

## Research Article

**Sexual Health/Reproductive Health-Related Problems of Lesbian, Gay, Bisexual and Transgender People in Turkey and Their Health-Care Needs**Lale Taşkın<sup>1</sup> , Ayten Şentürk Erenel<sup>2</sup> , Şengül Yaman Sözbir<sup>2</sup> , İlknur Münevver Gönenç<sup>3</sup> ,  
Çiğdem Yücel<sup>4</sup> , Hacer Alan Dikmen<sup>5</sup> , Şahika Şimşek Çetinkaya<sup>4</sup> <sup>1</sup>Department of Nursing, Başkent University Faculty of Health Sciences, Ankara, Turkey<sup>2</sup>Department of Nursing, Gazi University Faculty of Health Sciences, Ankara, Turkey<sup>3</sup>Department of Midwifery, Ankara University Faculty of Nursing, Ankara, Turkey<sup>4</sup>Hacettepe University Faculty of Nursing, Ankara, Turkey<sup>5</sup>Department of Midwifery, Selçuk University Faculty of Health Sciences, Konya, Turkey,**ORCID IDs of the authors:** L.T. 0000-0002-5096-4452; A.Ş.E. 0000-0002-0841-2099; Ş.Y.S. 0000-0001-9870-5161; İ.M.G. 0000-0001-6834-1010; Ç.Y. 0000-0001-9287-356X; H.A.D. 0000-0001-9617-4897; Ş.Ş.Ç. 0000-0002-4518-5286.**Cite this article as:** Taşkın, L., Şentürk-Erenel, A., Yaman-Sözbir, Ş., Gönenç, İ. M., Yücel, Ç., Alan-Dikmen, H., et al. (2020). Sexual health/reproductive health-related problems of lesbian, gay, bisexual and transgender people in Turkey and their health-care needs. *Florence Nightingale Journal of Nursing*, 28(1), 97-109.**ABSTRACT****Aim:** To determine sexual and reproductive health problems and needs of lesbian, gay, bisexual and transgender people based on their experiences and to develop solutions.**Method:** A mixed method, which includes quantitative (descriptive) and qualitative (phenomenological) methods, was used (n=106). An online questionnaire was used to collect the data.**Results:** Of the participants, 42.5% stated that they had experienced problems receiving sexual and reproductive health-care services, and 77.8% of those who stated they had problems indicated that the attitude of the health-care professionals was discriminatory or unfavorable. In the qualitative analysis, two themes were created: "Experiences during Health-care Services" and "Recommendations for Health Services."**Conclusion:** It was determined that lesbian, gay, bisexual and transgender individuals have sexual problems, sexually transmitted diseases, and suffer from sexual harassment. However, it was found that they do not receive sufficient health-care due to health-care professionals' attitudes, homophobia, and disregard of privacy or confidentiality. In line with the results of the present research and the suggestions of the participants, it is suggested that training programs should be organized for health-care professionals providing services for lesbian, gay, bisexual and transgender people to raise awareness and ultimately promote more effective services.**Keywords:** Homosexuality, reproductive health-care services, sexual dysfunctions, sexual harassment, sexually transmitted diseases**INTRODUCTION**

Today, lesbian, gay, bisexual, and transgender (LGBT) individuals are increasingly visible in society and becoming more socially recognizable, and accordingly have a higher demand for health-care services (Lim, Brown & Kim, 2014). However, LGBT people have a greater risk of negative health outcomes due to social and structural inequalities such as stigmatization and discrimination. According to the 2011 report of the National Institute of Medicine, LGBT people are generally at risk of violence and hate crimes, sexually transmitted infections (STIs) and human immunodeficiency virus (HIV), suicidal thoughts and committing suicide, chronic stress, smoking, and alcohol, and substance abuse (IOM, 2011). In addition, they

have problems in accessing health services and making use of them effectively due to the negative attitudes, and prejudices of health professionals. For these reasons, LGBT people should be considered an at risk group and their health needs should be taken into consideration. It is important that at risk groups be addressed in programs designed primarily to improve community health (Cahill & Makadon, 2014).

Differences in sexual behavior among LGBT persons may negatively affect their sexual and reproductive health (SRH). In general, studies discuss the SRH problems of LGBT people according to the sexual orientation. For this reason, each sexual orientation has unique SRH health-care needs.

