determine the extent to which homophobia plays a part in the experience of LGBT people. Other observations made in the Hungary report refer to an under-resourced health care service in general, where quality has suffered in overall terms and a system which does not lend itself to the type of doctor-patient relationship conducive to any type of disclosure of personal information. Indeed, some of the people surveyed in Hungary felt that such a relationship was not necessary to receiving good medical care, and even doubted if LGBT had any health care needs specific to their sexual orientation or gender identity. The author of the Hungary report offers that this perspective might be due in part to the relatively low profile of the LGBT community in that country, and also to the low expectations in general of the health service. An interesting, seemingly contradictory set of findings in Hungary, relates to the large number (almost 70%) who indicated that they would use a LGBT-specific health service provider if it existed; this despite a majority of respondents reporting that they do not feel it is necessary to discuss their health needs as LGBT people with their doctor.

It was noted also that BiH has just begun to develop a system of family medical care with pilot programmes underway in just a small number of municipalities.

Medical Testing

In the five countries surveyed, a fairly high proportion of the respondents report having been tested for HIV. The figures are highest in Hungary and Romania with 70% in each case. The authors of the reports on Moldova and Hungary note that free anonymous testing is available in their countries. In the BiH report it is noted that just 0.1% of the total population of the country have undergone HIV testing compared to 35.5% of the survey respondents. In terms of those who tested positive for HIV, the highest percentage is in Hungary, with 6.8%, next is Moldova with almost 5%, and finally BiH and Romania with 3% and 1.8% respectively.

Testing for Hepatitis C ranged from almost 30% of respondents in Hungary to almost 50% in Moldova. The percentage of those who tested positive for Hepatitis C is highest in Hungary at 5.4%, next is Moldova at 4.1%. None of the respondents in Romania tested positive for Hepatitis C, and only one person in BiH. The Moldova report refers to the widespread nature of Hepatitis B and C in that country.

In relation to testing for other STIs, Moldova report that this pertains to 15% of those surveyed, and this is considered by the author to be low in view of the widespread nature in the country of a number of STIs. Romania has the highest level of testing for STIs at 46.2% of respondents. In Hungary, Romania and Moldova, the most prevalent STIs among the survey population is gonorrhoea; these figures are not available for BiH.

Table 7 shows the responses to a question about whether respondents trusted their health care provider to keep their test results confidential. With almost 82% giving a positive response to this question, Hungary ranks highest in term of the degree of trust exercised, and Moldova next with 72.2% of respondents reporting trust regarding confidentiality of test results. In BiH 61.8% answered positively; however, in that country, almost one-third report that they are not sure if they can trust their health care providers in relation to the confidentiality of test results. Romania's respondents indicate that 35.7% of them exercise trust, while the number of those who do so is lowest in Macedonia, with only 28% believing that their health care provider will maintain confidentiality regarding test results.

Table 7 Level of Satisfaction with Medical Care Services

	YES	NO	DK ⁴
Bosnia & Herzegovina	61.8	5.9	32.6
Macedonia	28	12	20
Hungary	81.7	9.2	9.2
Romania	35.7	18.1	13
Moldova	72.2	6.5	21.3

Responses to a final question under medical testing related to self examination of breasts or testicles produced a wide range of responses. In BiH almost 40% check their breast regularly or occasionally. Of these, 84.8% are biological females and 15.25 are biological males. Further findings from BiH indicate that while 82.3% of the total male population regularly or occasionally check their testicles, 21.5% of females never check their breasts. In Hungary, 53.2% of respondents report never checking their testicles and 25% never check their breasts, leaving the author of the Hungary report to comment on the low level of consciousness about cancer-prevention in that country, but unable to say if this is related to sexual orientation or gender identity. In Moldova, 41% of the women surveyed never check their breasts and almost the same percentage of the men surveyed (42%) never check their testicles.

⁴ DK = Don't know

Mental Health



While there were a range of questions on this subject ranging from sense of self-esteem, stress, anxiety through to suicide attempts, for the purpose of this report we have chosen to look at the incidence of depression, suicidal thoughts and attempted suicide, and the extent to which respondents felt these issues related to their sexual orientation and/or gender identity. In addition we look at responses to questions on the availability of LGBT counselling services.

Table 8 Respondents' YES answers to questions on suicide (%)

	Bosnia Herezgovina	Macedonia	Hungary	Romania	Moldova
Have you ever had suicidal thoughts?	24	18	56.2	43.4	42.2
If yes, have you ever attempted suicide?	16	0	18.3	44.7	50
Those attempted suicide as a per cent of total surveyed.	3.8	0	10.2	19.3	21
If yes to either question, do you feel this was related to your sexual orientation or gender identity?	25	n/a	65	61.8	58

Over 56% of those surveyed in Hungary report having suicidal thoughts. In the other countries the proportion ranges on the lower end from 18% in Macedonia and 24% in BiH, to just over 42% and 43% in Moldova and Romania respectively. In terms of those with suicide thoughts going on to attempt suicide, we see that this happens in 50% of the cases in Moldova, and in almost 45% of the cases in Romania. The percentages drop considerably in the remaining countries and range from 0% in Macedonia to 18.3% in Hungary. In Moldova it was noted that of those who reported having suicidal thoughts, women had a slight majority at 55.6%. When it comes to a gender breakdown of those reported having attempted suicide, that majority goes up to 60%.

An important statistic to note, which is shown in Table 8, is the percentage of the total population who report having attempted suicide. In this instance the figures range from 10% in Hungary to 21% in

Moldova. While it is difficult to compare these findings with studies of similar variables, it does seem that there is a lower incidence of reported attempted suicide in our survey populations than is reported in most other studies currently available. It is not possible to satisfactorily explain this disparity. However, further research focussed on measuring mental health, and using well-tested survey instruments has the potential of yielding more relevant and reliable data that are different and perhaps more reliable.

It is significant to note that in three of the countries surveyed, in the region of 60% of respondents felt that these experiences related to their sexual orientation and/or gender identity.

Respondents were asked if they knew about and used a LGBT friendly counselling or health care services. Table 9 presents the results. While in Romania the percentage of those surveyed who know of such a facility is just under 40%, in the other four countries the proportion ranges from almost 63% to 75%.

Table 9 Questions regarding LGBT-specific/friendly services (responses as %)

	Bosnia Herezgovina	Macedonia	Hungary	Romania	Moldova
Do you know of the existence of an LGBT specific or friendly health care provider?	39	75	62.8	38.3	67
If yes, do you use it?	78	66	38.3	28.7	62.6
Would you use such a facility if it existed?	48.1	63	70	85.2	81

In Moldova the research reported that a significant majority of respondents rated themselves highly on a number of self-image indicators: 87% are pretty sure about themselves; 92% believe that they are easy to like; 86% like themselves and 97.3% consider that they have a number of good qualities. At the same time, 23.8% of respondents have a low opinion of themselves and 33% wish they were someone else. Of those who report experiencing depression or anxiety, just 19% have sought medical help, while 6.8% report having been referred to a mental health provider because of their sexual orientation or gender identity. The BiH report also notes that 14.2% of their respondents have at one time or another sought help from a mental health provider in relation to their sexual orientation or gender identity, and a further 6.6% have been referred to “be cured”. Of those referred, seven report visiting a mental institution – of these four did so on a voluntary basis, while three were forced into treatment.

In seeking to understand their data more fully, BiH and Hungary applied additional interpretative tools. In the case of BiH a psychologist working as a consultant to the project, grouped the responses to the questions on self-image into 5 groupings. The largest grouping was classified as stable because their answers were said to correspond to what would be considered mentally stable. This group represented 37.7% of the total. The characteristics of the sub-stable group vary from the stable group in that they feel they would like to change some/many things about themselves; the sub-stable middle group represents a mild version of the characteristics of the sub-stable group. With those grouped in the soft negative group, these are people who are generally satisfied with their lives but only because they cannot have any other and so sometimes experience feelings of wanting to be someone else. Those in the tough negative group often wish they were someone else and claim that there are a lot of things they would like to change in their lives. In addition they exhibit high levels of anxiety and depression. Finally the anxious group are characterised by heightened expectations of themselves and their world, a belief that they are not easy to like, and experience high levels of anxiety and depression. The anxious group represents 11% of the total number of respondents in the BiH survey. The author of that reports notes the limitations of this approach to the data, particularly within the overall context of the survey and its much broader and more general focus, and recommends that further research on LGBTIQ mental health.

In Hungary there was an attempt to test a hypothesis that the more out (i.e. able to be open and talk freely, at least with close friends) about one's sexual orientation and gender identity, the more responsible one would be about one's health and health care. To do this a range of indicators were identified, and responses to corresponding questions were disaggregated according to whether the respondents were out or closeted. The report does not indicate what benchmark was used to measure being out or being closeted. The authors conclude that their hypothesis was only partly substantiated. For example, contrary to what was expected, almost 40% of those in the out group practised unsafe sex, while the percentage was lower, 28.6%, among the closeted group, and 59% of the out group report consuming drugs while the percentage is only 12.5% in the closeted group. As was expected, a considerably higher percentage of the out group (81%) frequent gay or gay-friendly social venues, compared to 44% of the closeted group.

Experience of Discrimination



The experience of discrimination, in whatever form, impacts not only on physical and mental health, but also on one's freedom to exercise one's rights including the right to access appropriate health care. Respondents were asked about the forms of discrimination they experience, the places where discrimination most often occurs, whether they reported the discrimination and whether they were

satisfied with the response. They were also asked about the experience of discriminatory actions or attitudes within the health care system.

The practice of name calling was reported as the most common type of discriminatory behaviour in all five countries. In Hungary and Romania, almost 60% of the population surveyed report the experience of abusive name calling. For Moldova and BiH the proportion who experience name calling is over 40%, while in Macedonia it is 26% of those surveyed. In four of the five countries the threat of physical violence is the second most commonly experienced form of discrimination, while for those surveyed in Moldova it is the threat of sexual assault that ranks second. Table 10 shows the distribution of responses for the top three ranked in each country. In terms of where discrimination is experienced, the most commonly cited places are on the street, in cruising areas, in school and at work.

Table 10 Have you experienced any of the following because someone knew or presumed your sexual orientation / gender identity or expression? (responses as %)

	Bosnia Herezgovina	Macedonia	Hungary	Romania	Moldova
Name calling	40.4	26	59.2	58.3	42
Threat of violence	21.3	20	21.1	28.6	-
Sexual assault	2.2	-	14	22.8	27.2
Police harassment	-	18	-		10

The numbers of those who reported the discriminatory behaviour to either the police or other official agency are very low in all countries. The Hungary and Romania reports did not mention this aspect, while only three reported in Macedonia, five persons in BiH and seven in Moldova. Asked if their complaint was dealt with to their satisfaction, just one responded positively in both Moldova and BiH.

In relation to the experience of discriminatory treatment within the healthcare system, respondents were asked two questions. The responses are shown in Table 11. It is not possible to explain the significantly different responses in some instances to questions which are seemingly focused on similar topic. Why do only 1.5% of respondents in Moldova report having experienced a problem because someone in their doctor's practice knows or assumes their sexual orientation or gender identity and yet 19% indicate that they have been treated worse because of their identity? There is a similar gap in the numbers in Macedonia, while no such gap exists in Hungary's figures.

Table 11 Questions regarding experience of discrimination in healthcare services (reponses as %)

	Bosnia Herezgovina	Macedonia	Hungary	Romania	Moldova
Have you experienced a problem because of someone in your doctor's practice knowing about your sexual orientation or gender identity?	n/a	4	9.7	10.5	1.5
Have you ever felt that you were treated worse because of your sexual orientation or gender identity?	8.2	18	8.9	n/a	19%

Legal Environment

Legislative and Institutional Infrastructure



In this section we report the findings of a study of legislative and institutional framework within each country as it pertains to i) anti-discrimination and the promotion of human rights, and ii) relevant aspects of health care policy. The section begins with an introductory overview and this is followed by a report on the status in each country.

Introduction



The capacity of a state's legislative and institutional infrastructure with regard to the protection and promotion of human rights have a significant bearing on how individuals experience health and well being, particularly minority and marginalized populations.

The decriminalisation of consenting same-sex acts took place in most of the five countries surveyed in the late 1990s and for Romania in 2001. In all countries the age of consent is the same for same-sex and different-sex acts.

One of the factors that has a strong impact on the development of equality legislation and accompanying equality machinery is the state's relationship with the European Union. Currently Hungary is the only EU member state, while Romania is due to become a member in January 2007, and Macedonia became a candidate country in November 2005. BiH is participating in the EU Stabilisation and Association process and is therefore on track to attain to the status of candidature of the EU in due course. Moldova is, therefore, the only country among the five for which EU membership is not on the horizon. It is, however, part of the EU Neighbourhood Policy and has an EU Action Plan, which includes commitments to advancing human rights.

