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HEALTH LGBTI

REDUCING HEALTH INEQUALITIES EXPERIENCED BY LGBTI PEOPLE

TASK 1: State-of-the-art study focusing on the health inequalities faced by LGBTI people

D1.1 State-of-the-Art Synthesis Report (SSR)

June, 2017

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Health4LGBTI

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Executive summary

AIMS

This report is a state-of-the-art review study carried out in the context of the European Union (EU) funded pilot project Health4LGBTI (SANTE/2015/C4/035). The review study focused on the health inequalities faced by LGBTI people (especially those in vulnerable situations) and the potential barriers faced by health professionals when providing their care. It brings together scientific research and grey literature in a way that leads to new insights and recommendations supported by evidence.

METHODS

This State of the Art Synthesis Report (SSR) is a summary document that brings together the findings of two companion reports: A Scientific Review (SR) of relevant primary research literature published in academic peer reviewed journals (in English only), and; a Comprehensive Scoping Review (CSR) of relevant European/international grey literature and a unique collection of grey literature elicited for this study from 27 European Member States.

RESULTS

Root causes of health inequalities experienced by LGBTI people

Health inequalities relating to LGBTI people occur due to the consequences of a complex interaction of environmental, social, cultural and political factors. Root causes likely to contribute to the experience of health inequalities by LGBTI people include: i) cultural and social norms that preference and prioritise heterosexuality; ii) minority stress associated with sexual orientation, gender identity and sex characteristics; iii) victimisation; iv) discrimination (individual and institutional), and; v) stigma.

What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

LGB people are at higher risk of developing certain types of cancer (e.g. anal cancer in gay and bisexual men) at a younger age compared to heterosexual people. For mental health, LGBTI people are at significantly higher risk of experiencing mental distress with LGB people twice to three times more likely to report an enduring psychological or emotional problem including suicidal ideation and suicide, substance misuse, and deliberate self-harm compared to the general population. Limited research is available exploring the mental health profile of intersex people and needs to be addressed. Whilst accessing care, LGBTI people are more likely to report unfavourable experiences including poor communication from health professionals and dissatisfaction with the treatment and care provided. For trans people their dissatisfaction often stems from experiencing discrimination whereas intersex people dissatisfaction was evident where health professionals failed to communicate openly or due to a lack of informed consent prior to 'normalising' treatments (e.g. genital surgeries). There

is a lack of research with trans and intersex people to understand their health profile and their experiences and health needs in service provision.

What is known about the health inequalities of LGBTI people focusing on vulnerable intersections as it relates to healthcare?

Intersections of LGBT(I) identities were found to contribute to LGBTI health inequalities. For example, living in rural areas appears to contribute to health inequalities and have implications for access to services, particularly for gay men and trans people. Older LGB people can also experience both physical and mental health difficulties as they age and become more dependent, however social support can act as a protective factor (no research on ageing and health was evident for intersex people). Many young LGBT people experience mental health difficulties and substance misuse in ways that can affect educational attainment. Although limited research exists on the health of LGBT(I) people whom may also be migrants, refugees, and/or asylum seekers, findings suggest that some may have experienced abuse in their country of origin (by parents, caregivers or peers) which is correlated with negative mental health outcomes. Similarly, LGBT(I) people on lower incomes may be at a higher risk of mental health problems and substance (mis)use. Finally, LGBT(I) people with disabilities are more likely to be disabled at a younger age. In general, there appears to be very little research exploring intersectionality for LGBTI people but particularly so for trans and intersex people.

What are the potential barriers faced by: 1) LGBTI people when using or trying to access healthcare and; 2) health professionals when providing care for LGBTI people?

The findings from both the SR and the CSR revealed a number of barriers faced by LGBT(I) people when accessing healthcare. These include; prejudicial attitudes and intolerant or discriminatory behaviour of staff including inappropriate curiosity; unequal treatment; needs not being recognised (e.g. lesbian women not being invited for cervical screening due to wrongly being assumed that they are a 'low-risk' group); LGBTI people being subjected to humiliation; denial of access to treatment (e.g. assisted reproductive technology); or fear of disclosure of gender identity, sexual orientation or sex characteristics. When LGB people access health services, practitioners often assume heterosexuality and use language accordingly meaning LGB people experience exclusion and invisibility. For trans and intersex people, health professionals using pathologising language and incorrect pronouns can result in avoidance of healthcare, as well as other problems.

In terms of the potential barriers faced by health professionals when providing care for LGBTI people, the following were identified: lack of knowledge and cultural competence concerning the lives and healthcare needs of LGBTI people where health professionals may (un)knowingly and often (un)intentionally subject LGBTI people to heterosexism, homophobia, biphobia, transphobia and/or interphobia resulting in significant barriers to healthcare. Other barriers include a lack of awareness of the sexual orientation, gender identities and/or sex characteristics of LGBTI people who access health services; institutional barriers such as a lack of specialist mental health services and counselling services for LGBTI people, or a lack of relevant documentation (e.g. leaflets, flyers, information, marketing materials) and

protocols (e.g. processes for recording patient information and care pathways) appropriate for LGBTI patients. Reviews overwhelmingly show generic and specialist health professionals lack the appropriate knowledge regarding the lives and related health needs of LGBTI people as well as lack the appropriate culturally competent skills necessary to meet the needs of LGBTI people.

What examples of promising practice exist to address the specific health needs of LGBTI people?

Despite the difficulties, inequalities, and barriers that LGBTI people still encounter in the field of health, a number of **promising practices** were evident in Europe. Examples included: inclusive policies to ensure that LGB people can access healthcare alongside other people and that their specific needs are met; free, anonymous HIV testing and counselling including provision of centres providing assistance and support for people living with HIV; peer mentoring for LGBT people in crises; a queer social group to interact with refugees and thereby foster mutual understanding; and suicide prevention strategies for LGBT people.

CONCLUSIONS

Overall this state-of-the-art review study demonstrates the existence of key health inequalities, barriers, and discrimination based on sexual orientation, gender identity, and sex characteristics of LGBTI people. Inequalities can be addressed through health services that are attuned to the needs of LGBTI people. This may require specific efforts by health systems and health professionals, and they are also aligned to European efforts to abolish discrimination on any grounds and to uphold and promote the fundamental rights of LGBTI people. Although some promising practices can be identified in various health settings, there is much to be done. A key challenge for health professionals and health systems is to develop the structures for both specialist and universal health service provision that are truly inclusive and equally accessible to all. Appropriate and mandatory training for health professionals across all European Member States is an important step in this direction.

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List of abbreviations

AIDS	Acquired immune deficiency syndrome
CAIS	Complete Androgen Insensitivity Syndrome
CoE	Council of Europe
CSR	Comprehensive Scoping Review
DSD	Disorders of Sex Development
DSM-5	Diagnostic and Statistical Manual of Mental Disorders V5
EC	European Commission
EP	European Parliament
EU	European Union
FGR	Focus Group Report
FRA	Fundamental Rights Agency
HCP	Healthcare Professional
HIV	Human Immunodeficiency Virus
ICD-11	International Classification of Diseases V11 R
LGBTI	Lesbian, Gay, Bisexual, Trans, and Intersex
MS	Member State
MSM	Men who have Sex with Men
RR	Rapid-Review
SOGI	Sexual Orientation and Gender Identity
STI	Sexually Transmitted Infection
SR	Scientific Review
SSR	State of the Art Synthesis Report (this report)
TGEU	Transgender Europe
UN	United Nations
UNDP	United Nations Development Programme
UNPFA	United Nations Populations Fund
WHO	World Health Organisation
WSW	Women who have Sex with Women
PACE	Parliamentary Assembly Council of Europe

Glossary of key terms

Here we provide some of the most commonly terms used throughout this report and in the two companion reports (see Appendices). They are taken directly from ILGA-Europe's most commonly used phrases and acronyms which can be found here: www.ilga-europe.org/resources/glossary.

Cisgender	A term referring to those people whose gender identity and gender expression match the sex they were assigned at birth.
Gay	Refers to a person who is sexually and/or emotionally attracted to people of the same gender. It traditionally refers to men, but other people who are attracted to the same gender or multiple genders may also define themselves as gay.
Gender	Refers to a social construct which places cultural and social expectations on individuals based on their assigned sex.
Gender expression	Refers to people's manifestation of their gender identity to others, by for instance, dress, speech and mannerisms. People's gender expression may or may not match their gender identity/identities, or the gender they were assigned at birth.
Gender identity	Refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms. Some persons' gender identity falls outside the gender binary and related norms.
Gender reassignment surgery (GRS)	Medical term for what trans people often call gender confirmation/affirmation surgery, which is sometimes (but not always) part of a person's transition.
Homosexual	People are classified as homosexual on the basis of their gender and the gender of their sexual partner(s). When the partner's gender is the same as the individual's, then the person is categorised as homosexual. The term focuses on sexuality rather than on identity and may, in some contexts, have a negative and pathologising connotation.
Intersex	Relates to a range of physical traits or variation that lie between binary ideals of male and female. Intersex people are born with physical, hormonal or genetic features that are neither wholly female nor wholly male; or a combination of female and male; or neither female nor male. Many forms of intersex exist; it is a spectrum or umbrella term, rather than a single category.
Heteronormativity	Refers to the set of beliefs and practices that gender is an absolute and unquestionable binary, therefore describing and reinforcing heterosexuality as a norm. It implies that people's gender and sex characteristics are by nature and should always be aligned, and therefore heterosexuality is the only conceivable sexuality and the only way of being 'normal'.
Heterosexism	Heterosexism is a set of discriminatory attitudes, bias and behaviours relying on gender as a binary to favour heterosexuality and heterosexual relationships.
Queer	Previously used as a derogatory term to refer to LGBTI individuals in the English language, queer has been reclaimed by people who identify beyond traditional gender categories and heteronormative social norms. However, depending on the context, some people may still find it offensive. Also refers to queer theory, an academic field that challenges heteronormative social norms concerning gender and sexuality
Sex	The classification of a person as male or female. Sex is assigned at birth and written on a birth certificate, usually based on the appearance of their external anatomy and on a binary vision of sex which excludes intersex people. A person's sex however, is actually a combination of bodily characteristics including: chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics.