**Corresponding author:** İlknur Münevver Gönenç

E-mail: imgonenc@gmail.com

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Lesbian and bisexual women (LB) often form an invisible minority within the health-care system, and therefore their SRH needs are handled inadequately, especially compared with those of heterosexual women (Munson & Cook, 2016). It has previously been stated that in comparison with heterosexual women, LB women are at a higher risk of sexually transmitted infections (STIs), unwanted pregnancies, sexual violence, and partner violence, and have a higher likelihood of using emergency contraceptives, and pregnancy prevention methods and of receiving SRH services (Agénor, Krieger, Austin, Haneuse & Gottlieb, 2014; Blosnich, Farmer, Lee, Silenzio & Bowen, 2014; Marrazzo & Stine 2004; Ward, Dahlhamer, Galinsky & Joestl, 2013). Bisexual women have a higher likelihood than lesbian and heterosexual women of having more than one partner and of a partner using drugs during sexual intercourse, meaning that this group is exposed to more risks (Estrich, Gratzner & Hotton, 2014). In addition, it has been found that LB women are screened for colon, breast, and cervical cancer less often than heterosexual women, and this is attributed to a fear of not receiving decent health services (Blosnich, Farmer, Lee, Silenzio, Bowen, 2014; Walker, Arbour & Waryold, 2016; Ward, Dahlhamer, Galinsky & Joestl, 2013).

It has been determined that STI rates, primarily HIV, are high in gay people (Carabez et al. 2015; Lim, Brown & Kim, 2014), and it has been reported that gay people with HIV and AIDS are also at high risk of hepatitis B and C infections (Sanchez, Scheer, Shallow, Pipkin & Huang 2014). In addition, the rates of human papillomavirus (HPV) infection, and anal cancer associated with HPV are higher in this group than those in heterosexual individuals. It has been found that factors such as sexual orientation, passive anal sex, and having 15 or more partners throughout one's life increase the risk of anal cancer (Daling et al., 2004).

Transgender individuals carry health risks related to their previous gender even if they have completed their sex change transition. For example, most transgender women have a prostate, so if they have a family history of prostate cancer they are at high risk of this disease and need prostate examinations. Similarly, even if transgender men have undergone breast reduction surgery, they still have residual breast tissue and need mammography screening for breast cancer. In addition, most transgender men

have a cervix and should be screened for cervical cancer (Cahill & Makadon 2014).

Health professionals play an important role in efforts to provide decent health-care services and have the opportunity to offer decent health-care to all individuals regardless of sexual orientation. For this reason, health-care professionals are central in providing decent care to LGBT people who are at risk of SRH and who have health-care needs that differ to those of heterosexual people. However, studies report that the homophobic or transphobic attitudes of health-care professionals, their discomfort while serving LGBT persons, and their lack of knowledge and clinical experience of SRH problems and care needs specific to LGBT people hinder their provision of decent health-care services (Walker, Arbour & Waryold, 2016). In addition, the focus of SRH services on heterosexual individuals may prevent health professionals from taking differences in sexual orientation into account, even though LGBT people have different health-care needs than heterosexual individuals (Baker & Beagan 2014; Walker, Arbour & Waryold, 2016).

Due to their sexual orientation and gender identity, LGBT people, particularly gay and transgender individuals, are exposed to discrimination in Turkey, which has a traditional and conservative society. Social pressure causes difficulties to arise following an explicit expression of sexual orientation and identity by LGBT persons, making it difficult to determine the health risks, problems and health-care needs of these individuals. According to the findings of the 2014 'Research on Social and Economic Problems of LGBT People' carried out on 2875 LGBT people across Turkey, 7.6% of respondents (219 persons) stated that they gave up or postponed treatment due to fear of discrimination, 7.2% (208 persons) reported that health-care professionals attempted to treat their homosexual and/or transsexual identity, and 50.3% (1447 persons) of respondents said they did not know where and how to access sexual health-care services. This report did not touch on the specific SRH problems of LGBT people (Yılmaz & Göçmen 2015). Furthermore, in Turkey, the general health and SRH problems of LGBT people are dealt with only in a limited way in the undergraduate programs responsible for educating health-care professionals, such as medicine and nursing. This lack of education can adversely affect the attitude of health professionals toward LGBT people. Given all these

factors, there is a need for research to determine the SRH problems of LGBT people in Turkey. Therefore, this mixed method research study was conducted to determine the SRH problems and health-care needs of LGBT people. To the best of our knowledge, this is the first study focusing on SRH problems and health-care needs of LGBT individuals in Turkey. The outcomes of this study provide guidance to health-care professionals working in academic and clinical settings, raising their awareness of these issues and leading to an increase in qualified, accessible, and equal health-care services being offered to LGBT people.

### Research Questions

1. What are the sexual and reproductive health problems of LGBT people?
2. What are the healthcare needs of LGBT people related to sexual and reproductive health?

## METHOD

### Study Design

The study was a mixed-type research.

### Sample

The study population consisted of members of the Kaos Gay and Lesbian Cultural Research and Solidarity (KAOS GL) Association, the Pink Life LGBT Solidarity Association, the Red Umbrella Sexual Health and Human Rights Association and the Social Policy Gender Identity and Sexual Orientation Studies Association. These associations are institutions with a large number of members that actively operate across Turkey in the fields of sexual orientation, sexual identity, transgender rights, and the rights and problems of sex workers. No information was provided by the associations on the number of their members in order to maintain confidentiality. The original study design was to sample individuals who were members of these associations and who agreed to participate in the study. However, although reminder emails were sent to associations once a week for two weeks, only 35 people responded and participated. Therefore, another 71 people were recruited via a web link shared on the social media pages of Hacettepe University Anti-Homophobia and Transphobia Students' Community, and via an email forwarded by an LGBT student from Gazi University to his/her LGBT friends' group. As a result, a total of 106 participants made up the study sample.