In the last four years, BiH, Hungary and Romania have all brought in new equality legislation which seeks to provide protection against discrimination, both direct and indirect, in the work place and in the

provision of goods and services. While it is not within the scope of this report to provide an analysis of the scope of these laws, it would appear that in general terms, they have been modelled on the EU Council Directive 2000/78/EC, generally known as the Framework Directive. Member States and candidate countries (which would include Romania) are required to transpose the provisions of the Directive into their national legislation and while the Directive covers four grounds (i.e. religion and belief, disability, age and sexual orientation), some member states have chosen to expand the group of protected categories. Recognised as the most important legal development in the area of non-discrimination, the Directive represents an important step forward in the achievement of equal rights for LGB people in EU member states. In the first instance, national laws have to change. Furthermore, in the process of changing laws, legislators, employers, trade unions and other relevant stakeholders will have to engage, some for the first time, with the workplace issues relevant to LGB people. The debate thus initiated will contribute to the broader project of changing societal attitudes to LGB people.

It has been observed that there is a gap between the establishment of the law and its full implementation and therefore the realisation of the law's potential benefits. One concern relates to an uneven spread of compliance. In addition, it has become apparent that there are weaknesses and shortcomings in the Directive itself which means that aspects of discrimination against LGB people are not covered, or, in some cases, are rendered more discriminatory. There is also the fact that in order to be activated, never mind effective, the legislation requires the person experiencing discrimination to come forward and initiate proceedings in order to prove the discriminatory practice and seek redress. This can be particularly problematic for LGB people.

Status Country by Country

Bosnia and Herzegovina

With the signing of the Dayton Peace Agreement following the 1992-1995 war, Bosnia and Herzegovina (BiH) emerged as an independent state. The tremendous social and political change for everyone in the region, which this event symbolized, extended to the LGBTTIQ⁵ community. Previously invisible, a community began to emerge.

Consenting same-sex acts were decriminalised in the Federation of BiH (FBiH) in 1996 and the Republica Srpska (RS) in 1998. The country's new status within the international community – as a new member of the Council of Europe and its developing relationship with the European Union – contributed to a new climate of courage in which the LGBT population felt the freedom to come out to friends and family and to become involved in activism. In 2001 a small group of people started organising around gay issues. Again in 2002, another group took an initiative, finally resulting in a formation of the Organisation Q, the first LGBTIQ organisation in BiH.

In 2003, anti-discrimination legislation – referred to as the Gender Equality Law – was adopted. This legislation prohibits discrimination on a number of grounds, including sexual orientation and gender. Covering direct and indirect discrimination, the law covers the fields of education, employment, social care, health care, sport and culture, and public life and media. There is a long way to go before the law is fully implemented and harmonized with other laws, and before the appropriate support and monitoring mechanisms are in place. The Ministry of Human Rights and Refugees is responsible for the implementation of the Gender Equality Law, and the Gender Equality Agency of Bosnia and Herzegovina is monitoring its implementation.

There are a number of factors particular to the situation in FBiH which have a bearing on the slow pace of legislative harmonization. In terms of full protection for the LGBTTIQ population being articulated in all appropriate laws, this will be a slow progress with the major influence and motivation coming from the

⁵ Organisation Q uses the abbreviation LGBTTIQ (Lesbian, Gay, Bisexual, Transexual, Transgender, Intersex and Queer) when it is about people, and LGBTIQ (without spelling out transexual people, as they are included in the umbrella term "transgender"), when it is about activism, movement, etc.

international community. Organisation Q points to the lack of dialogue about LGBTIQ issues, and therefore a lack of political will to tackle the issues. This position does not only mean sexual orientation, but also the issues of gender (defined individually and not by society alone), gender identity and/or expression and (inter)sexual characteristics which, as grounds for discrimination should also be included in and protected by this and other laws.

Organisation Q has noted that the Law on Gender Equality, nor indeed any other law in BiH, defines sexual orientation. Furthermore, Law on Gender Equality uses the word sex instead of gender, thus making word “rod” (gender) totally invisible or a conglomerate of word “*spol*” (sex). Thus the definition of gender is very unclear and confusing, suggesting that BiH legislation is only partially complete and could result in clarification having to come through legal processes in the courts.

Despite the commitment contained in the constitution regarding the protection and respect for the human rights of all individuals, there is no culture within the political apparatus or machinery of government of encouraging debate which would result in the development of a comprehensive concept of human rights and freedoms.

More recently a working group of NGOs began preparing a draft for new anti-discrimination legislation that would address widespread abuse of the rights of a number of vulnerable social groups in BiH. The draft legislation, a first version of which was due in June 2006, will cover women, national and ethnic minorities, the elderly, youth, persons with disabilities, persons of different political affiliation from the ruling parties, and persons of different sexual orientation.

Legislation Covering Healthcare

Recognized by the BiH Constitution, the right to health is also incorporated into the following national laws:

- Law on Gender Equality in BiH
- Law on Health Care FBiH
- Law on Health Care RS
- Law on Health Insurance FBiH
- Law on Health Insurance RS
- Law on Pension and Disability Insurance FBiH
- Law on Pension and Disability Insurance RS

The Gender Equality Law provides for non-discrimination in all spheres of life, including health care.

Article 13 specifically states:

“Everyone has an equal right to healthcare and access to healthcare services, including those relating to family planning, regardless of sex. Health care institutions shall take all necessary steps to prevent discrimination on the grounds of sex in the enjoyment of all forms of health care. The relevant authorities shall take all necessary steps to protect and advance the reproductive health of women.”

Although not specifically mentioned in Article 13, sexual orientation is actually covered by virtue of its being cited in Article 2 as one of the protected categories.

The laws pertaining to health care do not specify sexual orientation or anything besides sex as a ground for non-discrimination. They do, however, specify that these laws guarantee right to health to any/all persons.

Three main types of social and health insurance are recognised:

1. National health insurance
2. Extended health insurance
3. Voluntary health insurance

In all of these, the marriage partner can have benefits. However, Family Laws of BiH do not recognize same sex partnership and in such regards they discriminate against LGBT individuals and their partners. Same sex partners are disqualified from health, taxes and other benefits in a way that heterosexual partners are not⁶.

Most health institutions claim that their patients are not LGBTTIQ and that they have not worked with such clients, thus not having relevant experiences or special services for them. Among all the interviews conducted with health institutions, only one psychiatrist from Brcko District claimed she had one gay patient. According to her, this patient came for a different reason and not due to his sexual orientation or sexuality in general.

BiH does not have a national health policy and/or social policy. A few years ago the World Health Organization drafted a proposal on Reproductive Health Policy in BiH, but to date this has not been discussed or considered for adoption.

In addition, the overall health budget has been considerably decreased in comparison with the pre-war state. This of course means a lower level of health care service for everyone in the country.

⁶ Although the Family Law of FBiH was adopted after the Law on Gender Equality, it was not harmonized with it as stipulated in the Law on Gender Equality.

Data Protection and Privacy

All information regarding health status, diagnosis, prognosis, therapy and other medical procedures and treatment is protected and classified under professional privilege, even after patient's death. A patient is entitled to nominate other persons to whom this information can be disclosed.

Confidential data can only be revealed to the third parties with the patient's, or representative's, explicit consent, or in some cases of legal procedures where it is necessary according to the law.

Patients have the right to see their medical records, including all documents related to their diagnosis, therapy, treatments and other medical procedures, and to get their own written copies.

Medical professionals are prohibited from asking private questions which are not considered necessary for diagnosis, treatment or public health concerns. This would particularly concern questions on sexual orientation, sexual/gender identity and sexual practices. These questions become very important in cases of some epidemic/pandemic diseases such as HIV/AIDS, Hepatitis B and C, and similar situations where the official record on patient's private life are necessary, such as sexual practices, possible abuse of intravenous drugs etc. In these cases, private information provided by the patient is never linked to their identity without their consent, but used just for the purposes of statistics, tracking the disease, prevention and epidemiology campaigns for fight against the respective disease.

Despite these stipulated protections, the reality is often very different and the rights very rarely adhered to. It is quite common, for example, for patient's medical records can be accessed by almost anyone. It was observed that the specifics of individual cases were being used for public presentation, but no steps were taken by officials or by the individuals whose rights were violated, to stop such practices. Additionally, no legal procedures were undertaken in order to prosecute and/or punish the medical and media parties responsible for such events.

Transsexuality

According to the Diagnostic Standard Manual issued by the American Psychiatric Association, transsexuality is listed as a disorder of sexual identity. In many countries, individuals who are diagnosed with sexual identity disorder are provided with an array of health services as well as surgical modification of their sex and bodily integrity. Such services and procedures are covered by health insurance.

In BiH, transsexuality is not treated in any single way. Surgery for change of sex is not performed; nor is pre- and post-surgical procedures (e.g. hormonal therapy). Some of the interviewed officials/doctors admitted that their knowledge on issues of transsexuality is very modest and framed by instruction received at university. There is even considerable confusion with the terminology.

Surgeons who were interviewed were very clear that they have no interest in performing sex-change surgery, because they have no experience in it, and also because the respective pre- and post-surgical procedures are not provided within health care services in BiH. Therefore, all patients are being referred to bigger centres such as Belgrade, Zagreb, and Ljubljana. It is unclear whether health insurance covers such procedures, but this is unlikely.

Legislation of BiH does not recognize transsexuality and change or modification of sex in that regard. There is no single law regarding this issue, nor is there a law or standard procedure regarding modification of identity documents in regards to sex and unique birth number.

In 2003, when the new ID procedures were announced under the standards of EU, the question of sex change was featured in the form. Officials on the municipal level stated that change of sex would be administratively addressed the same way as wrongful write-up of sex, that is correction would be made based on the statement of a doctor. At the national level, an official stated that BiH will be adopting laws which will regulate sex change and that current forms include that information because of that reason.

It has to be noted that some BiH citizens who identify as transsexuals have initiated and completed sex change abroad. Furthermore, they were able to change their ID documents in BiH regardless of the fact that no standard procedure exists regarding this issue. The number of such cases is unknown.

Intersexuality

From the information available through the research, it would appear that the subject of Intersexuality is not addressed either medically or legally; neither in relation to health, nor human rights. It is unlikely that surgeries are being performed. Organisation Q has observed that intersexuality is regarded as a taboo subject, and as such it is unclear how much individual sexual identity plays a role, or is allowed to play a role in society.

Blood Donations

Anyone who wants to donate blood in BiH undergoes a brief interview, during which they are asked general medical questions as well as questions about drug use, recent piercing and/or tattoo, promiscuity, and homosexuality. The interview is seen as routine practice as a pre-screening and to minimize the possibility of contaminated blood that might arise when a donor might be infected, but has tested as negative for one or more STIs.

However, while there are risk behaviours there are no inherent risk groups. Whether a person uses protection is far more important than their sexual orientation. It is doubtful that gay candidates declare themselves as homosexuals when asked. However, this question is offensive and discriminatory because candidates declared as homosexual, especially male candidates, are not allowed to donate blood because homosexuals are considered to be promiscuous.

Artificial Insemination and Surrogacy

BiH has no legislation regarding artificial insemination, donation of egg cells and spermatozoa and/or surrogacy. Prior to the war, most patients seeking artificial insemination were referred to other centres in the state. Since 1995, there are a few clinics where the procedure is available. However, it is relatively expensive and costs are sometimes only partially covered by health insurance system. Even given the lack of legislation, the procedure is only available to married heterosexual couples.

Bosnia and Herzegovina and European Union

The Stabilisation and Association Process is the EU's policy framework for Bosnia and Herzegovina. Countries participating in the Stabilisation and Association Process have been offered the possibility to become, once they are ready, Member States of the EU. Bosnia and Herzegovina is therefore a potential candidate country for EU accession. Formal contractual relations between the EU and Bosnia and Herzegovina will be established through the signature of a Stabilisation and Association Agreement.

The process of including BiH into European integrations and Council of Europe membership contributed significantly to the process of LGBTTIQ visibility in BiH. Different forms of activism appeared along with decreased fear ratio of coming out in circles of friends and families.

If and when BiH becomes a candidate country, it will then have to engage with the process of satisfying the *acquis communautaire*, which has the potential of enhancing the legal protection of human rights.

Macedonia



Macedonia seceded peacefully from Yugoslavia after an independence referendum in September 1991, and was recognised by the United Nations in April 1993. The Constitution of the Republic of Macedonia guarantees equal rights to all regardless of sex, race, colour of skin, national and social origin, political and religious beliefs, property and social status.

In the Republic of Macedonia, homosexuality was decriminalized in 1996. Since then, despite its obligations as a Council of Europe member and its status as a candidate for accession in the EU, no positive steps have been taken towards fighting homophobia and discrimination on the ground of sexual orientation.