Sex characteristics	A term that refers to a person's chromosomes, anatomy, hormonal structure and reproductive organs. OII Europe and its member organisations recommend protecting intersex individuals by including sex characteristics as a protected ground in anti-discrimination legislation. This is because many of the issues that intersex people face are not covered by existing laws that only refer to sexual orientation and gender identity. This is seen as being a more inclusive term than 'intersex status' by many intersex activists, as it refers to a spectrum of possible characteristics instead of a single homogenous status or experience of being intersex.
Sexual orientation	Refers to each person's capacity for profound affection, emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender.
Trans	Is an inclusive umbrella term referring to people whose gender identity and/or gender expression differ from the sex/gender they were assigned at birth. It may include, but is not limited to: people who identify as transsexual, transgender, transvestite/cross-dressing, androgyne, polygender, genderqueer, agender, gender variant, gender non-conforming or with any other gender identity and/or expression which does not meet the societal and cultural expectations placed on gender identity.
Transsexual	An older and medicalised term used to refer to people who identify and live in a different gender. The term is still preferred by some people who intend to undergo, are undergoing or have undergone gender reassignment treatment (which may or may not involve hormone therapy or surgery).
Transition	Refers to a series of steps people may take to live in the gender they identify with. Transition can be social and/or medical. Steps may include: coming out to family, friends and colleagues; dressing and acting according to one's gender; changing one's name and/or sex/gender on legal documents; medical treatments including hormone therapies and possibly one or more types of surgery.

SECTION ONE: Introduction and context

1.1 The Health4LGBTI project

Health4LGBTI: Reducing health inequalities experienced by LGBTI people (SANTE/2015/C4/035) is a pilot project of the European Commission to increase understanding of how best to reduce specific health inequalities experienced by lesbian, gay, bisexual, trans and intersex (LGBTI) people, focusing in particular on overlapping inequalities stemming from discrimination and unfair treatment on other grounds (e.g. age, ethnicity, disability).

Through action on five key Tasks (Figure 1 below) over two years (2016-2018), the project will explore the particular health needs and challenges faced by LGBTI people, and analyse the key barriers faced by health professionals when providing care. The aim is to raise awareness of the challenges and provide European health professionals with the tools by giving them the right skills and knowledge to overcome these barriers, and thereby contribute to the reduction in health inequalities.



Figure 1: The Health4LGBTI Project.

1.2 The Health4LGBTI Consortium

The Health4LGBTI project is led by Verona University Hospital in Italy (Figure 2 below). The wider consortium represents a partnership between EuroHealthNet (a health inequalities network based in Belgium), Verona University Hospital (a University Teaching Hospital in Italy), University of Brighton (Centre for Health Research, School of Health Sciences, in the UK), the National Institute for Public Health-National Institute of Hygiene (a Public Health body in Poland) and ILGA-Europe (the European region of the International Lesbian, Gay, Bisexual, Trans and Intersex Association).

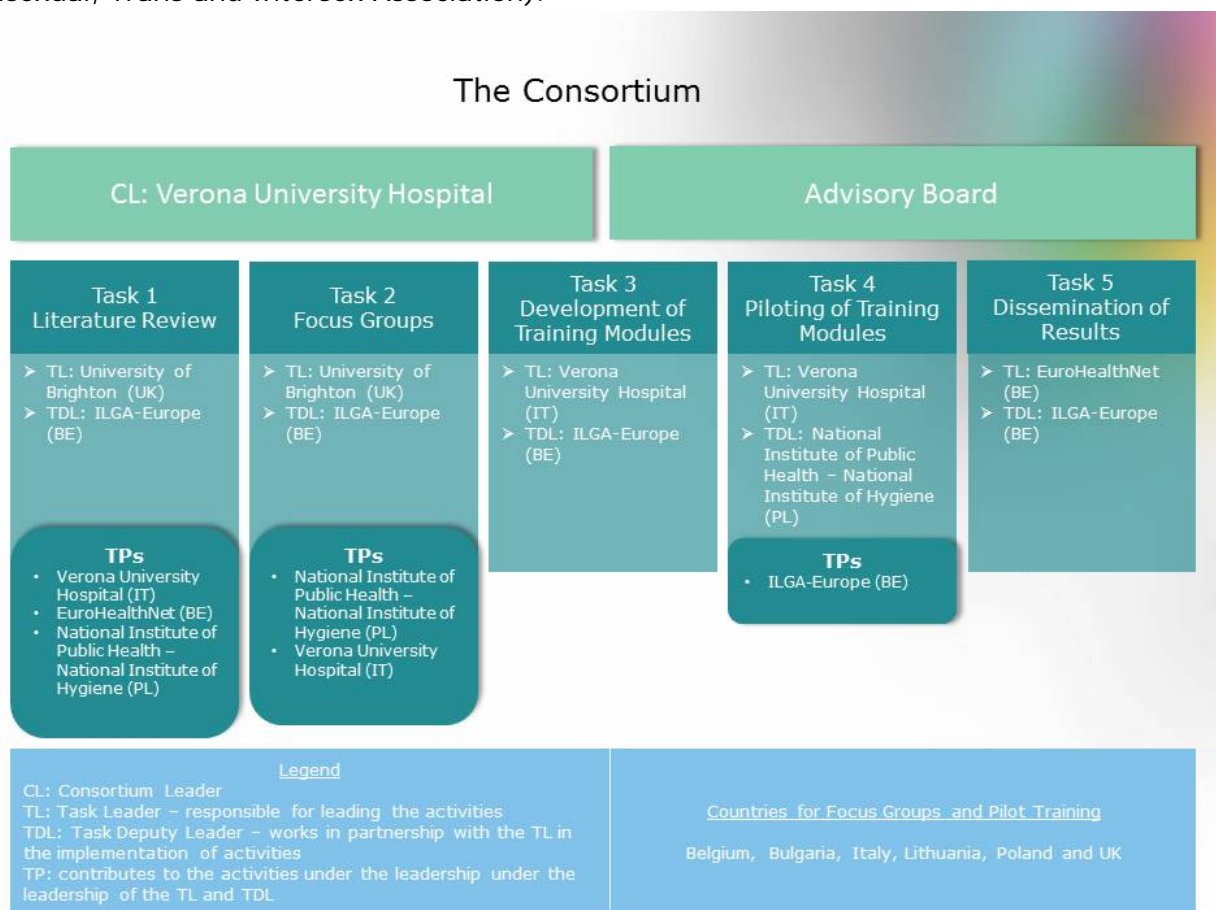


Figure 2: The Health4LGBTI project consortium

1.3 About Task 1

Task 1 of the Health4LGBTI project (March 2016-March 2017) was a state-of-the-art review study carried out in the context of the current EU funded pilot project Health4LGBTI (SANTE/2015/C4/035)¹. The review study focused on the health inequalities faced by LGBTI people (especially those in vulnerable situations) and the potential barriers faced by health professionals when providing care for LGBTI people. Co-led by the University of Brighton

¹ See: http://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en.htm#fragment2

(UoB) with ILGA-Europe in collaboration with all Consortium partners, the review study comprised two key activities:

- 1) A **Scientific Review (SR)** of relevant International/European primary research literature published in academic peer reviewed journals (in English only; see Appendix A).
- 2) A **Comprehensive Scoping Review (CSR)** of relevant grey literature from (where possible) all 28 European Member States (MS; see Appendix B).

Together, these two key activities informed the production of this present key deliverable for **Task 1: State-of-the-art synthesis report (D1.1)**; see Figure 1). Details of the methods used to conduct these reviews are provided in Section Two.

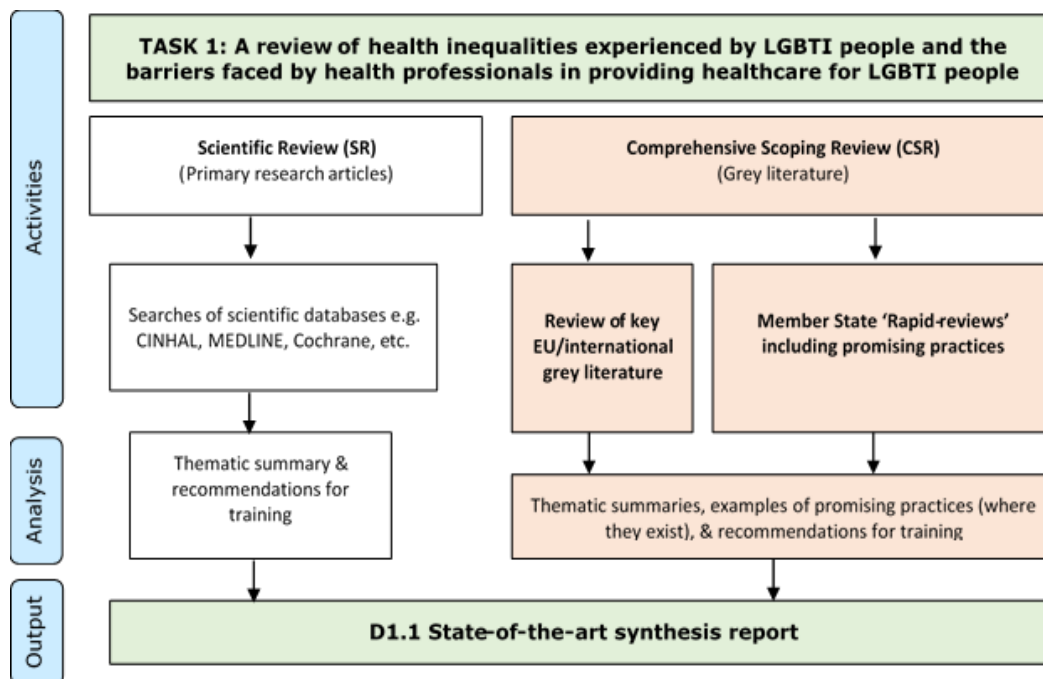


Figure 3: Overview of Task 1

1.4 About this report

A state-of-the-art review study considers the most current research in a given area(s) or topic and commonly summarises current and emerging trends reflected in the literature helping to establish ‘what is known’ as well as identify research and other priorities. Moreover, a state-of-the-art review can assist in producing a synthesis of current thinking that cuts across the field offering new perspectives on an issue and/or highlight new areas for further research, training, and policy development. In general, the outcome of state-of-the-art narrative reviews is typically a summary of review results².