### Data Collection

The research data were collected between 28 December 2016 and 22 October 2017 by means of emails sent to the participants who were members of the associations listed above and by the link shared on social media pages. The emails were sent via the managers of the associations, who received the link to the online questionnaire and emailed it to their members. People who agreed to participate in the study completed the questionnaire by clicking on the link. The questionnaire consisted of 45 multiple choice and open-ended questions, and was created using Google Forms software. The questions aimed to determine the participants' socio-demographic characteristics, SRH issues, and problems in receiving sexual, and reproductive health services. The six open-ended questions in the questionnaire were designed to investigate reasons the participants were not happy in their sexual life, sexual problems encountered, measures taken against STIs, reasons for not taking measures against STIs (if none were taken), experience of health-care personnel's attitudes toward sexual orientation or sexual identity, and recommendations of ways to improve access of LGBT people to sufficient health-care.

Data were collected in the email account of one of the researchers in the study, then stored in an Excel file on a personal computer with password protection. After transferring and saving the data, the related emails in the email account were deleted. The participants' data will be kept for five years and then deleted.

### Statistical Analysis

To analyze the quantitative data, data were first grouped using the tables and graphics provided by the Google Forms web page and then presented in numbers and percentages. To analyze the qualitative data, the responses given to the six open-ended questions to determine the experiences of the participants were analyzed manually by the researchers. The answers given by the participants were printed by the researchers, the answers coded, and then presented under eight titles.

### Ethical Considerations

Ethical approval of the study was given by the Non-Interventional Clinical Research Ethics Committee of Selçuk University (date: 18 January 2016; issue: 2016/08). Necessary permissions were procured from all associations involved in the study.

Before completing the online questionnaire, study participants first selected a confirmation box indicating that they had read all the information about the study and that they were volunteering to participate in the study. The researchers could see the

**Table 1.** Socio-demographic characteristics of the participants (n=106)

Socio-demographic characteristics	n	%
<b>Age</b>		
18–25	59	55.7
26–35	39	36.8
Over 35	8	7.5
<b>Education</b>		
Literate	1	0.9
High school graduate	25	23.6
Bachelor’s degree	69	65.1
Postgraduate degree	11	10.4
<b>Employment status</b>		
Employed	49	46.2
Unemployed	52	49.1
Student	5	4.7
<b>Health insurance</b>		
Available	87	82.1
Not available	19	17.9
<b>Place resided for the longest time</b>		
Metropolis	77	72.6
City	26	24.5
Town/village	3	2.9
<b>Household type</b>		
Live with family	40	37.7
Live alone	23	21.7
Live with friend	23	21.7
Live with partner	20	18.9
<b>The perception of income</b>		
Equal income and expenditure	50	47.2
Income lower than expenditure	37	34.9
Income higher than expenditure	19	17.9
<b>Total</b>	<b>106</b>	<b>100.0</b>

responses given but not the personal information of the participants.

**RESULTS**

Table 1 shows the socio-demographic characteristics of the participants. It was found that 55.7% of the participants in the study were in the 18–25 age group, 75.5% had university (including postgraduate) education, 49.1% were unemployed, and 82.1% had health insurance. The place of residence lived in for the longest time of 72.6% of the participants was metropolis-based, 37.7% lived with their families, and 47.2% perceived their income as equal to their expenditure.

Sex and sexual orientation of the participants are presented in Table 2. A total of 42.5% of the respondents gave their biological sex as male and 47.2% identified their sexual orientation as gay or lesbian.

Table 3 shows the sexual life characteristics of the participants. It was found that 81.1% of the participants had an active sexual life, 66% were satisfied

**Table 2.** Sex and sexual orientation of the participants (n=106)

Characteristics	n	%
<b>Biological sex</b>		
Male	45	42.5
Female	29	27.4
Trans-man	6	5.7
Trans-woman	1	0.9
Queer	15	14.1
Intersex	1	0.9
Unwilling to identify	9	8.5
<b>Sexual orientation</b>		
Gay/lesbian	50	47.2
Bisexual	26	24.5
Queer	11	10.4
Pansexual	8	7.5
Demisexual	2	1.9
Unwilling to identify	9	8.5
<b>Total</b>	<b>106</b>	<b>100.0</b>