As a signatory to the European Convention for Human Rights (ECHR), the Republic of Macedonia must adjust its legislation according to the recent decisions of the European Court of Human Rights. The state must take positive steps to overcome a) the discrimination and violence against homosexuals; b) the “differentiated treatment of homosexuals under the law and in practice”; and c) “contemptuous or intolerant attitudes towards them.” Furthermore, the state must adopt “...measures in the areas of education and professional training to combat homophobic attitudes”.

On 13 July 2004, the former Yugoslav Republic of Macedonia ratified Protocols No.12, dealing with non-discrimination, and No.13, concerning the abolition of the death penalty in all circumstances, to the Convention for the Protection of Human Rights and Fundamental Freedoms .

As a candidate for accession in the EU, the Republic of Macedonia, like any new member of the EU, must fulfil the Copenhagen Political Criteria, which sets out respect for fundamental rights as a priority. Sexual orientation is explicitly stated as a ground for discrimination in the “Charter of Fundamental Rights of the European Union” (Article 21, 1).

New Draft Laws

A new draft law Gender Equality and Equal Opportunities for people with disabilities is currently going through the Parliamentary procedure in Macedonia. In addition, a draft law on Anti-Discrimination is also ready to go through parliament. There is some concern about the competition that might be stirred between these two pieces of legislation. It is reported that the women’s lobby is particularly concerned that the anti-discrimination legislation will undermine the gender equality law, which could result in the latter not being adopted.

Protection of LGBT Rights

In general terms, discrimination on any grounds is prohibited, however sexual orientation as possible ground for discrimination has not been singled out. The year 2006 is of great significance for Macedonia, partly due to the allotment of EU candidate status, as well as the up and coming parliamentary elections. It is for these reasons that the need has arisen to discuss and regulate the status and issues of the LGBT population.

The willingness to accept the draft law on Registered Partnerships (drawn up by legal experts employed by Macedonian Association for Free Sexual Orientation - MASSO and in accordance with European standards) is of great significance in solving the LGBT question. MASSO is currently awaiting the return of questionnaires which it sent to political parties.

Hungary

A Constitutional Perspective

The Constitution of Hungary⁷ recognises the inviolable and inalienable rights of all persons and obligates the State to protect these rights. It does not establish, however, the form of legal protection and the standards by which the efficacy of the law can be measured. Whether we can judge the state to have been efficient in protecting rights depends on which right is in question and who is the subject.

According to the Constitution, the law should incorporate rules on fundamental rights, but must not impose limitations on the essential content. The essential content of a fundamental right is delineated by the Constitutional Court in its specific decisions. In each case the Court has to determine whether the legal limitations endanger the essential content of the given right.

The focus of constitutional debate is frequently on the concept of 'essential content'. If, for example, the Constitutional Court establishes that an issue does not affect an essential element of the given right, or does not establish what is held essential, doubt is cast on what was intended by the legislator. There are issues

⁷ The Constitution of Hungary dates to 1949 and has been amended on a number of occasions since then.

regarding the admission of HIV positive people to obligatory health care and their free choice of physician, which are not regulated by law. Habeas Corpus is, however, of the opinion that they should be so as to provide legal guarantees for the protection of fundamental rights. The complaint process in relation to health care providers is not adequately regulated by law either, and the elaboration of the details is delegated to the providers, who are interested in minimizing the loss of prestige and avoiding litigation.

The Constitution regards human dignity as an inherent right, and the Constitutional Court defines it as a 'mother right', from which various other personal rights can be derived, e.g. right to access information and right to bodily self-determination. The Constitution, however, also specifies the right to the protection of secrecy in private affairs and personal data, which the legislators regulated in the Data Protection Act and Health Care Data Protection Act.

Equal Treatment and the Prohibition of Discrimination

In principle, the Constitution of Hungary recognizes the human and civil rights of all persons in the country without any discrimination (on the basis of race, colour, gender, language, religion, political or other opinion, national or social origins, financial situation, birth or any other grounds whatsoever), and such discrimination is strictly punished by law. However, these constitutional guarantees remained merely declarative for LGBT people.

Until January 2004, when the Act on Equal Treatment and the Promotion of Equal Opportunities (Act Nr. CXXV. of 2003, hereafter: Equal Opportunities Act) entered into force, the only laws which prohibited discrimination were the Labour Code, the Act on Public Education and the Act on Public Health. Only the latter explicitly prohibited sexual orientation-based discrimination. In all other cases, the question whether sexual orientation is included under the heading "other situations" is a matter for interpretation. It is the case that the Hungarian Constitutional Court in 2002 ruled that those sections of the penal code which mandated a higher age of consent for same sex couples were unconstitutional and eliminated them.

As a member of the EU, Hungary is required to transpose the provisions of EU directives into its national legislation. For this reason the Hungarian law is based on what is regarded to be one of the most important advances in the field of non-discrimination. However, as in other EU member states, there is often a sizable gap between transposition and implementation. The law created the framework for setting up an equality body, which was established in 2005 and which functions as an administrative organ under the supervision of the government. It is vested the power to impose sanctions and victims can choose to pursue their rights through the equality body or through the courts.

Among its provisions, health care providers are obliged to observe the principle of equal treatment in creating legal relationships, as well as in all actions and procedures relating to such a relationship. The Act prohibits any conduct that treats an individual, or a group, disadvantageously based on their actual or assumed sexual orientation, gender identity or family status. An important aspect of the law is that the establishment of unequal treatment must be based on comparison. There are situations, however, where no comparative individual or group may be found.

The law protects against direct and indirect discrimination. With regard to the LGBT community and health care, an example of direct discrimination would be when a doctor refuses to examine a male homosexual patient. This type of discriminatory behaviour has happened in Hungary and is rooted in the stereotype that all male homosexuals are HIV positive. Indirect discrimination could occur when procedures are based on the assumption of heterosexuality, and may unknowingly discriminate against someone of a different sexual orientation.

The law also protects against harassment that is a behaviour that violates human dignity. In relation to sexual orientation, harassment might be said to have occurred when the purpose or effect of behaviour is the creation of an intimidating, hostile, humiliating, disgracing or aggressive environment. Perhaps the most frequent example is the deliberately offensive remark about the declared or assumed homosexuality of the patient. It might take the form of intimidation, maybe even blackmail of the patient, as a consequence of which they are unable to practice their right to the free choice of physician, and turn to another health care provider.

Unlawful segregation is also prohibited, and this related to, among other things, the placement of the patient in the hospital. There is no information about this kind of discriminatory behaviour in relation to sexual orientation, but there is evidence of segregation and other humiliating treatment of patients undergoing sex-change surgery.

Under the law, people are protected if they protest against treatment which they experience as discriminatory. Another important element of the law is in relation to a shift in the burden of proof, which means that the person who experienced discrimination does not carry the burden of proving discrimination; rather the onus is on the accused to prove that his/her behaviour did not constitute discrimination. It appears that Hungarian application of this principle goes beyond the EU minimum standard, in that it is extended to all procedures related to discrimination, whereas prior to the law the reversed burden of proof existed only in labour law. In addition, the law allows associations and

other entities with a legitimate interest to engage in judicial procedures on behalf, or in support of victims of discrimination.

A recent review of the legislation by the EU Network of Independent Legal Experts pointed to some of the limitations of the law, namely that sexual orientation is not defined within the law, the obligations of non-discrimination does not apply to all persons in the private sector, and the definite of discrimination is more restricted than that set out in the EU directive on which the law is based.

Same-Sex Partnerships

In 1995 the Constitutional Court legalised lesbian and gay partnership by declaring that the previous law limiting partnerships to 'those formed between adult men and women' was unconstitutional. The Parliament was ordered to make the changes necessary to recognise same-sex partnerships by 1 March 1996. The partnership law in its present form includes any couple, of whatever sex, that live together permanently in a state of 'financial and emotional communion'. It is a factual legal relationship, which comes into existence without any official registration; thus it has underlying problems of proof. Law reform is therefore needed to 'institutionalise' same-sex relationships and to prevent family and other policy practices discriminating against same-sex couples.

Data Protection

According to the Data Protection Act, data on health status and sexual orientation qualify as special data, which can only be managed with the written consent of the person concerned, or in any other case specified by law, for example by the Health Care Act. The Act limits the type of personal data that can be managed to that which is essential to a particular purpose, and only to the extent that is required to achieve the specified purpose. A Constitutional Decree establishes the principle that the collection and processing of personal data for undefined, arbitrary, future use ('collection for stock') is unconstitutional. This applies not only to special data, but to all personal data, and also to general enquiries which have no defined purpose, e.g. when police officers ask questions about sexual orientation during ID check.

The Health Care Data Protection Act defines health care data as any data regarding physical and mental status, addictions, data on the *circumstances of the development of the disease, as provided by the patient or any other person*, or observed, examined, measured, obtained or derived *by the health care provider*, furthermore any data related to, or influencing, *these* (e.g. behaviour, environment, occupation).

The sphere delineated by the italicized data includes cases in which the cause of the illness has only a distant relationship with the sexual life of the patient. When the physician asks questions about physical state, complaints, etc., it is not possible to know what information will influence, or be important regarding health care and medication. This uncertainty can mean that doctors have free reign when seeking information.

The Constitutional Court, however, struck out a provision of the act which stated: 'if the purpose requires, data on sexual habits qualify as health care data'. The purposes allowed by the Act are, among others, tracing the health status of the person concerned and carrying out necessary public health and epidemiological measures. Although as a consequence of the decision of the Constitutional Court, the sexual habits of the patients cannot be recorded on their own, they may become relevant in terms of 'behaviour'. Thus, the physician may ask about the circumstances of the development of the disease in cases where sexual behaviour may reveal relevant information (e.g. sexually transmitted diseases, or some illnesses or injuries of other kind).

Although information about sexual behaviour and the circumstances of the development of the disease do not include the sex of the partner (there are no sexually transmitted diseases, or any other illnesses, that can be transmitted only by a same-sex partner), the patient may be obliged to give information about the sex of the partner, since tracing the spread and growth of an infection qualifies as public health interest. At the same time, the examination of the partner or any other person living in proximity to, or together with the infected person might be important in the case of other illnesses, not only sexually transmitted diseases (e.g. tuberculosis or any other curable, but dangerous, infections).

According to Habeas Corpus, contact tracing is used, mainly with HIV positive patients, by the health care provider to intimidate patients. In the case of HIV, however, contact tracing is unsuitable for mapping the spread of the infection, since HIV is characterized by a relatively long window or latent phase, during which the antibody of the virus cannot be detected in the blood, but the infected person can unknowingly transmit the disease. These situations cannot be revealed by contact tracing, and distrust and fear of becoming defenceless may result in those practicing unsafe sex being afraid to attend screenings.

Thus, the Health Care Data Protection Act still enables contact tracing and the recording and management of the partners' personal data, if the partner was exposed to the danger of infection. In its decision, Nr.65/2002. (XII. 3.), the Constitutional Court rejected the request to establish the unconstitutionality of the section enabling contact tracing. Habeas Corpus believes that it would be in the interest of the public good if, instead of contact tracing, safe sex practices were encouraged and screening could be provided in an environment which does not leave people feeling feel humiliated and defenceless.

Artificial Insemination

Artificial insemination is a procedure regulated by the Health Care Act, which can be resorted to by women if the procedure is not used exclusively to 'correct' or cure certain types of female infertility. According to the Act, the reproduction procedure may be carried out in the case of spouses or persons living in heterosexual partnerships if there is a high probability that, due to the medical status (infertility) of either party, a healthy child cannot be conceived in the relationship. In this case, the Act respects the woman's right to have children even if restricted by the partner. The 'treatment of infertility' is allowed by the Act only if the legal position of the father is not in question, without requiring any biological link between the father and the child. Thus, discrimination against single women and lesbian couples stems from the regulation of the father's position, and thus cannot be changed unless the regulations of family law are changed as well. Single women can only be the subjects of artificial insemination if the marriage or partnership is terminated after the insemination of the female gamete.

While the requirement of equal treatment must be observed in all areas of healthcare, there are exceptions defined in the Act. One such relates to the conditions for artificial insemination. Accordingly, a behaviour, procedure, condition, omission, order or practice does not violate the requirement of equal treatment, *if it has an objectively deliberated, rational reason, directly relevant to the given legal relationship*. In the current legal environment, the exclusion of lesbian couples or single women from access to artificial insemination is regarded by many as a violation of the principle of equal treatment on the bases of marital status and sexual orientation. Habeas Corpus is of the opinion that when it comes to the consideration of the rights of lesbians, bisexuals and non-married women in relation to child-bearing, these are assessed on the basis of religion and ethics to such extent that the concepts of objective deliberation and rational reasons become legally uninterpretable.