² Elsevier (2017)

Thus, as set out in the accepted tender proposal for this Health4LGBTI project, this **State of the Art Synthesis Report (SSR)** is a summary document that brings together the findings of the two companion reports (see Appendix) including: 1) the **Scientific Review (SR)** which used a systematic literature search strategy to review international/European primary research published in peer reviewed journals (in English only), and; 2) the **Comprehensive Scoping Review (CSR)**³ designed to complement the findings of the SR by exploring additional grey literature from European bodies and agencies as well as from across all Member States. For both the SR and CSR, the reviews considered the most up-to-date literature available (where possible) from 2010 onwards in order to ensure the most current research findings from both the academic and grey literature were included.

In bringing together the findings from the SR and CSR, the the SSR synthesises the findings with a particular focus on the health inequalities faced by LGBTI people, especially those in vulnerable situations and the potential barriers faced by health professionals when providing care. At relevant places in the text, material that can be used for training is provided including questions to consider and learning points. Key recommendations for the training of health professionals in working with LGBTI people to maximise access to health and reduce inequalities are also presented along with implications for research including the identification of research 'gaps', as well as implications for policy, and practice.

This SSR is divided into **five key Sections** as follows:

Following this first **introductory Section** which sets the context for the SSR, **Section Two** briefly details the methods used in the SR and CSR. **Section Three** presents a synthesis of the findings from the companion reports drawing on both the primary research literature (from the SR) as well as European/international grey literature and the grey literature from 27 European Member States (from the CSR)⁴. In doing so, attention is drawn to some of the **root causes** of health inequalities experienced by LGBTI people before exploring some of the **known health inequalities** faced by LGBTI people across Europe relating to healthcare settings including a focus on **vulnerable intersections** (e.g. LGBTI people who may live in rural settings, older LGBTI people, and LGBTI people with disabilities). The Section goes on to present a synthesis of findings regarding some of the **potential barriers** faced by health professionals when providing care for LGBTI people as well as barriers faced by LGBTI people when using or trying to access healthcare, before presenting some examples of promising practices from MS. **Section Four**, draws attention to some limitations of the existing research explored in this SSR ending with some broad conclusions. Finally, **Section Five** presents a series of general recommendations (including research, policy, and practice) as well as recommendations for the training of health professionals.

³ The SR and CSR have both been written (and are available) as 'stand-alone' documents as well as appendices to this present SSR. This therefore necessitates some repetition in places.

⁴ Although the CSR aimed to engage with all 28 MS, following numerous attempts over a number of months, no rapid-review was received from Cyprus (see the CSR for further details in Appendix B).

1.5 A brief note on context and terminology

1.5.1 Health inequalities in context

With regards to the context within which this report has been commissioned and is situated, it is important to outline briefly what health inequalities are and the current approaches to reduce them.

The Communication from the European Commission (EC) and its supporting documents on reducing health inequalities in the EU (EC, 2009)⁵ notes how “health inequalities refer to the avoidable and unfair differences in health that are strongly influenced by the actions of governments, stakeholders, and communities and can be addressed by public policy”. (See also Gugglberger, Sherriff, Davies & Van den Broucke, 2016; Marmot, 2010; NHS Health Scotland, 2015; Sherriff, Gugglberger, & Davies, 2014). Moreover, in its accompanying memo on *Questions and Answers on Solidarity in health: Reducing health inequalities in the EU*, the EC further clarifies that “what we are interested in are those differences in health which arise not from chance or from the decision of the individual but from avoidable differences in social, economic and environmental variables (e.g. living and working conditions, education, occupation, income, access to quality health care, disease prevention and health promotion services) that are largely beyond individual control and can be addressed by public policy.”

This latter statement is key because it recognises and acknowledges that health inequalities go against the principles of social justice because they are unfair and avoidable. Inequalities in health do not occur randomly or by chance, but are socially determined by circumstances largely beyond an individual’s control with their roots in political and social decisions resulting in unequal distributions of income, power and wealth across populations and between groups. Such fundamental causes of health inequalities (income, power, wealth) can influence the wider environmental influences on health such as availability and access to housing, education, work, and so on as well as access to health, social, and cultural opportunities in society. The wider environment in which people live and work then shapes their individual experiences of, for example, low income, poor housing, discrimination and access to health services. The consequences are then seen in the unequal and unfair distribution of health, morbidity and mortality (NHS Health Scotland, 2015).

Reducing health inequalities is regarded as one of the most important public health challenges facing the EU and its Member States (EC, 2009). Indeed, reducing health inequalities has been a key priority of the EU Health Strategy (2008–2013) and is prominent in within the Europe 2020 strategy as part of its goal on achieving inclusive growth; it is also an investment priority for the European Structural and Investment Funds (ESF) for 2014-2020. However, reducing inequalities is difficult and has been termed a ‘wicked’ problem denoting a complex issue with multiple root causes that has no simple solution (Fosse, Sherriff, Helgesen, & Davies, in press). However, it is nevertheless generally accepted that tackling inequalities requires a blended approach by addressing the fundamental causes of inequalities, preventing harmful wider environmental influences, and mitigating the negative impacts on individuals (NHS Health Scotland, 2015).

⁵ http://ec.europa.eu/health/social_determinants/policy/commission_communication_en

It is within this latter approach of taking action to tackle (mitigate) the unfair differences in people's experiences of health (including access to) services that the current Health4LGBTI project is located. Such an approach recognises that health inequalities experienced by LGBTI people in relation to health care/services are largely beyond an individual's control but can limit their chances of living longer, more satisfying, and ultimately healthier lives. Action on reducing health inequalities therefore is not about action on individuals or lifestyles, but on understanding and addressing barriers to opportunities for health which, can include the training of health professionals to ensure the workforce is appropriately skilled and sensitive to all social and cultural groups regardless of gender identity, sexual orientation, or sex characteristics.

1.5.2 Terminology

With regards to terminology, throughout this report the terms sexual orientation, gender identity and sex characteristics are used where relevant in line with commonly accepted language reflected in European policy directives, national guidelines, and third sector recommendations⁶. Where possible, certain sections in this report refer specifically and precisely to LGB or LGBT people instead of LGBTI people; this is done to acknowledge the original research participants in the particular literature/study in question. However, in relevant areas of the SSR (e.g. recommendations) where a study only included certain groups such as LGB, but the issues also appear relevant for 'T' and 'I' people, then we indicate this by including the latter in parenthesis e.g. LGB(TI), LGBT(I) etc.

Finally, although we recognise that some LGBTI people may understandably resist fixed identity categories such as lesbian, gay, bisexual, trans and intersex, we also acknowledge that such categories can be useful when aiming to understand the health inequalities associated with LGBTI people's lives, in order to inform future healthcare training, practice and policy initiatives. Consequently, it is within this context of the SSR that we use these terms. For a more detailed overview of the relevant contextual and terminology issues see the companion reports.

⁶ See www.ilga-europe.org/resources/glossary

SECTION TWO: Methods

2.1 Introduction

This Section presents briefly the methods and process used to generate the data for this [State of the Art Synthesis Review \(SSR\)](#). In doing so, a summary of the Scientific Review (SR) process is provided with full details available in the dedicated companion report (Appendix A). The Section then presents an overview of Comprehensive Scoping Review (CSR) process, with again full details provided in the dedicated companion report (see Appendix B)⁷.

2.2 The Scientific Review

Using a narrative review and synthesis design, a SR of international/European primary research literature published in peer reviewed journals (English only) was conducted. 57 relevant papers comprising either primary research, systematic reviews, or meta-analyses of primary research studies were extracted, reviewed, and synthesised. Searches were conducted using Web of Science, CINAHL, PsychINFO, MEDLINE, Cochrane Library, Google Scholar, and additional hand searching. Precise inclusion/exclusion criteria for paper extraction were agreed amongst Consortium partners in order to present a varied literature on the subject within scope of the Task and project specification⁸. The following review questions were addressed:

1. What is [known](#) about the health inequalities faced by LGBTI people as it relates to healthcare settings?
2. What is known about the health inequalities of LGBTI people focusing on [vulnerable intersections](#) (e.g. rural, older, younger, refugee, immigrant, disability, poverty) as it relates to healthcare?
3. What are the [potential barriers](#) faced by health professionals when providing care for LGBTI people?

SR results are summarised in Section Three of this report. For full details of the process and findings, refer to Appendix A.

2.3 The Comprehensive Scoping Review

A comprehensive Scoping Review (CSR) to complement the findings of the SR was conducted by exploring additional [grey literature](#) from European bodies and agencies as well as country-level rapid-reviews from across European Member States (MS) of the EU (see Appendix B). An adapted version of Arksey and O'Malley's (2005) framework for conducting scoping studies was used to structure the CSR activities. [European/international grey literature](#) were

⁷ Protocols for the Scientific Review and the Comprehensive Scoping Review are available on request.

⁸ A notable exclusion in this respect were papers focusing *purely* on HIV/AIDS and other STIs due to being an already over-researched and previously reviewed area. Although clearly a pertinent literature for LGBTI population, inclusion may have overshadowed many of the other key health issues experienced by LGBTI people. However, HIV/AIDS and other STIs are nevertheless present in both the SR and CSR reports as well as this current SSR given the topic(s), perhaps inevitably, were nonetheless present in many papers focusing on health inequalities and LGBTI people.

collected, reviewed, and analysed around the core questions for the CSR (next page). Searches were pragmatic utilising a combination of non-scientific electronic databases, reference lists of included literature, and hand searching of relevant EU/International organisations and if/where relevant conference sites/reports.

In addition to the European review, [rapid-reviews of relevant grey literature](#) from MS were conducted. The aim was to access grey literature that might not otherwise be accessible (e.g. non-English and/or not indexed in [scientific] databases), ensuring a good geographical [coverage](#) of the information and data collected across MS and in doing so, embracing different social and cultural contexts. Data from both the European review and the rapid-reviews were analysed thematically.