**Table 3.** Sexual life characteristics of the participants (n=106)

Characteristics	n	%
<b>Sexual activity status</b>		
Sexually active	86	81.1
Sexually inactive	20	18.9
<b>Satisfaction with sexual life</b>		
Satisfied	70	66.0
Dissatisfied	30	28.3
Not sure	6	5.7
<b>Causes of dissatisfaction with sexual life (n:30)</b>		
Lack/low frequency of regular relationship	12	40.0
Unable to find the right partner	8	26.7
Psychological (lack of self-confidence, depression, embarrassment, lack of excitement)	7	23.3
Haven't yet undergone the operation	3	10.0
<b>Problem in sexual relationship</b>		
Yes	24	22.6
No	82	77.4
<b>Problems experienced in sexual relationship (n: 24)</b>		
Erection problems/vaginismus/premature ejaculation/orgasm problems	13	54.2
Have STIs (herpes simplex virus 2, HIV, gonorrhea, fungal infections)	5	20.8
Fistula/hemorrhage	4	16.7
Fear of having STIs	2	8.3
<b>Preventive measures against STIs</b>		
Yes	64	60.4
No	42	39.6
<b>Preventive measures taken against STIs (n:64)</b>		
Using condom	58	90.6
Not having sex with at risk individuals	2	3.1
Having treatment	1	1.6
Being tested regularly	3	4.7
<b>Reasons for not taking preventive measures against STIs (n:32)*</b>		
Thinking that a condom is uncomfortable and reduces pleasure	8	25.0
Monogamy	17	53.0
Difficulty accessing condoms	3	9.4
Ignoring the risks	2	6.3
Being unaware of the measures	2	6.3

\* Ten people did not answer this question.

with their sexual life, 40% of those who were not satisfied with their sexual life stated that the reason was lack or low frequency of a regular relationship, 77.4% did not have any sexual problems, and 54.2% of those experiencing sexual problems stated that they had erection problems, vaginismus, premature ejaculation, and/or orgasm problems. It was determined that 60.4% of respondents took measures against sexually transmitted infections, 90.6% of

**Table 4.** Participants' characteristics related to sexually transmitted diseases (STIs) (n=106)

Characteristics	n	%
<b>Had STIs before</b>		
Yes	32	30.2
No	74	69.8
<b>Being treated for STIs (n:32)</b>		
Yes	27	84.4
No	5	15.6
<b>Health center for STIs treatment received (n:27)*</b>		
State hospital	21	77.8
Private hospital	13	48.1
Dermatology and venereal diseases hospital	4	14.8
Self-treatment through pharmacy-obtained medication	6	22.2
<b>Assistance in selecting the health center where treatment was received (n:27)</b>		
No one/self-decision	6	22.2
Guidance of a friend	4	14.8
The internet	1	3.7
Guidance of LGBT association	1	3.7
No answer	15	55.6
<b>Reason for not receiving treatment for STIs (n:5)*</b>		
Lack of health insurance	1	20.0
Feeling embarrassed/being shy	2	40.0
Seeing it as unnecessary	3	60.0
Lack of time	2	40.0
Thinking it cannot be treated and it will recover in time	2	40.0

\*Participants could select more than one answer to this question.

those who took measures against STIs said that they were using condoms, and 53% of those who did not take measures against STIs said this was because they were monogamous.

Table 4 shows the participants' characteristics related to STIs. It was determined that 30.2% of the participants had STIs, 84.4% of those who stated they had STIs were treated, and 60% of those who

stated that they did not receive treatment said they thought it was 'not necessary'. Of the participants who were treated for STIs, 77.8% indicated that they received treatment from a state hospital and 50% stated that they chose this institution without guidance from anyone.

Table 5 shows the characteristics of participants regarding their experience of sexual violence. Of the respondents, 29.2% reported that they had

**Table 5.** Characteristics of the participants regarding their experience of sexual violence (n=106)

Characteristics	n	%
<b>Exposure to sexual violence</b>		
Yes	31	29.2
No	75	70.8
<b>Perpetrator of sexual violence (n=31)*</b>		
Partner	15	48.4
Stranger	12	38.7
Relative	4	12.9
Friend	4	12.9
<b>Being treated for sexual violence (n=31)*</b>		
Yes	5	16.1
No	28	90.3
<b>Health center where treatment for sexual violence received (n=5)*</b>		
State hospital	5	100.0
Private hospital	2	40.0
Psychological support from a teacher	1	20.0
<b>Assistance in selecting the institution where treatment was received (n=5)</b>		
No one/self-decision	5	100.0
<b>The reason for not receiving treatment for sexual violence (n=28)*</b>		
Seeing it as unnecessary	16	57.1
Feeling embarrassed/shy	13	46.4
Thinking that they will be exposed to discrimination in the health-care institution	5	17.9
Being unable to seek treatment due to young age	3	10.7
Lack of health insurance	2	7.1

\* Participants could select more than one answer to this question.