In Hungary, the procedure of artificial insemination is only available under the public healthcare systems, unlike in other states where single women, who can afford it, may take advantage of private providers as well.

Mental Health and the Law

The Constitution of Hungary recognizes everyone's right to the highest possible level of physical and mental health through the organization of health care institutions and medical treatment. Medical treatment and services are regulated by the Health Care Act (Nr. CLIV of 1997). The aim of the act is to secure everyone's equal access to health care services and to provide conditions in which the patients'

rights are respected and protected. According to the Act, the protection of health and prevention from illness can only be accomplished through the provision of equal opportunities. The rights of patients enumerated in the law are as follows:

- The right to choose the doctor.
- The right to not be subject to torture, inhumane or degrading treatment.
- The right to keep in touch with members of the family and next of kin.
- The right to leave the health care institution.
- The right to easily accessible information.
- The right to self-determination in relation to treatment, including the right to refuse treatment.
- The right to know the content of the medical records.
- The right to patient doctor privilege.

Habeas Corpus has observed that the right to choose a doctor is very limited in the case of HIV positive persons and people living with AIDS, since the necessary level of treatment is only available at few service providers, often far from the patient's residence. In the case of people living with AIDS, there is only one hospital department in the country that provides the necessary treatment, and many of the persons living with HIV/AIDS are refused basic services on behalf of dentists and family doctors.

With regard to the legal definition of next of kin, this includes the same-sex partner (cohabitant) of the patient. The patient has the right to decide who is allowed to visit and who is not, as well as the qualified health information that may be shared with family members and next of kin. A number of respondents in the research felt that the health care service providers do not take these rules seriously.

There are two exceptions to the patient's right to refuse treatment: in the case of life-saving interventions and measures taken in the event of an epidemic.

Romania



The Constitutional Framework

The equal treatment of all citizens is guaranteed by the 2003 Romanian Constitution. An entire chapter is dedicated to the freedom of citizens, including the right to life, the right of physical and mental integrity (Art.22), individual freedom (Art.23), the right of defence (Art.24), the right to private and family life (Art. 26), freedom of conscience (Art.29), freedom of expression (Art. 30), right for health protection (Art.34), right of assembly, etc.

All of these human rights, which are constitutionally protected, are to be interpreted and applied in accordance with the Universal Declaration of Human Rights and other international treaties and conventions signed and ratified by Romania. Nevertheless, appropriately drafted and effectively implemented legislation is required for their realization and enjoyment. It should be noted that the Romanian Constitution does not prohibit discrimination on all the grounds covered by the anti-discrimination law (such as sexual orientation), despite the proposed drafts submitted by several NGOs, including ACCEPT, during the Constitutional Forum.

Anti-discrimination Legislation

The first step in the reform of the legal system to provide protection against discrimination on the basis of sexual orientation came in 31 August 2002, with the adoption of Ordinance no. 137/2000. This is concerned with the prevention and punishing of all forms of discrimination. Protected groups are defined on comprehensive grounds including:

Art. 2.1. "race, nationality, ethnic belonging, language, religion, social status, beliefs, sex or sexual orientation, belonging to a disfavoured category or any other criterion..."

Art.4: "disfavoured category" is the category of persons that is either placed in a position of inequality as opposed to the majority of citizens due to their social origin or to a handicap or is faced with rejection and marginalization due to specific circumstances, such as a chronic non-infectious disease, HIV infection or the status of refugee or asylum-seeker."

The areas of application of the anti-discrimination legislation are defined by Art.3 as amended by Law 48:

- a) employment conditions, criteria and conditions of recruitment and selection and promotion, access to all forms and levels of professional orientation, professional training, and refresher courses;*
- b) social protection and social security;*
- c) public services or other services, access to goods and facilities;*
- d) the education system;*
- e) enforcement of public peace and order;*

The ordinance provides legal remedies for a separate civil action claiming civil remedies granted by the courts. However, this procedure is not designed to support and encourage the access of victims to justice, because of the need for a separate legal action. It is also still unclear how this procedure can be used in the court. A positive provision of the ordinance is that which allows for an active legal role by a relevant NGO.

Mechanisms to Ensure Implementation

The main body charged with ensuring the implementation of the legislation is the National Council for Combating Discrimination (NCCD). The Steering Board was appointed in July 2002 and the Council was given powers to levy penalties and to forward policy recommendations. However, the European Commission and other human rights/minority rights NGOs have expressed concern that NCCD is not truly independent due to its administrative subordination to the Government. Thus, although the first among the accession countries to adopt anti-discriminatory legislation, Romania faces undesirable delays in the implementation of its provisions. One of the main factors in this delay is seen to be the failure of the NCCD to exercise its mandate.

EUMAP⁸ has reported that other factors relate to the general low level, in all aspects of life in Romania, of awareness of human rights. It points to the fact that lawyers and the courts very seldom invoke human rights principles in judicial proceedings. Moreover, it notes that the media frequently uses racist or sexist language, and discriminates against various categories of people with impunity, “thus creating the impression that such conduct is normal and acceptable to society at large.”

Equal Opportunities Legislation

In 2002 Romania also adopted new legislation on equal opportunities between men and women. As part of the process of adopting the *acquis communautaire* in line with accession to the EU, the new legislation

⁸ EUMAP, a program of the Open Society Institute which monitors the development of human rights and rule of law standards and policies both in the European Union and candidate countries

was based on EU directives. As such, it incorporates many important and progressive elements: it covers, and explicitly, defines, direct and indirect discrimination, harassment, positive discrimination, the reversal of the burden of proof, etc. In addition it covers all aspects of employment relations, as well as education and access to health. However, the state has not yet developed adequate mechanisms to implement the law and to promote and develop policies for equal opportunities. Under the law a range of agencies and departments within the Ministry of Labour, the Ministry of Health, the Ministry of Education, and the Ombudsman are charged with its implementation.

The first step in effecting the equal opportunities legislation is a process of mediation during which the trade union can act on behalf of the victim. If the mediation fails, the victim can initiate a legal action before the labour courts or before the administrative courts, during which she/he can demand civil damages and the re-establishment of his/her prior status. Significantly, the trade unions and NGOs with a legitimate interest in this area can have active legal standing and might be able to represent the victim with his/her consent.

A difficulty in effectively implementing these legislative instruments – Ordinance 137 and the Equal Opportunities Law – is the overlap and, some observers have noted, the contradiction in some of the respective provisions. Despite parliamentary debate on both instruments having taken place during the same period, it would appear that no attention was paid to their harmonization in the context of effecting equal rights for all. Some examples of discordance include different level of fines and different procedures for access to remedy. In addition the more recent legislation – the Equal Opportunities law – makes no reference to Ordinance 137 and takes no account of its legal provisions. Neither does it make any reference to the National Council for Combating Discrimination. Instead, the law establishes various ministerial committees and recommends making use of other existing institutions.

Thus the responsibilities between the NCCD and the Ministry of Labour, Family and Social Solidarity are overlapping. At this moment, the National Agency for Equal Opportunities between Women and Men within The Ministry of Labour, Family and Social Solidarity can assess and suggest sanctions in cases of alleged discrimination based on gender. The Agency then submits a notification to the NCCD, the only institution with a clear legal mandate to apply a sanction.

HIV/AIDS Legislation

A positive feature of the legal system in Romania is the existence of a specific law to prevent and limit the spreading of AIDS, including provisions for the protection of people who are HIV positive and people living with AIDS (PLWA). However, the law fails to explicitly mention some vulnerable groups, such as MSM

(men who have sex with men) and CSW (commercial sex workers). This could result in these groups being excluded from the national strategies of intervention.

Several provisions on protection, confidentiality and adequate treatment are included in the law and seems satisfactory from the medical point of view. However, due to the importance of these measures in this sensitive field, it is felt that it is important to establish specific penalties (fine, warning, dismissal, etc.) in order to ensure uniform compliance. It is necessary to mention that, in some cases, if the confidentiality of the medical act is not respected, a LGBT patient can use provisions of the anti-discrimination law which cover both sexual orientation and HIV positive status as legitimate grounds.

The law recognises the role of NGOs in HIV/AIDS prevention, stipulating that the activity of these organisations is supported by the Romanian Government. It is important for NGOs that their HIV/AIDS prevention activities and support for PLWA is not just recognized, but encouraged through state grants and tax facilities. The law neglects entirely this fundamental element of supporting the capacity of NGOs who are completely dependent on external financial resources.

National Strategy for Surveillance, Control and Prevention of HIV/AIDS, 2004-2007

The national strategy was put together by the AIDS National Commission, an inter-sectoral body under the authority of the Prime Minister. Eight NGOs, including ACCEPT, were actively involved in the preparation and developing of the national strategy, in partnership with a significant number of international agencies and donors. The strategy proposes three major areas of intervention: (1) prevention of HIV transmission in order to maintain the HIV incidence in 2007 at the level of the year 2002, (2) access to treatment and care for PLWA and vulnerable groups, and (3) the surveillance of HIV and associated risks factors.

A distinct chapter is dedicated to men who have sex with men (MSM), which is partially reproduced below:

“Key elements for HIV and STI prevention among homosexuals

a) Creating an enabling environment for program development

Objective

Reduction of discrimination and promotion of the active involvement of people with homosexual orientation in the elaboration and implementation of strategies and programs.

Strategies

- Continuation of the discrimination reduction campaign using also institutional instruments as the

National Anti-Discrimination Council and the National HIV/AIDS Surveillance, Control and Prevention Commission.

- Establishment of partnerships among public programs and the organizations of the people with a homosexual orientation in order to develop joint programs.

b) Expanding programs at national level

Objective

Reinforcement of community based organizations and model replication in order to develop activities to a national scale that will reach at least 60% of the people with homosexual orientation.

Strategies

- Initiation of partnerships between community organizations and local authorities in order to increase the efficiency and coverage of programs;
- Increase the number of organizations which develop HIV prevention activities among this group and creation of a collaboration framework;
- Expansion of pilot programs in other areas where such programs are needed, based on research/evaluation
- Expansion of peer educators programs among people with homosexual orientation;
- Promotion of MSMs' access to health and preventive programs;
- Large-scale introduction of condoms and appropriate lubricants".

However, this multi-sectoral approach and involvement in HIV/AIDS prevention targeting MSM has not been supported financially by the Romanian Government. The entire budget for MSM activities for 2004-2006 was covered by the Global Fund to Fight AIDS, Tuberculosis and Malaria. There are no signs of political will so far that the Romanian Government will finance such types of prevention programs and activities toward MSM in the future.

Law on Reproductive Health and Medically Assisted Human Reproduction

The draft law approved by the Parliament in 2005 restricts access to artificial insemination based on marital status. Gay couples are explicitly rejected. If the Law is passed, then it will clearly infringe on the civil rights of those from within the LGBT community who would want to avail of artificial insemination. Recently, the Presidential Office redirected the draft to the Romanian Constitutional Court.

Mental Health

In July 2002, Romania adopted the Law on Mental Health and Protection of people with mental disability, acknowledging that mental health is an inseparable part of public health policy. This law is a step forward, since it is widely known that Romania is facing a severe crisis in terms of the lack of basic human rights protection for people with mental disabilities, especially those who are placed in psychiatric institutions where their rights are basically suspended.

In its Resolution on Romania's progress towards accession, the European Parliament issued a call concerning cases of human rights violations and ill-treatment in mental hospitals. The Parliament expressed its deep concern at the fact that people with mental disabilities are subjected to arbitrary detention in mental hospitals and other residential institutions.

What is the connection between this particular situation and the health status of LGBT people? Information received by ACCEPT raises concerns that in some cases, especially among the youth, LGBT people can be involuntarily referred to psychiatric institutions based on decisions taken by their parents eager to find a "cure" for homosexuality. Despite the fact that Romania is a member of World Health Organization, there are still psychologists and psychiatrists who believe that homosexuality *per se* is an indicator of mental and/or emotional disorder, if not a mental illness. The expression of such views in public is not a rare phenomenon in contemporary Romania. Some mental health practitioners have pointed out that homosexual orientation can be changed through a therapeutic process. A significant number of psychological counsellors working in the public educational field have little or no information about sexual orientation issues, often reacting to the needs of their LGBT beneficiaries in a judgmental and negative way.

The Mental Health Law contains a controversial paragraph which could attach negative value to homosexuality: "Mental health protection consists of the adoption of measures by institutions empowered by law, in order to limit the spreading of concepts, attitudes and behaviour harmful for mental health, especially drug abuses, violence, *unnatural sexual behaviour* and pornography" (Article 7, par.1).

Contrary to any attempt to tackle stigma, discrimination and inequality associated with homosexuality, this particular provision runs the risks of being instrumental in the stigmatization of the LGBT lifestyle, legitimizing societal prejudice and discrimination.