The CSR mirrored closely the aims of the SR (with some minor differences) focusing on the following key questions:

- 1) What is [known](#) about the health inequalities faced by LGBTI people as it relates to healthcare settings?
- 2) What is known about the health inequalities of LGBTI people focusing on [vulnerable intersections](#) (e.g. rural, older, younger, refugee, immigrant, disability, poverty) as it relates to healthcare?
- 3) What are the [potential barriers](#) faced by: 1) LGBTI people when using or trying to access healthcare, and; 2) health professionals when providing care for LGBTI people?
- 4) What [examples of promising practice](#) exist to address the specific health needs of LGBTI people?

2.4. The State of the Art Synthesis Report

A synthesis report is a combination, usually a shortened version, of several texts made into one containing the important points in the text; in this case, the [State of the Art Synthesis Report \(SSR\)](#) is a summary document drawing on the companion texts of the SR and CSR.

The overall structure of this SSR was not only shaped by the key overarching research questions underpinning the Health4LGBTI project and specifically Task 1 activities, but also the [key thematic findings](#) emerging from the companion reports.

Methodologically, the SSR was thus formed using a thematic approach eliciting key findings from the SR and CSR, and in doing so, refers to both findings from the academic literature as well as the grey literature at European and Member State level.

SECTION THREE: Synthesis of main findings

3.1 Introduction

This Section provides the main summary of findings including the root causes of health inequalities experienced by LGBTI people, some of the known health inequalities experienced by LGBTI people in the context of healthcare settings, as well as barriers experienced by LGBTI people when accessing care, and barriers faced by health professionals when providing care. Summaries are presented in table format and content is drawn from both primary research papers extracted from the SR and from the CSR including European/international grey literature and findings from the rapid-reviews of Member States.

3.2 Root causes of health inequalities experienced by LGBTI people

In general, research suggests that health inequalities occur due the consequences of a complex interaction of environmental, social, cultural and political factors. This includes in countries where lesbian, gay and bisexuality is highly stigmatised, the health outcomes of LGB people are significantly impaired compared to countries where there is less stigma and LGB people have equal rights and protection against discrimination. Similar outcomes are observed where gender variance of trans people are socially sanctioned, compared to countries where there is greater acceptance of gender plurality (Meads, Carmona, & Kelly, 2012). The causes of health inequalities for LGBTI people which have been documented in research reviewed as part of the SR (Appendix A) and grey literature collated via the CSR (Appendix B) include: heteronormativity; heterosexism; minority stress; victimisation; institutional discrimination and stigma.

Each of these are presented briefly in the sub-sections that follow.

3.2.1 Heteronormativity ⁹

Root Cause - <u>Heteronormativity</u>	
<p>Meaning: A set of beliefs and practices that gender is an absolute and unquestionable binary, therefore describing and reinforcing heterosexuality as a norm. It implies that people's gender and sex characteristics are by nature and should always be aligned, and therefore heterosexuality is the only conceivable sexuality and the only way of being 'normal'.</p>	
Impact examples	Example document/source
<p>Being heterosexual and cisgender is often assumed and accepted as the status quo.</p> <p>Actions of health professionals may be (un)intentionally disrespectful and insensitive towards LGB people.</p> <p>Health professionals may not acknowledge the sexual orientation and partners of LGB people.</p> <p>Individuals are less likely to be open and disclose their sexual orientation to health professionals where heterosexuality is assumed.</p> <p><i>Example from rapid-reviews:</i></p> <p><i>"After experiencing the first symptoms of an illness, I feel huge emotional stress, because I know that after turning to a healthcare facility either I will have to come 'out' as lesbian and shock my doctor or I will have to conceal this fact and to face many misguided questions. As long as I have the choice, I will stay at home and will try to treat myself independently. The healthcare sector is alien, unsafe and not understanding my needs."</i> (Lesbian woman, Lithuania)</p> <p><i>Example from rapid-reviews:</i></p> <p><i>"I went to a terrible specialist, to who I am not going any more. When the guy examined me down there, he totally demolished me... I was bleeding... I realised that [to have sex with a man I will have to undergo] 500 surgeries... no way... And by the way, I sleep with girls, so I do not need it."</i> (Young intersex woman, Croatia)</p>	<p>(Marques, Nogueira, & De Oliveira, 2015)</p> <p>(Fish & Williamson, 2016; Sharek <i>et al.</i>, 2015) (Utamsingh, Richman, Martin, Lattanner, & Chaikind, 2016)</p> <p>(Rose, Ussher, & Perz, 2016)</p> <p>(Source: Brochure – LGL 2010 Ten things about LBT women's health. The National LGBT* Rights Association)</p> <p>(Source: Jagušt, M. 2015 Discourse analysis on intersex identity, politics and the body. Masters thesis. Faculty of Political Sciences)</p>

⁹ For intersex people heteronormativity is relevant because it refers to the normalisation of only two sexes from birth and can be seen for example, where surgical intervention on intersex infants aim to align the body to female sex markers to offer the possibility of penetrative intercourse in adult women. See Bauer & Truffer (2017).

3.2.2 Heterosexism

Root Cause - <u>Heterosexism</u>	
<p>Meaning: A set of discriminatory attitudes, bias and behaviours relying on gender as a binary to favour heterosexuality and heterosexual relationships.</p>	
Impact examples	Example document/source
<p>LGB people experience high rates of rejection by families, friends and peers resulting in social exclusion and stress</p> <p>LGB people may experience overt disapproval when accessing care linked to heterosexist attitudes of health professionals</p> <p>LGB people may experience an internalised sense of guilt or shame leading to mental health problems</p> <p><i>Example from rapid-reviews:</i></p> <p><i>"I went to my doctor with a stress-related illness and mentioned that 'coming out' to my family had been a recent source of stress. He responded by telling me that his sister had recently 'come out', told me that he was still revolted by it, and said that his family were operating a 'don't ask don't tell' policy. He didn't seem to have any awareness that this might have an impact on my reaction to him!" (Bisexual woman, UK)</i></p>	<p>(Katz-Wise & Hyde, 2012)</p> <p>(Van Beusekom, Bos, Kuyper, Overbeek, & Sandfort, 2016; King, Semleyn, Tai, Killaspy, Osborn <i>et al.</i>, 2008)</p> <p>(Source: Report – TLGF 2014 Beyond babies & breast cancer: Expanding our understanding of women's health needs. The Lesbian and Gay Foundation)</p>

3.2.3 Victimization

Root Cause - <u>Victimization</u>	
<p>Meaning: Victimization takes place where one person treats another less favourably based on a range of factors such as gender identity, sexual orientation, sex characteristics, sex, disability etc.</p>	
Impact examples	Example document/source
<p>LGB people may often experience victimisation including verbal harassment discrimination and some physical assault.</p> <p><i>Example from rapid-reviews:</i></p> <p><i>"I was abused by a gynaecologist. I was so shocked and hurt that I didn't report him. But it was clear that the nasty man conducted a brutal exploration when he learnt that I was a lesbian woman. When I told some lesbian friends they called me a fool for telling him about me being lesbian." (Lesbian woman, Spain)</i></p> <p>Young people with non-binary gender identities and/or trans youth show significantly higher rates of victimisation.</p> <p>Health professionals can help LGB youth learn how to avoid and cope with victimisation by peers. Social mentoring and support from parents and other elders can act as a protective factor.</p>	<p>(Katz-Wise & Hyde, 2012)</p> <p>(Source: Report - López <i>et al.</i>, 2013 Sexual orientation and/or gender identity-based discrimination in Spain. FELGBT)</p> <p>(Haas, Eliason, Mays, Mathy, Cochran, & D'Augelli, 2010)</p> <p>(Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014)</p>

3.2.4 Minority stress

Root Cause – <u>Minority Stress</u>	
<p>Meaning: Stigma, prejudice and discrimination create a hostile environment where people are subject to stressful social exchange.</p>	
Impact examples	Example document/source
<p>LGB and other young people may experience victimisation, but for young LGB people victimisation is often a direct consequence of their minority status linked to their sexual orientation, gender identity or sex characteristics.</p> <p><i>Example from rapid-reviews:</i></p> <p><i>“I felt that my doctor needed to constantly inform me that I am a sick person – she called me a toy of nature, a deviation. She told me that people like me used to be shown in circus freak shows. It was a constant part of the visit that she reminded me where I belong, in relation to her and society.” (Trans person, aged 30, Slovakia)</i></p> <p>LGB young people who experience resistance from others (including health professionals) when they ‘come-out’, show higher rates of substance use. Minority stress of young LGB people can lead to higher rates of substance use.</p>	<p>(Bourne, Davey, Hickson, Reid, & Weatherburn, 2016; Elliott, Kanouse, Burkhart, Gary, Lyrtzopoulos <i>et al.</i>, 2015; Goldbach <i>et al.</i>, 2014; Semleyn, King, Varney, & Hagger-Johnson, 2016)</p> <p>(Source: Guidebook - Transfúzia 2015 The standards of trans-inclusive environment in the healthcare system. Transfúzia)</p> <p>(Goldbach <i>et al.</i>, 2014)</p>

3.2.5 Institutional discrimination

Root Cause – <u>Institutional Discrimination</u>	
<p>Meaning: Institutional discrimination occurs where laws and policies in the public domain sustain inequalities, e.g. the prohibition of same-sex marriage, or where laws do not protect against discrimination based on sexual orientation, gender identity and sex characteristics.</p>	
Impact examples	Example document/source
<p>LGB people who are not protected against discrimination show higher rates of mental health problems.</p> <p>The incidence of mental health problems for LGBT people who live in areas where there are no protective policies, are considerably higher compared to the general population.</p> <p>In areas where same-sex marriage is banned, the prevalence of mental health problems (anxiety, mood disorders and substance misuse) in LGBT people increase over time.</p> <p><i>Example from rapid-reviews:</i></p> <p><i>“A trans woman went to the pharmacy with a valid receipt. The pharmacist did not fill the prescription and said: ‘You won’t get female hormones, I can see that you are a man’.” (Trans woman, Austria)</i></p>	<p>(Meads <i>et al.</i>, 2012)</p> <p>(Haas <i>et al.</i>, 2010)</p> <p>(Haas <i>et al.</i>, 2010)</p> <p>(Source: Magazine Article – Kunert, C. 2014 What’s the point of that masquerade? WLP News, Zeitschrift des Wiener Landesverbandes für Psychotherapie)</p>