**Table 6.** Participants' views on the sexual health services they received (n=106)

Characteristics	n	%
<b>Had problems in receiving sexual health services</b>		
Yes	45	42.5
No	46	43.4
Received no service	15	14.1
<b>Problems experienced in receiving sexual health services (n:45)*</b>		
Discriminatory/bad attitudes of health professionals	35	77.8
Feeling embarrassed/shy	31	68.9
Disturbance by other patients or relatives of the patients	8	17.8
Refusal of health professionals to provide health-care	7	15.6
Inadequacy of health professionals, health-care system, or health-care services	5	11.1
Lack of health insurance	4	8.9
<b>Desired characteristics of individuals who provide sexual health service</b>		
Should be a health professional	87	82.1
Should be reliable	51	48.1
Should be LGBT	32	30.2
Should be someone unfamiliar	13	12.3
Should be a peer	12	11.3
Should not be discriminatory/prejudiced/homophobic	7	6.6
Should have knowledge of health problems of LGBT people and approaches toward them	6	5.7
Should have effective communication skills	3	2.8

\* Participants could select more than one answer to this question.

been exposed to sexual violence and 48.4% of those who were exposed to sexual violence stated that the perpetrator was their partner. A total of 16.1% indicated that they received treatment for the sexual violence, and most of the participants who received treatment reported that it was given by a state hospital and that the institution was their own choice. The most common reasons for not receiving treatment despite sexual violence were seeing it as unnecessary (57.1%) and feeling embarrassed or shy (46.4%).

Participants' views on the sexual health services they received is presented in Table 6. Of the participants,

**Table 7.** Participants' characteristics regarding sexual health education (n=106)

Characteristics	n	%
<b>Had information/education on sexual health</b>		
Yes	86	81.1
No	20	18.9
<b>Source of sexual health information/education (n:86)*</b>		
The internet	67	77.9
Magazines/books/encyclopedias	53	61.6
School	38	44.2
Friend	28	32.6
Health professional	24	27.9
Family	18	20.9
LGBT associations/organizations	18	20.9
Television	9	10.5
<b>Demand for information/education on sexual health (n:20)</b>		
Yes	20	100.0
<b>Sexual health education subjects desired*</b>		
Sexually transmitted infectious diseases	74	69.8
Reproductive system diseases	62	58.5
Anatomy and physiology of the reproductive system	46	43.4
Contraceptive (pregnancy prevention) methods	32	30.2
Sexual rights	79	74.5
Sexual intercourse	3	2.8

\*Participants could select more than one answer to this question.

42.5% stated that they encountered problems in receiving sexual health services, and 77.8% of those who reported problems said that the health professionals exhibited discriminatory or bad attitudes toward them. Almost all of the participants stated that health professionals should be reliable.

Table 7 shows the participants' sexual health education. Of the respondents, 81.1% said they had information or training about sexual health, 77.9% of those who stated that they received information or training got it from the internet, while 61.6% took it from magazines, books, or encyclopedias. All the participants stated they wanted to get information or training on sexual health and 74.5% wanted information on sexual rights, while 69.8% wanted information on STIs.

Of the respondents, 43.4% made suggestions regarding the provision of satisfactory health-care services for LGBT people. These suggestions were categorized under eight headings: (1) the awareness of health professionals should be increased, (2) health professionals should be informed about services especially for LGBT people, (3) health-care units especially for LGBT persons should be established, (4) health professionals with no prejudice or discriminatory attitudes against LGBT people should be available, (5) health professionals providing service to LGBT people should be chosen from among LGBT persons, (6) health-care services should be easily accessible, (7) a temporary identification card should be given during the trans-period, and (8) the entire community should be trained on sexual health. Participants' comments under each heading are given below in italics.

1. The awareness of health professionals should be increased.

*First of all, to me, all health-care professionals should be made aware of general patient rights. There should also be awareness about LGBT.*

*Raising awareness of LGBT in medical education.*

*In health faculties, there should be lessons about LGBTI+ individuals and faculty members should not be discriminatory.*

2. Health professionals should be informed about services especially for LGBT people.

*First of all, in the light of my impressions, which I have gained from educational studies and institutions for many years, health-care professionals should undergo serious training. I believe this is the most significant matter. More experienced and knowledgeable personnel should look after LGBT people when they visit a health center (with no exposure to discrimination).*

*I am convinced that these problems will be eliminated when all personnel working in health institutions (caretakers, attendants, security officers, secretaries, etc.) should be given a sound training on LGBT people. In short, EDUCATION is a must.*

*Health professionals - should have information and education on sexual orientation and sex identity.*

*There must be trained health personnel who can look after LGBT people. Not everyone always has the chance to go to one of the small number of Turkey's main hospitals.*

3. Health-care units especially for LGBT persons should be established.

*LGBT hospital / unit should be established.*

*We can benefit from equal health services with other citizens as long as we can prevent discrimination.*

*There must be medical fields raising professionals such as gynecologists and urologists that serve LGBT individuals because do not have the type of sexuality that classical medicine predicts/assumes.*