Other aspects of the law could also prove problematic, from a general human rights perspective, such as that

which provides for the transfer of medical files and other information. The law states that this can be done “when the transfer of the patient is carried out, if the patient agrees to be transferred”. It is not specified whether the medical files can be transferred in the case when a patient is transferred without his/her consent.

Involuntary admission is a particular sensitive area, knowing that for many years the Communist Romania detained homosexuals in psychiatric facilities. The law specifies that the patient and his/her representative “can apply to a competent judicial body, challenging the decision of involuntarily admission”, (article 54, par. 1). It is unclear what decision can be challenged: the physician’s decision or the commission’s decision who approves (or not) the physician decision. No proceedings applying to the hearings in the court or within the psychiatric units are specified.

Data Protection

In November 2001, the Romanian Parliament enacted Law No. 677/2001 for the Protection of Persons concerning the Processing of Personal Data and the Free Circulation of Such Data. The law was intended as a transposition into national legislation of the EU Directive on data protection. Establishing the fundamental legal framework for the protection of individuals related to processing personal data, the law regulates the specific circumstances under which the processing of personal data can be considered lawful. Its provisions also address crucial factors such as legitimate processing, data quality, definitions of the fundamental terms (e.g. operator, data subject, processing etc.), and the rights of the data subjects and the obligations of the operators of personal data.

Crucially it designates the People’s Advocate, or Ombudsman, as the Romanian Supervisory Authority on data protection. In addition to providing guarantees in relation to the collection and processing of personal data, it outlaws the processing of “sensitive” data on a person’s race, politics, health, religion, sexual life, criminal record, etc., in the absence of proper legal safeguards. The Law also recognizes fundamental rights for the data subject, such as the right to be informed about the processing, the right to access the information, the right to oppose at any time to the processing, provided that the person has legitimate reasons in this sense. Furthermore, the data subject has the right to oppose to the processing of its personal data, if the purposes of the processing are directed towards marketing research, to obtain or to transmit commercial, advertising or marketing information. Law 677/2001 applies to the processing of personal data performed, totally or partially, through automatic means, as well as to the processing through means other than automatic, which are part of, or destined to, an evidence system. Personal data is understood to be any information referring to a natural person, identified or identifiable; an identifiable person is that person who can be identified, directly or indirectly, particularly with reference to an

identification number or to one or more specific details of his/her physical, physiological, psychological, economical, cultural or social identity. The law stipulates the rules regarding the processing of personal data and the principle of prohibition of processing personal data linked to ethnic or racial origin, to political, religious or philosophic opinions or of another, similar nature, to trade-union adhesion, and also of personal data referring to state of health or sexual life.

However, observers have noted that the Romanian authorities have failed to pay enough attention to the protection of personal data, and that the office of the Ombudsman was not adequate to the task. The EU Commission was critical in its 2004 report on Romania, urging that changes needed to be made to bring Romania in line with other member states. The situation significantly improved in 2004, when the number of people employed within the personal data protection division of the People's Advocate institution increased. In addition, there was a significant increase in the level of training in specific sectors, promoting personal data protection and the obligations related to this domain.

Finally, there are plans for the establishment of a National Authority for the Control and Supervision of Personal Character Data Processing" (ANSPDCP). The New Authority shall have at its disposal all necessary resources (logistical, human capital-dedicated specialists, administrative structures, as well as financial means) in order to ensure an efficient and correct promotion and implementation of the Law. The Authority shall have a President with the rank of Ministry and a Vice-President with the rank of Secretary of State. It is intended that this new body will have the independence and autonomy to adequately enforce the legislation with regard to personal data, in a way that protects human rights.

Moldova

Adopted in 1994, the Constitution of Moldova codified certain basic human rights, and the Government of Moldova has committed itself to the adoption of laws and other measures that would ensure the protection of human rights. In particular, there is a commitment, in the context of its obligations to the Council of Europe, to ensure the rights of sexual minorities. In addition, within the terms of its relationship with the European Union, there is the expectation that such laws would be consistent with EU standards on anti-discrimination.

On April 29, 2003 Moldova signed ***The International Covenant on Economic, Social and Cultural Rights (CESCR)***. The provisions and obligations of the Covenant are elaborated by the UN Committee for

Economic, Social, and Cultural Rights, which has also detailed specific directives aimed at the implementation of the Covenant.

This Covenant sets a clear legal framework which recommends eliminating any aspect of discrimination from national legislation, concerning adoption and the modification or the abrogation of national legislation. Further, the Covenant encourages the signatory states to develop anti-discriminating programs oriented towards socially vulnerable groups.

These commitments are given expression in the National Action Plan for Human Rights, adopted by the Parliament of Moldova in the autumn of 2003 and are also included in the EU-Moldova Action Plan. The latter clearly indicates the “development of the anti-discrimination law for minorities in line with European standards”.

Even though the plan to introduce such legislative changes is included in the Calendar Plan of Legislative Activities, there is no mention of protection of sexual minorities in the document adopted by the Parliament of the Republic of Moldova (Decision No. PP0284/2005) on November 11, 2005.

Moldova established relationships with the European Union in 1992, when it was included in the program of assistance provided to the newly independent states. At that time Moldova signed a Partnership and Co-operation Agreement (PCA) with the EU. More recently the EU expressed its intention to significantly upgrade its political and economic ties with Moldova, a decision which resulted in the EU-Moldova Action Plan as part of the EU Neighbourhood Programme.

The Right to Medical Assistance

The right to health care is guaranteed by the Constitution of the Republic of Moldova and provided for in Health Care Law no. 411 of 28.03.1995. However, because of scarcity of funds and the budget available for health care services, the law which assured a minimum level of service free of charge was annulled in January 2004. Instead, compulsory medical insurance came into force and the minimal free of charge medical services system granted by the Program of compulsory medical insurances was introduced. This policy development is aimed at reviving an ailing health service in Moldova.

The right to medical assistance is granted by the state to all people under state jurisdiction without discrimination. However, in reality, some categories of people have limited access to primary medical services. According to a report by the United Nations Development Program and the Institute of Public Politics of Moldova, 44.1% of the population has full access to medical services, another 40% has limited

access, and 15,1% has no access to these services. Among those with limited or no access, it is safe to conclude, are some from the LGBT community.

Data Protection

The deontological code and the medical care legislation stipulate that the personal medical data of the patient shall remain confidential. The patient has the right to be informed, and the doctor is obliged to inform the patient about his/her state of health, the diagnosis, the prescribed treatment and the indicated medicine. In a case where the patient is unconscious or declared irresponsible, the doctor is obliged to inform the relatives.

Sexual minorities are granted the right to confidentiality of their medical data according to general principles, just as any other patient. Article 14 of the Medical Care Law stipulates that doctors, other medical staff, and pharmacists are obliged to keep secret information on the disease and the personal life of the patient, except in cases of transmissible infections, as a request of the criminal law authorities.

Mental Health

There is evolving legislation and policy development in the area of mental health in Moldova. Currently, there is only legal provision for psychiatric assistance and psychoactive drugs. The responsibility for elaborating mental health legislation and policy is shared by a number of different divisions within the Ministry of Health. The provision of services is limited to psychiatric services with little or no psychological services on offer. There are a total of 2,400 psychiatric beds available and the main treatment method is with medication. Social and vocational treatment is minimal.

A recent development is a document published by the Ministry of Health elaborating mental policy and activity for the period 2005-2008. A primary motivation for this policy document was a 2004 project entitled "Enhancing Social Cohesion through Promotion of Mental Health Community Services in South-Eastern Europe". According to the mental health policy "Community assistance will integrate into these types of structures of mental assistance, which suit the needs of the community and have as their purpose eliminating brands and discrimination of the people with mental disturbance, observance of human rights and psychical and social integration." The World Health Organisation is working in collaboration with the Ministry of Health in the development of these new approaches.

GenderDoc-M team, in a dialogue with Mr. Mihai Hotineanu, the chief psychiatrist with the Ministry of

Health and member of the Mental Health policy Work Group, has received an assurance that the new policy will address the LGBT issues in this area. Currently there are no health care services specifically designed to meet the needs of the LGBT community in Moldova. Only a few have access to the gay-friendly services offered by GenderDoc-M (social counselling and medical consultations). These services are accessible only to people living in Chisinau, while those in the Southern and Northern regions of Moldova lack this possibility. State psychiatric services are available through the normal avenues but they are not geared to meet the specific needs of the LGBT community and, fundamentally, they are delivered within a system in which homosexuality is still presented as a sexual deviation in institutes of higher education.

Artificial Insemination

Medically assisted human reproduction is an ensemble of clinical, biological and laboratory procedures that allow artificial insemination, *in vitro* fertilization, embryonic transfer, as well as other techniques equal to procreation except the natural process. The right to Medically Assisted Human Reproduction is granted by the Law of Reproductive Health Care and Family Planning (No. 185-XV of 24.05.2001), article 10(1). The right to artificial insemination is stipulated in a separate document, a regulation adopted by the Government, at the proposal of Ministry of Health. According to the information received from the Ministry of Health, the National Scientific and Practical Centre of Reproductive Health, Genetics and Family Planning has registered 150 artificial inseminations with the sperm of the husband or the donor, as well as in the region of one hundred *in vitro* fertilizations.

Because of the difficulties faced by members of the LGBT who want to have children, there is a desire to pursue the route of medically assisted human reproduction. However, this treatment is only available to married couples. Both husband and wife must submit separate written requests, citing the reason for applying for artificial insemination services. Single women are not entitled to access artificial insemination. Thus a lesbian cannot undergo inseminations by legal means.

Moldova's legislation does not stipulate any direct regulations about the surrogate mother, nor any relationship with the sperm donors and their judicial status to the child.

There is a regulation in the Family Code related to artificial insemination that stipulates that the husband who had agreed in written form to artificial insemination, or the wife's embryonic implant has no right to dispute paternity.

Surgical Change of Sex

The Moldovan Healthcare Law no. 411 of 02.04.1995, the main law of the health care system, does not directly stipulate for medical assistance for change of sex. However, sex change is recognised in that the civil state acts Law stipulates procedures for changing, rectifying of filling the civil state act in case of submitting an official document indicating the change of sex. This kind of assistance is offered to all people, depending on technical and medical possibilities, and is treated like any other surgical treatment. Thus, there is no legal prohibition of identification with the help of medical procedures of changing the biological sex.

According to a letter from the Ministry of Health (nr. 06-32/244 of 11.10.2002), in Moldova there is no record of people undergoing mental treatment or being hospitalized in mental clinics wishing to change sex. This same letter makes reference to the fact that homosexual relationships are studied as sexual perversion within the teaching of psychiatry.

Since 1992 only 2 people diagnosed with “transsexualism” were examined and treated. The persons received a certificate presenting no contraindications to change their sex.

Reproductive Health, HIV/AIDS and Other STIs

Reproductive health is regulated by the Reproductive Health Care and Family Planning Law (No.185-XV of 24.05.2001). This law grants some basic rights of the reproductive health that have common aspects with the LGBT community. For example this law stipulates for the right to donate sexual cells and the right to artificial insemination.

Another aspect of interest for research is the right of minors to reproductive health care and to sexual education (Article 8). It is of interest if the **sexual education** curricula for young people includes the notion of sexual orientation, and describes the risks of different sexual practices for heterosexuals as well as for homosexuals.

The Ministry of Health elaborates laws, national plans, and strategies in the field of reproductive health, HIV/AIDS and other Sexually Transmitted Infections (STIs). Recently, the Ministry of Health has initiated a strategy for communication in the field of HIV/AIDS, in which GenderDoc-M participated, together with other organizations working in this field. The Communication Strategy is intended to become part of the

National Program of HIV/AIDS and Sexually Transmitted Infections, and will be integrated in the Health Care Communication Strategy. According to the text of the strategy, Men Having sex with other Men (MSM) are included as a target group, and the Ministry will also collaborate with other NGOs and LGBT members in implementing the strategy.

The Republican AIDS Centre is an institution that carries out HIV tests. GenderDoc-M has collaborated with this institution for about 3 years. At the same time the AIDS Centre is active part in preparing and developing different activities for HIV/AIDS prevention within the LGBT community. The AIDS Centre also gives support in establishing contacts with the Ministry of Health. It should be mentioned that *the National Program of HIV/AIDS and Sexually Transmitted Infections prophylaxis and control in the Republic of Moldova for years 2001-2005*, included prevention activities for groups like people with homosexual orientations and MSM from the military corps, carabinieri troops and penitentiary institutions.

The Republican Dermatovenereal Dispensary is the only organization offering qualified medical assistance to people living with AIDS (PLWA). The Public Dermatovenereal Dispensary is an institution that also offers services of diagnosis and treatment of STIs. Neovita is a medical NGO offering treatment services for GenderDoc-M's beneficiaries.