3.2.6 Stigma

Root Cause - <u>Stigma</u>	
<p>Meaning: Stigma is a perceived negative attribute that causes someone to devalue or think less of the whole person.</p>	
Impact examples	Example document/source
<p>Stigma can affect health-seeking behaviour. Where LGBT people have internalised stigma they also have lower self-esteem, which increases the likelihood of negative health-seeking behaviours.</p> <p>LGB people may anticipate stigmatising attitudes or beliefs from health professionals leading to evasion of treatment or the postponement of treatment.</p> <p><i>Example from rapid-reviews:</i></p> <p><i>"They made [asked] me various intimate questions, including on my biology and sexuality. I was so uncomfortable that I left as soon as possible. I was afraid for my well-being." (Trans man, 21 years old, Portugal)</i></p> <p>Gay, bisexual and trans people can be deterred from seeking HIV testing and treatment if they fear feared discrimination or encountering the stigmatising attitudes of health professionals.</p> <p><i>Example from rapid-reviews:</i></p> <p><i>"I once went for a stomach check-up and the GP asked me whether I had done an HIV test. He told me I should go to do it without even asking me whether I was promiscuous or not – I could have been a virgin." (Gay man, 51 – 60 year-old, Malta)</i></p> <p>Research found a correlation between stigma, health-seeking behaviour and self-reported health outcomes for LGBT people where a higher prevalence of stigma was linked to lower utilisation of health services such as vaccinations and screening that resulted in poorer health outcomes.</p>	<p>(Whitehead, Shaver, & Stephenson, 2016)</p> <p>(Wao, Aluoch, Owuor, Odoni, & Iznaga, 2016)</p> <p>(Source: Report/brochure - Pinto, <i>et al.</i>, 2015 Equality on health. Associação ILGA Portugal)</p> <p>(Whitehead <i>et al.</i>, 2016)</p> <p>(Source: Report – Xuereb, M. 2008 A survey on sexual orientation and gender identity discrimination against lesbian, gay, bisexual and transgender persons in Malta. MGRM)</p> <p>(Whitehead <i>et al.</i>, 2016)</p>

3.2.7 Summary

This Section has noted some of the root causes of why LGBT(I) people experience health inequalities. Primary research and grey literature indicate how such inequalities come about because of i) cultural and social norms that preference and prioritise heterosexuality and binary gender norms and bodies, ii) minority stress associated with discrimination and exclusion on the grounds of sexual orientation, gender identity and sex characteristics, iii) victimisation, iv) institutional discrimination as well as, v) stigma. Minority stress theory is presently the leading narrative that explains the health inequalities of LGBTI people (e.g. Bourne *et al.*, 2016). Stigma, prejudice, and discrimination create a hostile environment where LGBTI people are subject to stressful social exchange that may have adverse implications for health-seeking behaviour and health outcomes later in life.

3.3 What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

The primary research and grey literature overwhelmingly suggest that significant health inequalities exist for lesbian, gay, bisexual, trans and intersex people. For example, LGB people are more likely to report fair or poor physical health, with LGB people showing a higher risk of developing certain types of cancer at a younger age. In addition, research suggests that LGBTI people are at significantly higher risk of poor mental health compared to the general population with the incidence of suicidal ideation, substance misuse, anxiety and deliberate self-harm markedly raised. For instance, in a 2015 online Australian survey of 272 people with intersex variations, incidence of suicide attempts amongst intersex participants in the sample were 19% with as many as 60% having considered suicide compared to under 3% in the general Australian population (Jones, 2016).

Example of evidence of health inequalities from rapid-reviews:

Rapid-reviews from Member states were consistent with primary research findings. According to a number of rapid-reviews LGBT people have increased rates of depression, suicide and self-harm [x7 MS: Belgium, Hungary, Ireland, Poland Slovakia, Spain, Sweden] with those who are younger at greatest risk [x4 MS: Ireland, Poland, Spain and Slovakia].

Findings correspond between primary research studies in peer reviewed journals and rapid-reviews of Member states, underpinning a dominant narrative that significant inequalities exist when comparing the health and wellbeing of LGBTI groups to the general population.

The next few sub-sections provide a brief overview of some of the most pertinent health inequalities experienced by LGBTI people in relation to access to healthcare. It was not possible to consider each L.G.B.T.I. grouping separately given research commonly collapse LGBTI people into a single group (e.g. lesbian and bisexual women; gay and bisexual men; trans and cisgender people) despite often collecting detailed data on sexual orientation and gender identity (few collect any data on intersex). Although aggregating data together in this way can be useful for research and analytical purposes, it does blur important issues which may be specific to each group and merit specific attention. Consequently, in the following sub-sections findings are presented as follows: lesbian and bisexual women; gay and bisexual men; trans people; and intersex people.

3.3.1 Lesbian and bisexual women

Examples of health inequalities	Lesbian women and bisexual women	Research example
General	<ul style="list-style-type: none"> □ Lesbian and bisexual women experience disproportionate health inequalities compared to the general female population. □ In a study of over 2 million people including 27,497 LGB people, Lesbian and bisexual women more commonly reported fair or poor general health in comparison to heterosexual women. 	(Elliott <i>et al.</i> , 2015; Fish & Bewley, 2010)
Cancer	<ul style="list-style-type: none"> □ Only half of lesbian and bisexual women in one sample attended cervical screening due to the perception that they did not need screening; placing them at a higher risk of developing cancer. □ Amongst bisexual women the reported cervical cancer rates were more than twice that of other women. □ There is no conclusive evidence of higher rates of breast cancer for lesbian and bisexual women. 	(Boehmer <i>et al.</i> , 2011a; Cochran & Mays, 2012; Meads <i>et al.</i> , 2012; Meads & Moore, 2013)
Cancer survivorship and support	<ul style="list-style-type: none"> □ Lesbian and bisexual women who accessed cancer care had more pronounced psychological and emotional care needs and reported poorer health after treatment. 	(Hill & Holborn, 2015)
Polycystic ovaries	<ul style="list-style-type: none"> □ In a study of 254 lesbians and 364 heterosexual women, a higher rate of polycystic ovaries (80% vs. 32%) as well as higher rates of polycystic ovary syndrome (38% vs. 14%) was found in lesbian women compared to heterosexual women. 	(see Meads <i>et al.</i> , 2012)
Weight discrepancies	<ul style="list-style-type: none"> □ In a review of studies on weight discrepancies, lesbian and bisexual women showed a substantially higher risk of raised weight compared to heterosexual women with an increased body mass index (BMI) or a higher ratio of BMI over 30. 	(Eliason, Ingraham, Fogel, McElroy, Lorvick <i>et al.</i> , 2015)
Mental distress	<ul style="list-style-type: none"> □ In a sample of 937 bisexual-identified and 4,769 lesbian-identified women, bisexual women reported poorer mental health and psychological distress than did lesbian women. Bisexual women were more likely to report an eating problem, more likely to have deliberately self-harmed in the past year, more likely to have felt sad/miserable or depressed in the last year, and more likely to have felt anxious or nervous in the last year, compared with lesbian women. 	(Colledge, Hickson, Reid, & Weatherburn, 2015; Semley <i>et al.</i> , 2016)
Psychological or emotional conditions	<ul style="list-style-type: none"> □ In a study of over 2 million people including 27,497 LGB people, 15% of bisexual men reported an enduring emotional or psychological condition and 18.8% bisexual women, compared to 12.3% lesbian women and 10.9% gay men. Figures were lower for heterosexual women where 6% reported an enduring psychological or emotional condition and 5.2% of heterosexual men. 	(Elliott <i>et al.</i> , 2015)
Suicide and deliberate self-harm	<ul style="list-style-type: none"> □ A meta-analysis showed that lesbian and bisexual women are 1.82 times at higher risk of suicide attempts compared to heterosexual women. In a sample of 6,178 lesbian and bisexual women, 5% had attempted suicide in the past year, and 20% had deliberately harmed themselves during the same period. 	(King <i>et al.</i> , 2008; Hunt & Fish, 2008; Meads <i>et al.</i> , 2012)
Substance use	<ul style="list-style-type: none"> □ In a sample of 937 bisexual-identified and 4,769 lesbian-identified women, lesbian and bisexual women were at three times higher risk of developing alcohol and drug dependence compared to women in general. □ Bisexual women showed an increased risk of substance dependence. □ Bisexual women are significantly more likely to report poor physical health and use of marijuana or tranquilisers than lesbian women. 	(Colledge <i>et al.</i> , 2015; King <i>et al.</i> , 2008; Meads <i>et al.</i> , 2012)
Smoking	<ul style="list-style-type: none"> □ Bisexual women are at high risk of smoking for weight control. 	(Meads <i>et al.</i> , 2012)

Examples of inequalities experienced by lesbian and bi women from rapid-reviews:

For lesbian and bisexual women, those who were younger and older were reported in the grey literature reviewed to experience a higher incidence of depression, suicide, and self-harm [x7 MS: Belgium, Hungary, Ireland, Poland, Slovakia, Spain and Sweden]. A survey in Belgium for example, showed lesbian and bisexual women aged 18-23 were particularly prone to suicidal thoughts and actions with 56.6% of girls who participated (n=400) thought at least once of ending their lives, whilst 14.4% attempted suicide at least once as this quote indicates.

"Hmm, oh well ... purely out of feeling bad and if I now look back I think it was very stupid of me, but back then, I felt so badly and wanted the feelings to go away and so I did something stupid and needed help. That was really ... at that time it was really because I was not happy with myself and the fact that I was different, so that was really it purely out of being lesbian." (Young lesbian, Belgium)

Source: Report - Schoonacker *et al.*, 2009 A study of mental and social well-being of lesbian and bisexual girls in Flanders. University of Brussels

Questions to consider

1. Uptake of cervical screening services for lesbian and bisexual women is low. How might practitioners increase uptake of screening services for these women to ensure early detection of cervical cancer?
2. Practitioners unintentionally and unknowingly assume women who access cancer support are heterosexual. How might psychological support services avoid heteronormativity and target lesbian women who access cancer treatment and care to promote their emotional wellbeing and social inclusion?
3. How might access to mental health services for lesbian and bisexual women be increased where substance misuse problems may have occurred?
4. How might LGBTI communities, service providers and health practitioners foster greater social inclusion of lesbian and bisexual women to promote their health and wellbeing?
5. How might preventative programmes and health promotion initiatives address the causes of inequalities such as discrimination and minority stress?