*A constantly supervised branch on sexual health should be established within the scope of family medicine, regular training organizations should be arranged, materials should be distributed.*

4. Health professionals with no prejudice or discriminatory attitudes against LGBT people should be available.

*Elimination of the view that gays are diseased and resetting the effect of Islam. Non-homophobic health-care professionals.*

*The absence of discriminatory attitudes.*

*Open-minded people about sexuality.*

*Establishing gender-free health policies.*

*I think that there is a need for well-known health-care centers where there are no chances of discrimination and exposure to discrimination and which are known to be LGBT-friendly. Because a lot of LGBT people can't access the necessary controls or they can't receive treatment due to the fears that they may be humiliated or fail to receive service.*

5. Health professionals providing service to LGBT people should be chosen from among LGBT persons.

*There should be a peer-to-peer community service. That is, I prefer an LGBTI+ person to look after me.*

*There will be positive discrimination if the health-care services can be provided by people who are more conscious of and who are possibly serving with their LGBT identity.*

6. Health-care services should be easily accessible.

*They get the HIV test from a finger in other countries, in gay associations, for example, and the result is ready in 15 minutes This should be the same here.*

*.....Availability of institutions applying positive discrimination to LGBT individuals regarding accessing sexual health-care services will facilitate receiving services.*

7. Temporary identification card should be given during trans-period.

*In particular, it is imperative for trans-individuals to get a temporary id card until the transition process is completed. Most of us are unable to benefit from these services for this reason. Again, since the majority of us have been exposed to discrimination for many years, now we have the necessary strength to deal with this issue. Maybe, at least, we could struggle with it if we were given a temporary id card until the identity change is completed. We will still be exposed to this discrimination, yes, anyway. But at least they would not get rid of us claiming we don't match our identity legally...*

8. The entire community should be trained on sexual health.



*Not only LGBT persons but also everyone needs sexual education. This may not be at the elementary/secondary level, but there should be open lectures at the undergraduate level, seminars should be organized. These programs should have a content and inclusion that everyone, whether LGBT or not, can feel comfortable with, and believe it is possible...*

*To get 'adequate health-care', people first need to know the risks so that they can get the service; even the questions you asked above can be answered roughly by anyone who does not have any idea about the subject...*

*Establishment of necessary units from primary school to university level and provision of age-specific training.*

*The dissemination of information about sexual health, informing individuals at different times from elementary school, preventing society from seeing sex as a shame through attempts to remove it from taboo topics list.*

The negative attitudes exhibited by health professionals due to the participants' sexual orientation or sex identity were grouped under the following five headings: (1) behaving toward LGBT people as if they are heterosexuals, (2) exhibiting bad behaviors, (3) not knowing how to behave, (4) showing homophobic attitudes, and (5) not respecting privacy or confidentiality. The statements of the participants are given in italics below under each of the five headings.

1. Behaving toward LGBT people as if they are heterosexuals.

*It is assumed that I am heterosexual. So, I cannot supply the doctor with enough information. Also, it is not creating a safe zone. Because of this, I think that health-care workers have an attitude that does not respect heterosexist and patient rights.*

*When I go to the hospital, only some doctors are asking such ignorant questions as "Are you married?," "Do you have a discharge?" "If not, you have no problem."*

*Being an unmarried woman causes a problem.*

2. Exhibiting bad behaviors.

*Unfriendly gazes; not caring for you; disregarding.*

*When I reveal my sex identity, looks are completely discriminatory. They wear disturbed facial expressions.*

*Condemnation, blaming.*

*I have not had a problem with my sexual orientation until now, but being single and not a virgin often leads doctors to behave differently and to malpractice. I leave the hospital dissatisfied and having received poor treatment'?*

3. Not knowing how to behave.

*I went to a state hospital to have an HIV test. First, the personnel did not know where to refer me to, and then the person in charge asked strange questions. Why do you want to have it? Is there a problem? and the like. I guess he understood my feminine nature. I did not feel comfortable. So I'm going to the clinics recognized by the "positive life association".*

*They wrote "male" on the health form and then they put a cross on it:)*

*I usually go to a place where a friend has been before or is recommended somehow, people are sometimes confused about how to address me, they use different expressions, but this is not important, I have not encountered discriminatory behavior so far. I did not have a problem with the physicians who I first saw on appointments. There are those who ask questions out of curiosity or those who ask for information about the process.*

4. Showing homophobic attitudes.

*He speaks without looking at my face.*

*They are absolutely transphobic and homophobic.*

*The doctor who was going to examine me was a highly experienced one... He was at least 40–45. I entered the room. He asked what my problem was. I explained. He told me to lie down on the stretcher. I lay down on it. He touched my belly with bare hands, pressed it, etc. Then he said, "hold on a moment!"... He went to the computer. "There's a male name here. You are the wrong patient," he said. I explained the situation. "Why didn't you say this at first?, he said. Then, he put on gloves. You may think what's wrong about this, but the guy put on two gloves, one*

over the other. Do you think this is nothing to be misunderstood, either? He touched my belly again, etc. The thing is that the doctor who examined me without gloves before understanding my condition wore two pairs of gloves, one over the other – not one – when he realized my situation.