Criminal Charges for Infecting with AIDS

If a person knowingly infects another person with the AIDS virus, they are liable for prosecution under criminal law. Such an act is viewed as an offence against public health and social co-living. The legislation was adopted with a view to protecting the population from contamination with AIDS, to controlling the rapid spread of this disease, and to promoting a healthy life-style as a way of preventing the disease.

The Criminal Law stipulates for 3 components of the offence:

- put in jeopardy on purpose another person by contaminating with AIDS;
- contaminating with AIDS by a person that was aware of being infected with this disease;
- contaminating with AIDS by a medical worker.

In such cases it must be proved that the responsible person was aware of being infected and is at least 14 years of age. In the case of a medical worker, a case might exist if the person was found to have discharged his/her professional duties incorrectly.

Conclusions and Recommendations

Introduction



In making recommendations, ILGA-Europe is mindful that the partner organisations responsible for the research in the respective countries are best placed to formulate country-specific recommendations. As part of this project, ILGA-Europe is committed to facilitating these organisations to maximise their advocacy capacity in relation to the findings of the research, and to this end will facilitate a seminar in July 2006 in order to further interrogate the data and to develop advocacy programmes.

Demographics of Respondents



Mostly male, mostly white, mostly educated, mostly young, mostly urban – this is how the 968 LGBT people surveyed can be characterised. The difficulties of sourcing a survey group that is representative are well documented. The particular difficulties in relation to marginalized groups are also well known and well cited, and this challenge is by no means peculiar to any one geographic region. It is interesting to note, for example, that in a study of LGBT health in Australia, the findings of which were published in March 2006 and for which particular care was taken to reach as representative as sample as possible, females made up only 35.2% of the total, 77% lived in major cities and the median age was 34.

Factors which had a bearing on the make up of the target groups in this research project include the service delivery focus of the sponsoring organisations, which is often male, focussed on male health and lack of resources for outreach activities targeted at those not related or known in some way to the organisation. Of particular concern is the under-representation of women and of older people. On average, only 28.3% of respondents are women and only 9.4% are aged over 40 years. What is important for the organisations involved in this research is to be aware of the gaps and to commit to reducing the gaps in further research. Such awareness is demonstrated by the author of the Hungary report and, in relation to gender balance, by Moldova.

Often those not included are blamed for their own under-representation. This is particularly so for women, who are characterised as being unwilling to take part. A recent report in the USA that looked at the under-representation of minority ethnic communities in health research, observed it is up to funders and researchers to alter the balance; that what is required is additional resources to fund the design and execution of new methodologies.

ILGA-Europe is particularly concerned about the under-representation of women and older people in LGBT research. It is vital to broaden our knowledge of the health experiences and needs of lesbian and bisexual women. Indeed it is important to facilitate and promote the visibility and participation of women in the LGBT-community – in activism, in community-support work, in community social activities etc.

There are a myriad of challenges facing older LGBT people, about which, because of a lack of research, we know relatively little. The enormous challenges of coming out which most of those surveyed for this research experience, the level of homophobia in society and its institutional remnants, the stigma, the culture of 'hiddenness', coupled with the often-diminished confidence and general health frailties that come with age - all these combine to place a debilitating burden on older LGBT people.

It is imperative that those responsible for commissioning research commit to more focused targeting of women and older people among the LGBT populations, and that research funding is ring-fenced for these purposes. It is important to develop new methodologies for reaching these sections of the community which will include exploring smaller, more focused, quantitative studies. It is also imperative that efforts are made within the LGBT community, especially among those involved in support, advocacy and leadership, to explore the extent to which sexism and ageism contributes to the under-representation of women and older LGBT people.

Summary of Recommendations



Those who commission research and those who fund research should promote research on women and older people within the LGBT community, and should ring-fence resources for this purpose.

We encourage donors which fund research to become more involved in disseminating the findings, in particular in relation to the promotion of good practice and the support of health advocacy projects.

It is important that DG Sanco of the European Commission becomes more proactive in promoting research into LGBT health concerns. We urge DG Sanco to initiate a consultation process with relevant stakeholders in order to determine a strategy to broaden their focus on LGBT health.

New methodologies to reach these populations need to be explored, including smaller, qualitative studies.

LGBT-representative NGOs should explore the degree to which sexism and ageism contribute to the under-representation of women and older people in research studies.

Relationship with Health Care Provider



The research reveals a number of aspects of patient-doctor relationship which are cause for concern. Included among these are:

- Being known, or perceived to be of a different sexual orientation, or having to reveal one's sexual orientation or gender identity.
- Delaying a visit to a medical provider or not visiting at all because of the fear of one's sexual orientation or gender identity being revealed.
- Less than full trust in doctor's ability to keep information confidential.
- Inability to talk about sexual orientation and/or gender identity, even when understood to be crucial to proper treatment.
- Belief that doctors are not sensitive to people of different sexual orientation or gender identity.

Clearly if one is to secure the best possible care from doctors in particular and healthcare providers in general, trust, confidence, and freedom from fear are important elements of the total environment. This is not a luxury item, it is not about liking your healthcare provider, or about not being embarrassed; it is about being free from fear, it is about being able to discuss issues related to sexuality in an environment which is non-judgemental and supportive. It is also about the reasonable expectation that medical care providers are trained to know how issues related to the sexualities of LGBT people can impact on all aspects of health and well-being. For many LGBT people in the five countries surveyed, such an environment is not available to them.

The findings show that when it comes to securing the proper medical care, the percentage of those who delay or ignore a visit to the doctor because of sensitivities about their sexual orientation or gender

identity decreases. This is encouraging. One has to wonder, however, how decisions are made as to when information about sexuality is necessary for proper medical care. LGBT people who are in the position to make this decision, outside of the facility of a full discussion with their health care provider, face an undue pressure. What, it must be asked, are the health implications for those large numbers of LGBT people, who, for whatever reasons, do not feel comfortable talking openly about their sexuality or gender identity?

The findings reveal that a large percentage of those surveyed do not know if their doctor is sensitive to LGBT issues. The most likely explanation for this lack of knowledge is that they lack the confidence in the first place to reveal their sexual orientation or gender identity. It is clear that this catch 22 situation has to change. Health care providers need experience in working with openly LGBT people in order to develop the appropriate sensitivities to their specific health needs; but LGBT people need to feel free of the fear of possible discriminatory and hostile reactions if they decide to reveal their sexual orientation or gender identity. Currently the burden is on LGBT people, and this needs to be shifted.

An additional factor is the belief among some in the LGBT populations surveyed that there are no specific LGBT related health concerns. Taken together, these issues represent barriers to adequate and appropriate health care specific to the LGBT populations.

It was noted in some of the country reports that a different culture in relation to doctor/patient relationships pertains, and that there are generally lower expectations of the health care system than in the west. The latter is partly due to the lack of resources available to the healthcare system in these countries. Nevertheless, notwithstanding these realities, it is not unreasonable to suggest that the LGBT populations should experience the health care system in the same way as other members of society do.

Recommendations



Those agencies responsible for the development of health policy at national level should establish consultative mechanisms with LGBT-representative NGOs, so that health needs of LGBT can be addressed appropriately.

We urge the EU Commission, in particular DG Sanco, to address EU member states on the specific concerns of LGBT people in terms of access to and relationship with health service systems and personnel.

We recommend that DG Employment and Social Affairs introduce a focus on the access to health care issues for LGBT people within the Social Inclusion Strategy.

Health Educators – at all levels – should incorporate LGBT health issues into the curricula for all relevant health care professionals. This should include tackling any residual negative perceptions and concepts and sensitivity training as well as those health issues known to be specific to, or prevalent among the LGBT population.

The code of practices and protocols related to the patient/doctor confidentiality and data management should be reviewed and tightened. Training should be carried out to ensure that these aspects are fully understood by those responsible staff.

Further research should be carried out to better understand the specifics of the barriers in relation to lack of trust, or fear of having being known or being found out to be of a different sexual orientation or gender identity. Following the research, a strategy should be developed to work towards eliminating these barriers. It is envisaged that this will include public awareness campaigns.

We recommend that the World Health Organisation (WHO) encourage its member countries to make up the deficit in the budget for reproductive health and rights work, that has come about because of the reduction in funding available from WHO's Reproductive Health and Rights Unit.

Mental Health



It is difficult to make general comments on the findings on mental health. In the absence of comparative data, it remains unclear how the LGBT population compare in this area to the mainstream population. Almost all of the country reports indicated the need to carry out further research in this area.

What is clear from the findings is that LGBT people live day in and day out with pressures and stresses related to their sexual orientation. The data that is available from three country reports indicate that 60% of respondents report that their suicidal thoughts relate to their sexual orientation or gender identity.

ILGA-Europe has made a submission to the EU's green paper on mental health and we encourage DG Sanco to seek consultation on this issue with the broader LGBT community.

With many still unable to come out, even to family and friends, the burden can be immeasurable. In many cases, the hostility of homo-, bi- and transphobia is ever-present – in the media, in government institutions, in all-pervasive assumptions of heterosexuality.

It is important to reduce homo-, bi- and transphobia in society at large and to foster acceptance of diversity. In this respect, all of the countries involved in the research have a long way to go towards accepting people of different sexual orientation and gender identity on equal terms.

The analysis applied by Hungary to their data, whereby they attempted to measure whether being out translated into a more positive attitude to health care, was a very innovative and fruitful exercise. For one thing, it is an attempt to promote a positive perspective. It also has the potential to yield information which could influence policy makers with regard to initiatives that would enable and encourage acceptance of diversity.

Recommendations



LGBT-representative NGOs should work with relevant health researchers to design further research in mental health issues in the LGBT community. It is suggested that smaller, more focussed studies using well-established instruments could help produce clearer information on which to develop appropriate responses. Mainstream medical professionals should be encouraged to collaborate in these studies.

One useful approach would be to carry out age-specific and gender-specific research in this area. It will be important to look at older LGBT people, who may face additional stresses, with less access to resources.

It would be useful to attempt to measure positive psychological/emotional/health aspects related to membership of the LGBT community. This would include exercises similar to that carried out by Hungary.

Experience of Discrimination



Name calling, the threat of violence and the threat of sexual assault were listed as the three forms of abuse most experienced by those surveyed across all five countries. Most of these acts of abuse go unreported.

Recommendations



It will be important to explore why acts of abuse go unreported to the extent that they do. We urge the relevant justice and equality agencies to make a study of this phenomenon.

Mechanisms should be established between LGBT-representative NGOs and the police with a view to encouraging an understanding in the police force as to the abuse experienced by LGBT people.

National governments should consider the introduction of hate-crimes legislation and other policy measures to protect the LGBT community against this kind of abuse.

In the context of the European Year of Equal Opportunities for All, which begins in January 2007, we ask the EU Commission to remind member states of the implications on health and well-being of homophobia, and to urge them to use the resources available during this initiative to tackle homophobia in society, in the press and in institutional systems.

ILGA-Europe's Health Strategy Going Forward

Introduction



The level of learning acquired through this research project, both by ILGA-Europe and the partner organisations cannot be overstated. This section of the report seeks to lay out the range of options available to us, based on that learning, in order to adequately and strategically make a contribution to improving the access to health care for LGBT people throughout Europe.

At the outset it is clear that it will be important to use the findings of the research as the basis for further consultation, analysis and reflection so that we choose the best advocacy and capacity-building strategies. This can best be carried out with the full range of constituents, i.e. health and research professionals along with LGBT representative organisations.

What follows is an overview of the main elements of our strategy going forward.

Project Management



A frustration experienced by the project co-ordinators in the partner organisations was their lack of input into the design of the survey questionnaire. There were strategic as well as pragmatic reasons why this was so. In the first instance, this type of quantitative research was new to the partners, and there was nervousness, therefore, about competence. Pragmatically, there was some urgency about getting the research underway, and it was judged that we were working with a well-tested instrument that should require little modification.

In Phase 2 local co-ordinators were given more independence in re-structuring the questionnaire, to better reflect local situations. The Phase 2 questionnaire is more gender and transgender sensitive. It has also shifted somewhat away from a health focus to more of a rights focus. Obviously, the primary

objective remains the assessment of health and health needs but it was felt that, given the general state of public health services in these countries, the change in focus might illicit more relevant responses.

Project co-ordinators will be given more autonomy. This is likely to result in the adoption of different approaches in each country. While this will present its own challenges to ILGA-Europe it will, we believe, allow for stronger ownership by the partners. It will also produce a rich pool of learning, which can then be shared with all project partners.

Pressure of deadlines and the delays referred to above, meant that there was little time for follow through with the partner organisations. To redress this, ILGA-Europe has planned a seminar that will bring all five projects together for a facilitated workshop. This will include how to take the research further, how to further interrogate the existing data, how to build capacity within organisations for research, how to develop advocacy strategies etc. While ILGA-Europe is not in a position to commit significant material resources to this kind of work, we can play a useful role in facilitating the first steps in the process.