Learning points

- Research is needed to gain an understanding of the underlying reasons of higher rates of polycystic ovaries in lesbian women.
- More robust research is needed on cancer prevalence for lesbian and bisexual women with larger samples.
- Relatively little research has been done on the factors that protect the majority of lesbian and bisexual women from suicidal behaviour and how large sections of this population remain resilient in the face of adversity given that they experience minority stress, discrimination and marginalisation.
- Research indicates that bisexual people experience a high rate of health inequalities compared to heterosexual, lesbian and gay counterparts due to their minority status. Bisexual people may experience minority stress linked to biphobia in both heterosexual, gay and lesbian communities. Biphobia may lead to social isolation of bisexual people. There is much scope for initiatives to reduce biphobia and improve social inclusion of bisexual people.

3.3.2 Gay and bisexual men

Examples of health inequalities	Gay and bisexual men	Research example
General	<ul style="list-style-type: none"> □ Gay and bisexual men experience disproportionate health inequalities compared to the general male population. In a study of over 2 million people including 27,497 LGB people, gay and bisexual men more commonly reported fair or poor general health in comparison to heterosexual men. 	(Bourne <i>et al.</i> , 2016; Blondeel <i>et al.</i> , 2016; Boehmer, Miao, Maxwell, & Ozonoff, 2014; Elliott <i>et al.</i> , 2015)
Long term conditions	<ul style="list-style-type: none"> □ 10.2% of gay men (n=1632/16002) had long-term conditions or a disability that restricted their activities of daily living and ability to work. Most prevalent health problems in the total sample (n=16,002) included musculoskeletal problems (arthritis, spinal problems, nerve damage, chronic fatigue syndrome) in 3.4% of gay male participants. □ In a further study, up to 5% of gay and bisexual men (n=1,754) had long-term gastrointestinal problems, cancers, liver and kidney problems. 	(see Meads <i>et al.</i> , 2012)
Cancer	<ul style="list-style-type: none"> □ Gay and bisexual men are twice as likely to report a diagnosis of anal cancer, with those who are HIV-positive at highest risk. □ Gay men with prostate cancer may experience significant body changes such as surgical scars, loss of sexual function and weight gain leading to negative body image for some. 	(Blondeel <i>et al.</i> , 2016; Boehmer <i>et al.</i> , 2011b). (Hill & Holborn, 2015)
Physical activity	<ul style="list-style-type: none"> □ Compared to all UK adult males, 62% of gay and bisexual men (n=3547/5761) did not meet recommended levels of physical activity. 	(Bourne <i>et al.</i> , 2016)
Weight discrepancies	<ul style="list-style-type: none"> □ 44% of gay and bisexual men in the sample were overweight (n=2498/5694). The ratio increased sequentially with age where gay men over the age of 45 years were more than twice likely to be overweight, compared to those under 25 years. Gay and bisexual men with an upward level of education, showed lower rates of being overweight. 	(Bourne <i>et al.</i> , 2016)
Eating disorders	<ul style="list-style-type: none"> □ Meads <i>et al.</i>, (2012) found that the rate of eating disorders in gay and bisexual men was approximately 7% extrapolating that in the English context, this could mean that there are 875,000 gay and bisexual men with an eating disorder 	(Meads <i>et al.</i> , 2012)
Depression and anxiety	<ul style="list-style-type: none"> □ Gay and bisexual men experience worse mental health compared to heterosexual men. 21.3% (n=1155/5416) of the gay and bisexual men in the sample were depressed. Rates of depression were higher for those who are a member of a visible ethnic minority group and bisexual people. 17.1% (n=949/5556) of gay and bisexual men reported being anxious. 	(Gonzales, Przedworski & Henning-Smith, 2016; Hickson <i>et al.</i> , 2016; See also Meads <i>et al.</i> , 2012)
Suicidality	<ul style="list-style-type: none"> □ Gay and bisexual men are at two-fold higher risk of suicide attempts in the preceding year, and four times higher risk of suicide attempts over a lifetime compared to men in general. 	(King <i>et al.</i> , 2008)
Suicidal risk	<ul style="list-style-type: none"> □ Amongst LGB people, gay and bisexual men are at highest risk of attempted suicide particularly for those who are younger, those with lower educational attainment and lower income. 	(Hickson <i>et al.</i> , 2016)
Completed suicide	<ul style="list-style-type: none"> □ Research found disproportionately higher rates of completed suicide for gay and bisexual men compared to the general population. 	(Haas <i>et al.</i> , 2010)

Alcohol	<ul style="list-style-type: none"> □ Research found gay men were significantly more likely than heterosexual men to report heavy drinking. 43% of a sample of gay and bisexual men in England (n=2505/5770) drank alcohol on four days per week or more during the previous week. Of those men, alcohol consumption was highest for those over the age of 45 and lowest for men aged 16 to 35. 	(Bourne <i>et al.</i> , 2016; Gonzales <i>et al.</i> , 2016)
Smoking	<ul style="list-style-type: none"> □ 25% of gay and bisexual men who participated in one study smoked tobacco (n=1469/5755). Smoking decreased with age and the incidence of smoking was lowest for men aged 45 and over. 	(Bourne <i>et al.</i> , 2016)
Illicit drug use	<ul style="list-style-type: none"> □ 19% of gay and bisexual men had used illicit drugs during the past month (n=1103/5755). Illicit drug use was highest in gay and bisexual men aged 25 to 45, and lower in those aged 45 and beyond. 	(Bourne <i>et al.</i> , 2016; see also King <i>et al.</i> , 2008)
Drug dependence	<ul style="list-style-type: none"> □ Gay and bisexual men are at 2.4 times higher risk of developing drug dependence compared to their counterparts. 	(King <i>et al.</i> , 2008)

Questions to consider

1. Given that gay men are considered at high risk of anal cancer with gay men who are HIV-positive at the highest risk, how might practitioners promote screening programmes to ensure early detection of these forms of cancer?
2. Research shows gay and bisexual men experience worse mental health compared to heterosexual men. How might practitioners address this in their practice?

Learning points

- There is a greater need for substance misuse services and mental health services to address the needs of gay and bisexual men.
- Health inequalities could be considered in the context of protective factors that facilitate wellbeing rather than focussing only on factors that cause illness. Relatively little research has been done on the factors that protect the majority of gay and bisexual men from suicidal behaviour and how large sections of this population remain resilient in the face of adversity given that they experience minority stress, discrimination and marginalisation.

Lesbian, gay, bisexual access to healthcare

Access to healthcare	Research example
<p>Research findings suggest that LGB people are 1.5 times more likely to report unfavourable experiences of primary care provision compared to the general population. Gay men vs heterosexual men reported the following concerns: no confidence in doctor (5.6% gay vs 3.6% heterosexual men), very poor doctor communication (13.5% gay vs 9% heterosexual men), very poor nurse communication (7% gay vs 4.2% heterosexual men), and (5.9% gay vs 3.8% heterosexual men) dissatisfaction with overall care. Results show that gay men were in general less satisfied with care experiences compared to heterosexual men.</p>	<p>(Elliott <i>et al.</i>, 2015)</p>

Example of poor access LGB to healthcare from rapid-reviews:

In the Polish rapid-review, the experiences of a 21-year-old gay man were reported. He had been subjected to unprofessional behaviour by a doctor who made derogatory comments regarding pain relief:

"...[The Doctor] as a joke described the medical procedure as painless, unless the patient is homosexual, because such people are not anaesthetised." (Gay man, 21 year-old, Poland)

(Source: Report - Trociuk *et al.*, 2014 The principle of equal treatment - law and practice 14. Equal treatment of LGB patients in healthcare. Analysis and recommendations. Ombudsman Office)

Example of LGB dissatisfaction with healthcare from rapid-reviews:

Dissatisfaction with healthcare was reported around accessing assisted reproductive technology that were available to couples who experienced problems conceiving. Rapid-reviews in some MS highlighted how lesbian couples or those in same-sex partnerships (or single individuals) were denied access or struggled to gain access to reproductive medical interventions [x7 MS: Czech Republic, Hungary, Malta, Slovakia, Slovenia, Spain, UK]. As an example, Spain's rapid-review reported the following:

"We are a lesbian couple. [Name of a mutuality for public servants] denied us the access to assisted reproduction when we were, in fact, included in the legal event of being a sterile couple. We tried all administrative ways, just to receive a number of administrative resolutions, each one more insulting than the previous ones". (Lesbian woman, Spain)

(Source: Report - López *et al.*, 2013 Sexual orientation and/or gender identity-based discrimination in Spain. FELGBT)

For two MS (Spain, UK), the reviews highlighted that even when LGB people were legally entitled to assisted reproductive technology, they were sometimes prevented from accessing treatment by gatekeepers like health professionals, doctors or public/civil servants who found reasons not to refer them on to specialist services.