##### 5. Not respecting privacy or confidentiality.

*Some of the health-care personnel sometimes ask me personal questions. Once, I went to the hospital with my boyfriend. One of the nurses called me and asked me questions such as "who is he?"; "What is your relationship?"; "Has he been diagnosed "\*\*\*\*," too"?*

*I had an accident in 2015. I was very seriously injured. I was operated on at .....University Hospital. My identity name and my social name are different. However, the nurse showed my file to her friends and they started laughing. I got so furious at this situation that I got up with my operated body and shouted out as loudly as I could, my voice carrying through the corridors.*

*Four years ago, my social name and identity name were different. I am a trans-woman. I informed the secretary that I was a trans-woman and requested that they call me by my social name when I am called in and that she informed the caller. The secretary was a good person. But when I was called, I was called by my ID name, even though the secretary wrote my social name in parenthesis. I was so embarrassed and hurt in front of everyone. I did not get up to go to the clinic until the secretary noticed the situation. I got very angry and I left without receiving treatment.*

## DISCUSSION

### Reproductive and Sexual Problems of LGBT Individuals

In our study, 28% of the participants reported that they were not satisfied with their sexual life, and stated that the most important reason for the dissatisfaction was an irregular and low frequency sexual life. It has been previously reported that 38% of LB study participants were not satisfied sexually because they did not have sex and 31% were dissatisfied because they could not have sex more frequently (Henderson et al., 2001).

Previous studies have reported that for LGBT individuals, relational problems with their partners and high prevalence of STIs decreased their sexual satisfaction

(Charlton et al., 2011; Hacıoglu, Cosut Cakmak & Yildirim, 2011; Henderson et al., 2001). This is in agreement with the findings of the present study. Therefore, it is safe to deduce that the lack of regular sexual life in LGBT individuals is a factor in the decrease in low sexual satisfaction levels among them. When providing care to LGBT individuals, nurses who specialize in women's health should evaluate their sexual satisfaction, and provide sexual guidance as required.

In our study, the most common sexual problems were found to be erection problems, vaginismus, premature ejaculation and orgasm problems. However, study participants also held other fears, such as having an STIs or being infected. Breyer et al. (2010) reported that premature ejaculation prevalence is similar in heterosexual and homosexual men; however, it was found in the present study that erectile dysfunction was more common in homosexual men, and sexual dysfunction was more common among homosexual females. It has been reported that LGBT individuals experience more sexual dysfunction and sexual problems than heterosexual people (Grabski & Kasperek, 2017; Hirshfield et al., 2010). In addition, studies have reported that LGBT individuals are more at risk of having an STI and being infected than heterosexual individuals (Boehmer, Miao, Linkletter & Clark, 2012; Charlton et al. 2011; Lindley, Barnett, Brandt, Hardin & Burcin, 2008). The increased risk of infection with HIV in LGBT individuals, especially, is an important sexual health problem (Hacıoglu et al., 2011; Marshall et al., 2011).

A third of the individuals who participated in our study had a history of STIs and 15% of these individuals did not receive any treatment. We also found that many LGBT individuals did not take adequate preventative measures against sexually transmitted diseases—approximately 40% of participants stated they did not take any measures against STIs. Previous studies have shown that LB women have fewer pap smear tests than heterosexual women (Agénor, Krieger, Austin, Haneuse & Gottlieb, 2014; Charlton et al. 2011). On the other hand, it has been determined that LB women have more HIV tests than heterosexual women (Diamant, Wold, Spritzer & Gelberg, 2000; Marshall, 2011; Massachusetts Department of Public Health 2009; New Mexico Department of Health 2010).

Homosexual women acquire viruses by vaginal-vaginal, manual-vaginal or oral contact, or through artificial penises or sex toys. Gonorrhoea is caused by

unprotected oral-genital contact and *Giardia lamblia* and *Entamoeba histolytica* are transmitted by oral-anal contact (Lee, 2000). In homosexual men, anal-receptive intercourse makes them vulnerable to HIV, human papilloma virus, hepatitis B, herpes virus, urethritis (including gonococcal and chlamydial infection), and pharyngeal gonorrhoea (Lee, 2000). Health-care personnel, especially nurses, should obtain detailed sexual anamnesis from LGBT individuals. Nurses should inform LB women about the use of barriers, gloves, and dental dams against STIs, and homosexual men regarding the use of condoms.