Assimilation of the learning – or as one participant put it, “doing the learning” – is often not given the attention it needs. The time and reflection required to mainstream learning into our organisational structures and processes sometimes seem like luxuries as we move on with other work and to other projects. ILGA-Europe intends maintain a long term focus on, and to adapt systems to the mainstreaming of learning.

Research Methodology



For the most part, respondents in all three countries represented the younger, better educated, white, male, and openly out cohort within the LGBT population. This research would not be the first to report such biases in the sample, and it is not easy to overcome such biases. This is particularly so with a community, such as LGBT, which is marginalised and, especially in Central and Eastern Europe and the Newly Independent States (NIS), largely invisible. It is difficult, if not impossible – and this is reported worldwide from other research projects on the LGBT community – to target a representative sample. While some changes have been made to make the questionnaire for Phase 2 more gender and transgender sensitive, the changes will only bear fruit if we can reach more women, more transgender people and older people. To do this, promoting organisations will have to be more proactive in reaching a broader spectrum of people.

It will be important, as mentioned earlier in this report, to explore the degree to which ageism and sexism

within the LGBT community contributes to the under-representation and under-participation of women and older people. ILGA-Europe will encourage this work. Part of the effort to reach a more representative target group will be in relation to more targeted outreach and communications strategies. Design and administration of the survey questionnaire will also have a bearing. It will also require small, more qualitative and better targeted studies.

The survey questionnaire had been adapted from one that had been used by a number of studies in the UK. It is clear that more work needs to be done to design a questionnaire which takes account of the cultural and legislation situation in CEE and the NIS. This will require more time and resources than were available to this project, and will require a concerted collaboration with a number of agencies and professionals from a range of backgrounds.

The effective administration of a survey questionnaire is dogged by many challenges. In the absence of being able to select a random sample of the LGBT community, one is left with the time-consuming and resource-consuming task of devising outreach techniques to reach the target group. The partner organizations worked very hard at this aspect of the work. One of the impediments to such a painstaking approach is the pressure of deadlines. Other issues in questionnaire administration involve training of interviewers. ILGA-Europe hopes to work on these matters.

The inclusion of more expertise, particularly researchers, is an area that needs more focus. There is a range of well-established survey instruments; for example in the area of psychological health there is the GHQ12, the Rosenberg Self-Esteem Inventory, and to measure internalised homophobia the Nungesser's Homosexual Attitudes Inventory. Using these types of instruments would yield more manageable and comparable data.

More needs to be done in relation to the management of data, including data input and analysis. For example, SPSS could have been better utilised to disaggregate data, and also in making links between the five participating countries.

Capacity Building



Internal: If ILGA-Europe is to build on the work of this project – and it is our intention to focus in that direction – then we need to build our own capacity to do that. Some of this will be achieved through networking and coalition building, which is discussed separately below. In addition it seems that a lot could be gained by accessing training on issues related to research processes. Another useful facet of

capacity building could be finding out what research has been carried out in CEE and the NIS, and other countries closer in culture and administration than those of the West. This would necessarily involve additional resources which ILGA-Europe would have to source.

The partner organisations are the experts on LGBT matters in their respective country, and are therefore best placed to take the lead on this kind of research. They are perhaps more expert as advocates, lobbyists and campaigners – and this will be borne out in their follow-up advocacy work. Nevertheless, these organisations will benefit from capacity building in aspects of research methodology. This, it seems, could be achieved with minimal resources.

Advocacy

It is clear from this research that living as a LGBT person, within societies that are homo-, bi-, transphobic and hostile and where there is a widespread assumption of heterosexuality within public services and institutions, has repercussions not only in terms of well-being and mental health but also in relation to access to all health care services. This finding will inform the basis of our advocacy work. Much needs to be done to change culture as well as practice. Much of the work ILGA-Europe does will have an impact on the access to health care and good health for LGBT people. Going forward it will be important to incorporate the impact on health in our analyses.

Networking and Coalition Building

There is now a broad range of organisations working on issues of health in CEE and the NIS. Much of the work is becoming more focussed and targeted – Open Society Institute’s new SHARP programme is one example – and much is becoming more collaborative in its delivery. This has been ILGA-Europe’s first health project and part of our strategy going forward is to network with other relevant stakeholders – at local, national and international levels – so as to increase our knowledge and expertise. We already work within an extensive network of human rights activities and leaders, policy makers, social NGOs and LGBT partners. We want to expand our network to include health care professionals – providers, advocates, policy-makers, funders, researchers. Beyond networking is the prospect of building coalitions, which, of course will depend on a range of issues and which we will approach with the underlying strategy of coalitions that are mutually beneficial in terms of serving the interests of the LGBT health.

Profile of Partners

Habeas Corpus – Hungary



The Habeas Corpus Working Group is a non-profit, non-governmental organization operating since 1996 in Hungary. The name comes from the Habeas Corpus Act (England 1679), which provided legal protection against unlawful detention. The name was chosen to express the importance of the right of all people to self-determination concerning the body in the face of arbitrary rules and regulation.

The organization has been providing free legal aid since 1997 for the following beneficiaries:

- battered and sexually abused women, victims of sexual assault in the workplace,
- child victims of sexual and physical abuse,
- victims of violence and/or other forms of discrimination against women, gays, lesbians, bisexuals, HIV positive persons, transsexuals,
- persons requesting legal assistance concerning their civil rights as members of any sexual minority,
- gay and bisexual young men seeking advice concerning their compulsory military service.

At present Habeas Corpus focuses primarily on the equality of women and sexual minorities. The organization also has a history in lobbying and advocacy, being active in criticizing the chapters of the Hungarian Penal Code which regulates sexual crimes as being discriminatory against women, girls and homosexuals. An alternative bill supporting the rights to sexual autonomy was prepared and proposed. Habeas Corpus is also active in litigation for the rights of women and the LGBT communities, as well as public awareness activities.

ACCEPT – Romania



ACCEPT is a human rights organization whose mission is to create a better society for LGBT (Lesbian, Gay, Bisexual, Transsexual people) living in Romania. Working at the national level, the objectives or the organisation are:

- Pursuing all legal means towards defending persons whose rights and freedoms, as outlined in the Constitution of Romania and international treaties ratified by Romania, have been infringed.
- Educating society about the realities of life for LGBT people and people infected with HIV;

- Campaigning for the reform of the legal system so as to ensure the protection of the rights of LGBT people and people infected with HIV;
- Collaborating with other organisations working for various minorities and discriminated social categories;
- Developing services that meet certain specific needs of the LGBT in Romania, including health and education programmes

ACCEPT has developed projects in Bucharest and another 8 local communities to promote sexual health and safe sex behaviour among MSM (men who have sex with men). The projects entailed working with dermato-venerology specialist physicians in Bucharest. The following details the activity of the projects during the period 2002-2005:

- Research among MSM in Bucharest in order to develop culturally appropriate info/educational materials for promoting safe sex behaviour;
- Research among Bucharest physicians specialized in dermato-venerology in order to identify their attitude towards MSM patients and to identify the MSM-friendly physicians to whom beneficiaries could be referred within the project;
- Developing informational/educational materials;
- Training project staff and MSM volunteers on Social Marketing for MSM;
- Training physicians to work more effectively and sensitively with MSM;
- Training MSM volunteers on Promoting Health & Safe Sex Behaviour among MSM by Peer Education and Outreach;
- Provide a "Medical Counselling" Service, a "Counselling For Prevention" Service and a "SIDE by SIDE For HIV/STD Testing" Service;
- Performing outreach actions and health promotion meetings among MSM;
- Collaborating with key actors in elaboration of public health policies regarding MSM health needs.

As part of its ongoing work ACCEPT offers the following services:

- legal counselling for people discriminated because of their sexual orientation, (trans)gender and HIV positive status;
- psychological counselling for LGBT people and other persons in their family and environment;
- community development, by providing technical assistance to LGBT local groups and organizations
- Information and Documentation Centre, the first library in Romania to specialize in sexual orientation issues

GenderDoc-M – Moldova



The Information Centre GenderDoc-M works to improve the rights of sexual minorities. It is the only non-governmental, public organisation working to protect gay and lesbian rights in Moldova and was registered by the Ministry of Justice in 1998. GenderDoc-M's vision is for a society where the LGBT community is a visible and integral part with equal rights.

The organisation's mission is for the integration of the LGBT community by means of lobbying the community's interest; offering information, social, psychological, judicial, medical and other services; and developing partnerships with governmental and non-governmental institutions on the national and international level. One of the main goals of the Centre is the collection, processing and distribution of information on different aspects of homosexuality. To achieve this goal, GenderDoc-M created the cultural and educational magazine, *Mirror*. *Mirror* has many different news items: political news, information related to psychological issues, personal health, sexual education, safe sex, HIV/AIDS, lesbians, the church. It also includes articles on gay lifestyle and reports on cases of violence and violation of the rights of sexual minorities.


Another important area of work is the protection of gay and lesbian rights and the creation of a safe environment for the LGBT community. In order to help the living conditions of the LGBT community and to protect the gay and lesbian youth rights, "Moldovan Gay and Lesbian Empowerment", a joint project between COC Netherlands and GenderDoc-M, was launched in October 2001. This project works for the improvement of the legal, social and political situation of the LGBT community in Moldova by means of emancipation of the movement through the Information Centre GenderDoc-M. It consists of four programmes: awareness raising campaign, organisational development, safe environment and juridical assistance. Within the project many seminars and debates are scheduled, the magazine "Mirror" and three books will be published. Through the project assistance and social services will be provided to the gay and lesbian community, with special attention being paid to organizational development of the Centre. The project is funded by the Royal Dutch Embassy in Kiev, and is given political support by the Dutch Ministry of Foreign Affairs.

One of the main aims of the organisation is to lobby at local and European levels. GenderDoc-M has an ongoing lobbying strategy targeted at the various European institutions such as the Council of Europe, the European Parliament and Organisation for Security and Cooperation in Europe, thus raising awareness about the discrimination and abuse of gay and lesbian rights in Moldova.

At the end of April 2002 GenderDoc-M, with support of RFSL (Sweden) has organized the First Moldovan Gay and Lesbian Pride 2002. The event was organized for the gay and lesbian community and its supporters, and all gay friendly persons. It included an art exhibition, a movie festival, the presentation of a gay anthology, an international conference with participation of openly gay priest Ulf Lidman, openly gay parliamentarian Tasso Stafilidis and Stig Ake Petersson (all from Sweden), Dennis van der Veur (the Netherlands) as well as guests from Romania and Ukraine. Pride 2002 received significant media attention.

GenderDoc-M has participated in the elaboration of a range of policies related to HIV/AIDS prevention at national level in collaboration with experts from the National AIDS Centre, Ministry of Health and NGO's working in the field. The organization has close relations with medical institutions such as Ministry of Health, Republican Dermatovenereal Dispensary, and the National AIDS Centre. With their support and with the participation of experts from these institutions GenderDoc-M has successfully organized seminars for medical doctors from different regions of Moldova on the subject of homosexuality and working on HIV prevention in LGBT community. With the support of National AIDS Centre and Republican Dermatovenereal Dispensary the organizations has organised free anonymous testing on HIV and syphilis for the members of LGBT community.

Organization Q – Bosnia and Herzegovina



Organization Q for promotion and protection of culture, identities, and human rights of queer persons was formed in September 2002, under the working name of Bosnia 14th September. Formally registered in February, 2004, it represents the only LGBTIQ organization in Bosnia and Herzegovina.

Vision

The long term goal of Organization Q is to raise awareness in Bosnia and Herzegovina regarding human sexuality and gender diversity outside of hetero-patriarchal normative system, so that LGBTIQ issues become fully understood and acceptable within our society. By the same token, their objective is to improve the position and human rights of the LGBTIQ community, working towards equality for all.

Goals

Organization Q is dedicated to the protection of human rights of LGBTIQ persons, that is, (lesbians, gay men, bisexuals, transgender, transsexual, intersexual, and queer individuals), as well as to the empowerment, development and public visibility of queer identity and culture, so as to fight against human rights violations, discrimination, and inequality based on gender, sex, sexual orientation, sexual identity, gender identity and/or expression, and (inter)sexual characteristics.

The two main objectives of Organization Q are to provide concrete support to the LGBTIQ community and to eliminate all forms of gender/homo/bi/transphobia.

Platform

Organization Q's work and activities are based on the:

- standards and principles of human rights (Universal Declaration of Human Rights and 16 Conventions which are a part of the BiH legislation), including human rights-based approach which takes into consideration and respects human rights, needs, and individual characteristics of LGBTIQ individuals as well as everybody else in BiH;
- principles of peace, post-feminist and LGBTIQ movements.