Access to healthcare – Mental health services	Research example
<p>Bisexual and lesbian women were more likely to seek support and treatment for mental health problems compared to other groups. This increased service use may reflect an increased need. As lesbian and bisexual women showed an increased uptake of mental health services and talking therapies, their mental health needs are acknowledged and should be accommodated via dedicated services.</p>	<p>(Chakraborty, McManus, Brugha, Bebbington, & King, 2011)</p>

Access to healthcare – Cancer care	Research example
<p>Lesbian, gay and bisexual people have different cancer care needs compared to the general population.</p> <p>Some LGB people experienced discriminatory attitudes from health professionals. For example, lesbian women who were recovering from breast or gynaecological cancer were not offered reconstructive surgery due to the belief that lesbian women would be less likely to access this form of treatment. Here some health professionals asked participants to discuss reconstructive surgery with their 'husbands' not taking into account those whom may be in same-sex partnerships or without a partner. Discrimination in access to and treatment of LGB cancer care contributed towards the anxiety and depression of cancer survivors.</p> <p>Gay and bisexual men recovering from prostate cancer identified a number of deficits linked to communication with health providers where technocratic medical conversations filled with medical 'jargon' about diagnoses, treatment options and care pathways outweighed attention to their psychological support needs.</p> <p>Disclosure of their sexual orientation was often perceived as problematic due to experiences of rejection or a perceived absence of interest and knowledge from many health professionals. Understanding of the impact of prostate cancer on sexuality and body image was limited amongst health providers.</p>	<p>(Hill & Holborn, 2015)</p> <p>(Rose <i>et al.</i>, 2016)</p> <p>(Rose <i>et al.</i>, 2016)</p>

Learning Points
<ul style="list-style-type: none"> <li data-bbox="261 1465 1443 1556">□ Disclosure of sexual orientation <i>can sometimes</i> benefit both LGB people and health professionals to ensure people can come to terms of the impact of cancer and health professionals can avoid heterosexual assumptions that directly influence treatment and limits knowledge of key risks. <li data-bbox="261 1583 1443 1673">□ LGB support groups may be useful for people who feel isolated after diagnosis of cancer, where people can speak about their experiences and gain support from other LGB people in similar circumstances to promote their emotional and psychological wellbeing.

3.3.3 Trans people

Examples of health inequalities	Trans people	Research example
General	<ul style="list-style-type: none"> □ Across low-income, middle-income and high-income settings globally, trans people experience significant health inequalities. □ The general health of trans people including outcomes such as mortality, diabetes, hormone use, metabolic syndrome and cancer is the least researched component of the global burden of disease for trans people. 	(Reisner, Poteat, Keatley, Cabral, Mothopeng <i>et al.</i> , 2016)
HIV and other STIs	<ul style="list-style-type: none"> □ Higher rates of HIV and other STIs, mental distress, substance use and abuse (violence and victimisation) exist amongst trans people compared to non-trans people. 	(Reisner <i>et al.</i> , 2016)
Mental distress	<ul style="list-style-type: none"> □ Research undertaken globally indicates considerably higher rates of mental distress amongst trans people compared to non-trans people. 	(Reisner <i>et al.</i> , 2016)
Depression	<ul style="list-style-type: none"> □ Research with 351 trans people (n=226 trans women and n=125 trans men) found that rates of depressive symptoms (51.4% for trans women; 48.3% for trans men) and anxiety (40.4% for trans women; 47.5% for trans men) were significantly higher than those for the general population. □ Data consistently show that a high proportion of trans adults experience depression with estimates of depression prevalence as high as 64% in a sample of 573 trans women. 	(Budge, Adelson, & Howard, 2013; Bauer <i>et al.</i> , 2014; Nemoto, Bödeker, Iwamoto, & Sakata, 2014; Reisner <i>et al.</i> , 2016)
Attempted suicide	<ul style="list-style-type: none"> □ Studies in Europe, the U.S. and Canada indicate significantly increased levels of suicidal ideation and suicide attempts in trans populations with 22-43 % of trans people reporting a history of suicide attempts. □ In a research article presenting selected findings from the Trans Mental Health Study which represents the largest survey of the UK trans population to date exploring trans mental health and well-being of 889 trans people. The findings revealed an 84% lifetime prevalence of suicidal ideation. Up to 63% of trans people had thought about suicide in the last year, 27% had thought about it in the last week, whereas 4% thought about suicide on a daily basis. Of those who had thought about suicide, 48% had made a suicide attempt. □ Key risk factors identified in suicidal ideation and suicide attempts of trans people included 'gender dysphoria'; confusion/denial about gender; fears around transitioning; gender reassignment treatment delays and refusals; and social stigma. Some experienced confusion about their gender and did not know how to express this confusion or access the help needed to make sense of their emotional discomfort. Fear regarding the disruption and consequences of transitioning was another key risk factor for suicidal ideation and suicide attempts due to potential effects of gender reassignment treatments and the upheaval related to transitioning. Other risk factors associated with those who reported having a past suicide attempt included being assigned female sex at birth, experience of psychiatric hospitalisations, and having experienced trans-related violence. 	(Bauer, Scheim, Deutsch, & Massarella, 2014; Bauer, Scheim, Pyne, Travers, & Hammond, 2015; Bailey, Ellis, & McNeil, 2014; Maguen & Shipherd, 2010; Haas <i>et al.</i> , 2010; Reisner <i>et al.</i> , 2016)
Substance (mis)use	<ul style="list-style-type: none"> □ Data reporting on alcohol, illicit drug use, and tobacco use amongst trans people globally are inconsistent and heterogeneous, making comparison across a range of studies challenging. Although substance (mis)use is often described in the literature as a way of making minority stress manageable (a coping mechanism), further research is needed to gain a better understanding of the function of substances amongst trans people. 	(Reisner <i>et al.</i> , 2016)

Example of trans health inequalities from rapid-reviews:

Primary research findings are consistent with information gained via the rapid-reviews of Member states. For trans people increased rates of depression and suicide attempts were widely reported across MS [x8 MS: Belgium, Hungary, Ireland, Lithuania, Poland, Poland, Spain, Sweden].

Impact of transitioning on mental health

Comprehensive, large-scale research with trans people to explore the impact of transitioning is sparse and more research is required. However, notable exceptions include Budge *et al.*, (2013) and Bailey *et al.*, (2014) reported below.

Budge *et al.*, (2013) in a study involving 351 trans people aimed to determine the relationship of transition status, perceptions of loss, social support, and coping on the mental health outcomes of depression and anxiety for trans people. The authors argue that individuals in early stages of transitioning seem to use more avoidant coping, and consequently experience more distress. Budge *et al.*, (2013) conclude that individuals who are in the early stages of transitioning may use different coping strategies than those who are in the latter stages proposing as a consequence, that mental health interventions need to be aware of transition status.

A key finding from the Trans Mental Health Study reported by Bailey and colleagues (2014), was that transition was shown to greatly reduce rates of suicidal ideation and suicide attempt. Amongst the sample of n=889 trans participants, 67% of respondents reported thinking about suicide more before they transitioned with 3% reporting thinking about suicide post-transition. Their findings demonstrated the importance of timely access to gender reassignment treatment for those who required it. Transition had a positive impact on mental health and well-being. For instance, three quarters of participants reported that hormone therapy had led to changes in their emotional wellbeing or mental health. Participants described feeling more comfortable and confident in themselves since starting hormone treatment. They reported feeling more balanced and experienced more positive and less negative emotions on the whole. Though some participants reported greater 'mood swings', memory problems and reduced ability to concentrate after commencing hormone treatment. Of these participants, 85% were more satisfied with their body image after hormone therapy, and only 2% were less satisfied (Bailey *et al.*, 2014). Bailey *et al.*, (2014) propose that the processes of gender reassignment and social transition can serve to reduce rates of suicidal ideation and suicide attempt.

In terms of surgery, for those who accessed it, surgical intervention had a significant impact with 88% of trans respondents being more satisfied with their lives after having non-genital surgery (n=182) and 83% after genital surgery (n=131). 74% of trans respondents reported that their mental health had improved as a result of transitioning (Bailey *et al.*, 2014). Bailey *et al.*, (2014) propose that processes of gender reassignment and social transition serve to reduce considerably rates of suicidal ideation and suicide attempt.

Trans access to healthcare

Research reported that trans people who had used health services frequently experienced negative interactions with health professionals at gender identity clinics, mental health services and general health services. More specifically, whilst considering the experience of accessing healthcare of the trans people that attended gender identity clinics, long waiting times to access treatment was shown to impact negatively on their emotional wellbeing and mental health (Bauer *et al.*, 2014).

Example of trans access to healthcare from rapid-reviews:

Negative interactions with health professionals were reported in some MS rapid-reviews [x4 MS: Czech Republic, Finland, Hungary, Slovakia] showing that either a legal limitation existed or a social norm was evident which results in trans people being sterilised. For example, the Slovakian review reported on grey literature suggesting that trans people who wish to gain legal gender recognition have to undergo surgery including removal of their reproductive organs, which of course means losing the ability to procreate and have children:

"My doctor told me in a very insensitive way that hysterectomy is a necessity defined within the law. When I asked her what law, she talked it down. Then she asked me if I can imagine a man having a child. She said it is not normal and people 'like that' should not be able to procreate." (Slovakia)

(Source: Guidebook - Transfúzia 2014 The standards of trans-inclusive environment in the healthcare system. Transfúzia)

Research shows that trans people perceive health practitioners to be poorly informed about trans issues and experiences. Trans-awareness training to educate practitioners to challenge prejudice in practice settings is required (Ellis *et al.*, 2015). In a Canadian study with trans people who accessed residential treatment for substance use (n=34), the authors found that most trans participants experienced enacted stigma (real instances of discrimination) in the form of social rejection and transphobia. Those who experienced these effects were more likely to leave treatment prematurely due to feeling isolated. In contrast, those who experienced trans friendly and inclusive treatment recounted more constructive care pathways and positive treatment outcomes (Lyons T., Shannon, Pierre, Small, Krüsi *et al.*, 2015). Trans friendly and inclusive treatment programmes are needed to support trans people to deal with social stressors, such as discrimination and marginalisation often associated with the transphobia of others.

Questions to consider

1. Due to social factors such as minority stress, discrimination and experiences of violence trans people are significantly more likely to attempt suicide or experience suicidal thoughts. How might practitioners ensure that gender reassignment treatment and care occur in a respectful and socially inclusive manner?
2. How might mental health services and gender identity clinics become spaces without transphobia, where trans people feel able to discuss gender related health issues, and where they are treated sensitively and with respect?