### Reproductive Health-Related Needs of LGBTs

In our study, while LGBT individuals stated that they usually received assistance from friends, the internet, and LGBT associations in the selection of institutions for the treatment of STIs, they never consulted a health-care professional on this matter. Health professionals should understand that LGBT individuals are more at risk of STIs than heterosexual individuals and should inform individuals that certain sexual behaviors increase risks regardless of their sexual orientation or identity.

While approximately 30% of LGBT individuals in our study reported that they were exposed to sexual violence by intimate partners, only a small percentage (16%) received treatment for this problem. Sexual violence against all individuals, regardless of their sexual identity, is an important public health problem, and in recent years important steps have been taken both nationally and internationally in the fight against all forms of violence. However, prevention of sexual violence, especially toward LGBT individuals, is not at the desired level (Morris & Balsam, 2003). A systematic review of 75 studies reported that 15.6–85% of lesbian women and 11.8–54% of gay males were sexually assaulted throughout their lives (Rothman-Exner & Baughman, 2011). It is thought that incidents of sexual violence against LGBT individuals occur due to homophobia, biphobia, transphobia, and hatred toward LGBT individuals (Gentlewarrior & Fountain, 2009). Gay and lesbian individuals are more exposed to sexual violence than other groups that are not tolerated by society (Dunbar, 2006). This suggests that the most undesirable group in society may be LGBT individuals. In Turkey, homosexuality is still considered an abnormal and deviant behavior and perceived as a threat disrupting social order. This leads to discrimination against LGBT individuals by causing fear, anxiety, violence, intolerance, preju-

dice, and hatred (Kilic, 2011; Sarac, 2008). Discriminatory attitudes toward LGBT individuals in society lead to considerable inequality in access to and use of health-care services (Scott, Pringle, & Lumsdaine, 2004). LGBT individuals are likely to benefit less from health services due to worries about being exposed to homophobic attitudes and fear of being revealed to nurses, midwives, and other health professionals, and therefore they postpone treatment when a health problem occurs or seek help only when they have severe symptoms (Aaron et al., 2001; Celik & Şahin, 2012; Sahin & Bilgic, 2016). In our study, many of the participants (42.5%) stated that they had difficulties in obtaining health services for sexual health, and within this group, the most important problem was the discriminatory or bad attitudes of health-care personnel (77.8%). Other studies show that LGBT individuals do not trust health workers and have difficulty expressing themselves, and these factors negatively impact on the likelihood of these individuals receiving health-care services (Hutchinson, Thompson & Cederbaum, 2006; Sahin & Bilgic, 2016). LGBT individuals in our study want health-care workers to regard themselves, not to exhibit homophobic, discriminatory, and prejudiced attitudes, to respect their privacy, and to offer health services regardless of the patient's gender or sexual orientation.

It is pleasing that a large majority (81%) of LGBT participants in our study have received information or education on sexual health, but only 28% of these individuals received this information from a health professional. The fact that LGBT individuals rarely refer to health professionals for sexual health education may be due to the discriminatory and bad attitudes and behaviors of health-care professionals toward them. Our study found that within the field of sexual health, LGBT individuals mostly requested education about STIs. Given the fact that LGBT individuals have a higher risk of STI than heterosexual individuals, and have sexual function problems due to STIs, this is a highly significant and meaningful result. However, when LGBT persons cannot communicate with health-care professionals in a comfortable and healthy manner, this may lead to inaccurate information being received. This may in turn cause LGBT individuals to continue to have problems with their reproductive health, and therefore new problems may arise. At this point, health professionals should be more sensitive, understanding and open toward LGBT individuals in providing health-care services to them.

## Study Limitations

There are some limitations of this study worth highlighting. The results of this study are limited to the sampling group, so cannot be generalized to the whole of society. Because the study was conducted using an online questionnaire method, the reproductive health problems and needs of LGBT individuals who were unable to access the questionnaire could not be assessed. The study data were collected based on self-reporting by the individuals and the information provided by the participants was assumed to be correct.

## CONCLUSION AND RECOMMENDATIONS

Our study contributes significantly to the literature in determining LGBT individuals' reproductive health problems and needs. The findings of our study show that LGBT individuals have several reproductive health problems, but that they cannot access health-care at an appropriate level to cope with these problems. The main reason for the participants' inability to access the services was that they were worried about discrimination or ill-treatment in health institutions, and actually encountered such behaviors. Health professionals, who are responsible for providing an equal, respectful, and safe health-care service to all people in society, should have an equal approach to all individuals by eliminating the assumption that all individuals are heterosexual and accepting that there may be different sexual orientations. This would mean that when LGBT individuals refer to any health institution, they would be more comfortable explaining their health problems and exhibit more appropriate health-seeking behavior with the confidence and comfort that comes from being recognized and understood.

**Ethics Committee Approval:** Ethics committee approval was received for this study from the ethics committee of Selçuk University (Date: 18.01.2016 and Issue: 2016/08).

**Informed Consent:** Informed consent was obtained from participant who participated in this study.

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