Organization Q strives for the following rights:

- right to one's own body, sex, gender and (inter)sexual characteristics;
- right to self-definition and self-conception of sexual and/or gender identity and modification of the same;
- right to self-identification, bodily integrity, choice, gender expression, and one's own sexuality and dignity;
- right to a sexual orientation;
- right to an expression of gender and sexual/gender identity (through language, as well) including a right to gender ambiguity and contradiction;
- right to a life without sexual violence, maltreatment and torture of any kind; and
- right to human rights and dimensions of equality and non-discrimination.

EGAL (Equality for Gays and Lesbians) - Macedonia



EGAL (Equality for Gays and Lesbians), is a non-governmental organization based in Skopje in Macedonia. Its primary aim is to raise the awareness and to educate the LGBT community in Macedonia regarding HIV/STI issues, including how to protect against infection. It also works to advocate and lobby for LGBT human rights. With 4 full-time and 10 part-time staff EGAL seeks to work with other similarly minded organisations to promote LGBT visibility and culture.

Prior to its participation in ILGA-Europe's current health access research project, EGAL has worked together with HERA on a health policy related project. This project was focused on marginalized youth and EGAL was the partner organisation with expertise on LGBT youth. During this project the organization was involved in qualitative research mainly through focus groups.

The executive director of EGAL was involved in training for Facilitator of Focus Group on International Planned Parenthood Federation regional workshop on KAP survey in Sarajevo; training on VCCT (voluntary confident counselling and testing) delivered by WHO and is a coordinator of the Global Fund activities targeted at MSM Macedonia. The president of EGAL is currently involved in the ReLAP (Regional law advocacy and policy) project as a co-ordinator helping on the writing of the national manual on advocacy and lobbying on human right issues including health policy issues.

Overview of LGBT Health Concerns

A review of the literature on the health concerns of the LGBT community was not part of this current project. There are a number of very useful such reviews available and we reference these in the bibliography. However, for the purposes of this report, in particular to situate the findings from the field research from the five countries, it is useful to sketch out what is generally accepted as being the health-related issues common to LGBT worldwide. There are of course country-specific and even community-specific variations that apply and which must be taken account of. This fact itself points to the need to carry out local research as a first step to taking care of the health needs of LGBT people.

Nevertheless there are a number of issues which are experienced, to one degree or another, most everywhere in the world. These are discussed below and are grouped as follows:

- Barriers to Health Care
- Mental Health Issues
- Substance Abuse
- Tobacco Use
- Violence
- Youth
- Lesbian Health
- Reproductive Health
- Challenges to Research
- Transgender Health Concerns

Barriers to Health Care



- Fear of discrimination and stigma
- Withholding of relevant personal information
- Delay in seeking medical attention
- Reluctance to follow-up after negative experience

There are barriers to accessing health care that are specific to LGBT people. Those barriers experienced by other populations, e.g. lack of resources, geographic and social isolation, lack of information about and/or fear of medical procedures etc. may also pertain to LGBT people. However, those which are specific to many LGBT include the fear of discrimination and stigma, which act to prevent them from seeking care for themselves or their families. Once in care, LGBT people may withhold personal information that healthcare providers need in order to be able to give appropriate care. In addition, if a member of the LGBT community experiences homophobia and/or discrimination or feels that their needs are not being recognised or addressed, this less-satisfactory experience can result in them not going back for needed further care. Research shows us that there is a high degree of ignorance on the part of healthcare providers, not only of the specific health needs of LGBT people.

Mental Health



In the USA and other western countries, homosexuality was officially listed as a psychological pathology until the mid 1970s. In many countries, particularly in newly emerging democracies, the mental health profession is affected by this historical position whose orientation was to cure those inflicted with homosexuality. Research in 1991 in the US shows that over half of 2,500 members of the American Psychological Association surveyed reported knowing of negative incidents regarding the treatment of lesbian or gay patients.

In a study carried out in Scotland in 2001 among young lesbians and gay men aged up to 25 years, data comparisons with data from the mainstream population in the same age range showed a significantly higher incidence in the lesbian and gay population of self-harming behaviours, suicidal thoughts and attempted suicides. 29% of the men and 65% of the women reported having harmed themselves, and 50% of the man and 80% of the women reported having suicidal thoughts.

Research carried out in London in 2003 revealed a high incidence of anxiety and depression among young and bisexual men. Another 2003 study indicates that even with the same levels of social support and quality of physical health, LGBT people exhibit stronger proclivity than the heterosexual population toward a range of psychological problems.

In relation to suicide and self-harm, a recent review of the literature noted that almost three decades of research documents the link between suicidal thoughts and same sex attracted young people. One study in the UK reports 29% of 362 young LGBT people surveyed having attempted suicide; a study in Northern Ireland revealed that gay and bisexual men were 30 times more likely than their heterosexual

counterparts to attempt suicide; in the USA a 1997 study showed that LGBT young people were two to three times more likely to attempt suicide.

A more recent study published in March 2006 surveyed one hundred and ninety young same-sex attracted men in Northern Ireland. Using well-established survey instruments, including the GHQ12, the Rosenberg Self-Esteem Inventory and an adaptation of Nungesser's Homosexual Attitudes Inventory, the study showed that almost one-third of the respondents showed signs of a possible mental health disorder. Those who report having attempted suicide make up 27.1% of the total surveyed. This is consistent with other similar current studies. In relation to those who report having thought of suicide, 13.8% had often thought of suicide and a further 29.8% report having sometimes thought about taking their own life. The author of the report notes that a further 27.7% indicated that they had rarely thought about suicide, which in total would mean that a total of 71.3% had thought of suicide.

Positive Psychological/Emotional Benefits

In a study produced by the Medical Foundation of Boston in 1997 on Health Concerns of the Gay, Lesbian, Bisexual, and Transgender Community, reference is made to research literature which provides examples of the community's strength. It reports, for example, that lesbians are less likely than heterosexual women to have eating disorders, that lesbians were more satisfied with their bodies than heterosexual women, many reporting that their body image had improved significantly since coming out; gay men who were more out demonstrated lower levels of anxiety and depression, and had higher self-images than gay men who were less out. The study also reported evidence that the "collective social experience of the LGBT community may sometimes allow for a stronger support network than exists in the general population (Bradford, et al., 1994)."

Substance Abuse

The fact that alcohol, drug, and tobacco use all occur at significantly higher rates in the LGBT community than in the general population is one of the most widely acknowledged LGBT health issues. This is reported in almost every survey carried out. Factors put forward to explain the higher prevalence include the prominence of bars in gay and lesbian social life, the impact of homophobia and discrimination in terms of feelings of powerlessness, and, more recently, the aggressive marketing to the lesbian and gay community by the alcohol and tobacco industry. Among gay men there is evidence of links between higher rates of unsafe sex and substance abuse.

Tobacco Use



While there has been no large scale study on tobacco use among the LGBT community, there are a number of studies which point to a higher prevalence than in the heterosexual population. A review of the literature on the impact of homophobia in Canada, posited that in the LGBT community there were twice the number of deaths due to smoking than in the heterosexual community. According the American Magazine CLASH, the lesbian and gay community has become the third community for the tobacco industry to target after African Americans and women.

Violence



According to the U.S. Department of Justice, one of the most common forms of hate crime is violence towards individuals who are, or who are perceived to be, gay or lesbian. It has been shown that, contrary to popular belief that gays and lesbians make themselves vulnerable by going to gay bars and cruising areas, most of the violence is carried out in or near the home, on the street or in the workplace. A problem of particular concern that is receiving increased attention is that of domestic violence among lesbian couples. Evidence shows that service providers for women victims of domestic violence have been reluctant to address the fact that lesbians are among their potential clients. Lesbians are less likely to report domestic violence or to seek support, either from family or friends or from service providers.

Youth



The review of the literature on the health concerns of LGBT youth by the Medical Foundation of Boston paints a grim picture indeed. The following set of information is taken directly from the report:

- "It has been reported that a quarter of gay and lesbian youth drop out of school due to discomfort in the school environment (U.S. Dept of Health and Human Service, 1989)
- Gay and lesbian youth account for 30% of all youth suicide (U.S. Dept of Health and Human Services, 1989)
- Gay and lesbian young people are two or three times more likely to try to kill themselves than heterosexual youth (U.S. Dept of Health and Human Services, 1989)
- A substantial number of gay and lesbian youth are forced to leave home because of their sexual orientation (Paul Gibson, U.S. Dept of Health and Human Services)
- A quarter of all of youth living on the street may be lesbian and gay; many of these street youth engage

in prostitution to support themselves (Paul Gibson, U.S. Dept of Health and Human Services)⁹

Studies in the UK into bullying and its impact on the mental health of gay and lesbian youth reveal that the bullying which lesbians and gay men experienced in school was more severe in nature than general bullying.

Lesbian Health

A major concern in relation to health care and lesbians is the fact that lesbians do not access the health care system in the same way as heterosexual women, in that birth control and family planning services are not priority issues for lesbians. There is research evidence that shows that lesbians are less likely to get regular PAP smears or breast examinations, both important preventative measures.¹⁰ A study on lesbian health in Ireland notes the paucity of research in this area, which in turn points to an institutional refusal to acknowledge that lesbians might differ in their health needs to heterosexual women. Interestingly, the Department of Health in Ireland has included a section on the special needs of lesbian women in its 1997 publication, A Plan for Women's Health. Intended as a strategy for improved health services for women, the document indicates that health boards will be asked to ensure that health professionals are informed about lesbian health issues and "that staff respects the sexual orientation of lesbian women."¹¹

Reproductive Health

When it comes to artificial insemination, lesbians are discriminated against when it comes to artificial insemination, by both private and public providers. Indeed, in many countries, artificial insemination is regulated by legislation to exclude lesbians and single women from accessing the procedure.

Transgender Health Concerns

Little has been written about male-to-female transsexual issues and even less on female-to-male transsexual issues. A study by the Massachusetts Department of Public Health/AIDS Bureau looked at the risk for transgender people of HIV infections and on the barriers transgender people must face when seeking sensitive and appropriate health care services. Among the issues discussed in that study was the degree of marginalization and isolation means that the transgender people are some of the most misunderstood in

⁹ The Medical Foundation of Boston, Health Concerns of the GLBT Community, 2nd Edition, 1997

¹⁰ Dallas Women's Health Survey, 1988.

¹¹ Government of Ireland, A Plan for Women's Health, 1997

society. Fear of rejection and ridicule keep many transgender people from seeking medical and mental health care. The study points to the role played by targeted public campaigns in the preventing the spread of infections and notes that there are no such campaigns with which transgender people can identify. In relation to the increased risk of cancer after hormone treatment, as well as the need for careful monitoring of hormone levels, the study wonders if enough is being done to communicate the rights sort of information.

Challenges to Research



To conclude this section on the health concerns of the LGBT community as presented in the research literature, it is useful to point to some of the challenges in the area of research itself. To begin with, the dominance of the study of HIV/AIDS which has limited the focus on other LGBT health concerns. Indeed a focus on healthcare challenges precludes a broader inquiry into the status of the LGBT community's health which would take in the community's sources of strengths. Some few studies have highlighted the psychological benefits to membership of the LGBT community but this is limited.

A major challenge to research within the LGBT community, and one which was experienced in this research project is that of sampling and difficulties of collected data that is representative. With a community that is still marginalised and, in many countries, still faced with institutionalised homophobia and discrimination, there are immense difficulties of accessing a representative target group. This has resulted in much of the research being overwhelmingly focussed on younger, white, educated, urban and out lesbians and gay men – with men being significantly better represented than women.

In the West, where equality for gays and lesbians has been advanced to the point where issues such as civil partnership and marriage, right to adoption, new models of family, rights of inheritance are being debated, these issues are also becoming the subject of research. In this environment where the subject of gay and lesbian parenting is emerging as the last taboo, it is envisaged that the level of research in this area will increase exponentially.

The other major aspect of concern in relation to LGBT health that has yet to be adequately researched is that of the older generation of LGBT people. The policy Institute of the National Gay and Lesbian Task Force Foundation in the US conducted a study in 2002 which looked at the public policy issues affecting gay, lesbian, bisexual and transgender elders. Describing this population as among the most invisible, the study cites the "widespread failure of governmental and academic researchers to include questions about sexual orientation or gender identity in studies of the aged."

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This research project is the first of its size and scope to be carried out among LGBT communities in Bosnia and Herzegovina, Hungary, Macedonia, Moldova and Romania. As such, the initiative is of groundbreaking importance and the data collected will serve to inform ongoing advocacy and policy work. The report presents the findings on health and access to the health care system by the LGBT communities in five Central and Eastern European countries, as well as draws conclusions and makes recommendations to the relevant stakeholders, including international organisations. It also introduces a methodology and lessons learnt, which could be used for further research.