Learning points

- 'Gender dysphoria' is a contested term used to describe where trans people experience distress and disassociation due to the incongruence felt between their gender identity and their assigned sex at birth.
- Factors that protect against suicidal ideation or reduced suicidal thoughts in trans people are: increased social support from professionals, family and friends; parental support for their gender identity; reduced transphobia, and having personal identification documents changed to reflect the appropriate gender marker.
- Research findings have identified a gap in high quality international research to address the cancer burden and related care needs of trans people.
- There is very limited large-scale epidemiological data on the burden of disease for trans people. Further research is needed to gain an understanding of the general health profile of trans people.
- Further large-scale research is needed to explore the impact of transitioning
- Substance (mis)use is often described in research as a way of making minority stress manageable. However further research is needed to gain a better understanding of the function substances serve for trans people.
- In health settings, trans people feel they have to educate health professionals as service providers do not have sufficient knowledge to address trans related health needs. Research supports the requirement for training to increase knowledge of trans specific health needs and increased competence to address these needs.

3.3.4 Intersex people

There is a dearth of research on intersex health inequalities and healthcare experiences. Studies undertaken can fail to account for intersex people themselves, focusing instead on biomedical conditions. Much of the research on intersex health relates to surgical intervention that is focused on assigning (often forcefully and without consent) one gender within the male/female dichotomy. A range of intersex variations are diagnosed bio medically which unnecessarily medicalise intersex people based on physical difference. These terms are sometimes incongruous with how intersex people self-identify. More research is needed to address the lacunae in the scientific and grey literatures regarding intersex health and experiences of healthcare.

Intersex Spectrum

Intersex relates to a range of physical traits or variation that lie between binary ideals of male and female. Intersex people are born with physical, hormonal or genetic features that are neither wholly female nor wholly male; or a combination of female and male; or neither female nor male. Many forms of intersex exist; it is a spectrum, rather than a single category.

Primary and/or secondary sex characteristics of intersex people may be ambiguous and do not fit clearly defined anatomical male or female features. The lives of intersex people are unnecessarily medicalised as seen in biomedical terms describing intersex variations as '*disorders of sex development*'. Terms such as these pathologise intersex people and their bodies, however because diagnoses are required to provide access to medical interventions, surgical technologies and hormonal procedures, these can be seen as necessary where some intersex people may want to access medical intervention.

Examples of health inequalities	Intersex people	Research example
Assigned sex	<ul style="list-style-type: none"> □ In an Australian online survey of 272 students with intersex variations, 52% of participants reported being assigned female sex at birth. Of these participants, the same proportion (52%) continued to use the same assignation at the time of the survey. Amongst participants, 41% were assigned male sex at birth, with 23% continuing to use the same male assignation at the time of the survey. Thus, not all intersex people continued to use the same sex that they were allocated at birth. Male/female binary categories for biological sex markers (and/or sex characteristics) may not be appropriate and intersex bodies can be 'trapped' in these limiting categories. 	(Jones, 2016)
Mental health	<ul style="list-style-type: none"> □ Primary research exploring the mental health needs of intersex people is limited and there is a need for large-scale research into the psychological and emotional wellbeing of intersex people. □ Younger intersex people in particular report experiencing isolation due to stigma, bullying, discrimination or rejection from family or peers. □ In Jones's (2016) survey (n=272), the incidence of suicide attempts amongst intersex people was 19% with 60% having considered suicide compared to 3% people in mainstream populations. Furthermore 26% had self-harmed. 	(Jones, 2016)
Specialist services	<ul style="list-style-type: none"> □ A study with German, Austrian and Swiss participants (n=110) found that 28% of intersex people experienced difficulties accessing specialist care. □ 11% of intersex participants reported being offered counselling or talking therapies to help them make sense of events in adulthood. 28% reported that they had been offered such services but that they had no need for them. However, the majority of participants had never been offered access to psychological support services and these people reported the lowest satisfaction with care. Thus, access to psychosocial support services may increase patients' satisfaction with healthcare. □ People with intersex characteristics can require access to medical staff specifically trained on intersex people's needs where they can access appropriate services and/or interventions to maintain and promote positive mental health and wellbeing. Research suggests that within these services, long-term follow up should include assessment of psychosexual, emotional and social wellbeing. 	(Thyen, Lux, Jürgensen, Hiort, & Köhler, 2014)

Outcomes of surgery

In a review of recent publications on outcome data of 'disorders of sex development' (DSD), Lee *et al.*, (2012) reports on a Finnish mailed questionnaire study (see Fagerholm *et al.*, 2013)¹⁰ which looked at the attitudes of intersex people following feminising surgery (genitoplasty). With a 53% response rate yielding 24 participants up to the age of 36 years, 17 of the 24 respondents reported satisfaction, and five participants reported being dissatisfied with genital function.

In a study from the U.S., Nokoff *et al.* assessed the outcome of cosmesis before and after genital surgery in a cohort of intersex children <2 years of age with no prior genitoplasty at

¹⁰ 2011 at the time of online publication and inclusion by Lee *et al.*, (2012). 2013 published in print.

the time of enrolment (Nokoff, Palmer, Mullins, Aston, Austin, *et al.*, in press). In doing so the authors aimed to 1) describe the frequency of sex assignment, and types of surgery performed; and 2) prospectively determine cosmesis ratings by parents and surgeons before and after genital surgery. Parents and surgeons all rated the appearance of the genitalia unfavourably before surgery, with surgeons giving worse ratings than parents. Cosmesis ratings improved significantly after surgery, with no between-group differences.

These findings are in stark contrast to a European study citing considerable dissatisfaction with treatment and surgical intervention (Köhler *et al.*, 2012). Here amongst 57 intersex people who had undergone genital surgery, as many as 47% were unhappy with the outcome of surgery, 44% experienced prolonged sexual anxiety, 70% had problems with sexual desire and 56% described symptoms of dyspareunia whilst 44% XY males feared sexual contact compared to 66% XY females (Köhler *et al.*, 2012; see also Jones, 2016). For those with complete androgen insensitivity (CAIS), 81% reported problems with desire and 70% experienced dyspareunia (Köhler *et al.*, 2012). As many as 62% of participants reported that they experienced sexual problems because of their intersex embodiment (Köhler, Kleinemeier, Lux, Hiort, Grüters, & Thyen, 2012).

It should be noted that these studies had small numbers and thus further research is needed to explore the impact of surgery longitudinally. The authors suggest that genital surgery should be minimised and performed mainly in adolescence or adulthood with the persons' (informed) consent.

Opinions on research intervention for intersex young people are divided. However, research suggests that the 'patient' must be able to give informed consent prior to any surgical intervention.

Ethical accountability for surgery with intersex young people and children	Research example
Assumptions that early 'normalising' surgery is always in the best interest of intersex individuals are important to challenge.	(Köhler <i>et al.</i> , 2012; Thyen <i>et al.</i> , 2014)
Research findings conclude that early feminising surgery should be avoided at birth, and gonadectomy should only take place where there is a risk of gonadal malignancies and in consultation with parents along with the full consent of the child or young person. In addition, surgical intervention should be reduced to a minimum, and should only take place with full informed consent in accordance to the patient's needs in puberty and/or adulthood.	(Köhler <i>et al.</i> , 2012)
Parents should be consulted and involved with their child in decision-making regarding care pathways. Poor communication between health professionals, the family and patient and secrecy or stigma related to intersex bodies adds to the psychological burden of these conditions.	(Thyen <i>et al.</i> , 2014)
Research recommends that young people's gender identity should be respected (including when it is non-binary) as they approach puberty and beyond.	(Köhler <i>et al.</i> , 2012)
Patient satisfaction amongst intersex people increased markedly for those who were offered access to psychological support services in adulthood to help them understand intersex bodies, interventions and related impacts.	(Thyen <i>et al.</i> , 2014)

Example on 'normalising' surgery from rapid-reviews:

Some rapid-reviews report on literature showing that intersex people are commonly subjected to 'normalising' surgery at a young age without informed consent [x4 MS: Austria, Croatia, Denmark, Germany].

"While intersex children may face several problems, in the 'developed world' the most pressing is the ongoing Intersex Genital Mutilation, which present a distinct and unique issue constituting significant human rights violations." (Austria)

(Source: NGO Report – VIMO 2015 Intersex genital mutilation. Human rights violations of persons with variations of sex anatomy. Verein Intersexueller Menschen Österreich (VIMÖ) & Zwischengeschlecht.org)

The rapid-review from Germany highlighted literature stating that surgery on intersex young people with ambiguous sex characteristics to align their body with male/female sex markers can be regarded as interference with the right to physical integrity that may limit the ability for some intersex people to procreate. Decisions that impact on physical integrity or sexual and gender identity of intersex people should be based on their right to self-determine and any intervention should occur in the context of informed consent.

Similarly, the Maltese rapid-review reported that it is unlawful in this MS for medical practitioners or other professionals to conduct any sex assignment treatment and/or surgical intervention on the sex characteristics of a minor where treatment and/or intervention can be deferred until the person can provide informed consent.

For Germany in case of intersex young people whom may not be able to provide informed consent, such measures should only be adopted after thorough consideration of the advantages, disadvantages and long-term consequences for the child. Interventions should only be undertaken based on thorough assessment of the medical, psychological and psychosocial impact of early intervention where the guiding principle is the welfare of the child. In the event of doubt, such operations should be postponed until the person concerned has gained competence to consent to an intervention. Medical diagnosis and treatment of intersex people should be provided by specialised interdisciplinary centres (decentralised where possible) and conducted by teams comprising medical practitioners and experts in all the relevant fields. Ongoing medical care should be accompanied by advice given by other affected individuals. All interventions should be comprehensively documented and remain accessible to those concerned for at least 40 years.

Questions to consider

1. Numerous intersex variations are diagnosed biomedically which unnecessarily medicalises intersex people based on physical difference. These diagnoses can be inconsistent with how intersex people self-identify. How might practitioners ensure intersex people can self-identify instead of imposing limiting biomedical categories or terminology on them?
2. 'Normalising' treatment to masculinise or feminise intersex people without informed consent is questioned by intersex activists and individuals. As some intersex people may require surgery or treatment other than surgery, how might practitioners' discuss treatment options with intersex people and their next-of-kin and ensure they have gained full informed consent prior to any action?
3. How can practitioners ensure that psychological support services and/or talking therapies are available to intersex people longer-term in order to help them make sense of their experiences?

Learning Points

- Male/female binary categories for sex characteristics are not helpful as intersex people can be ‘trapped’ in these limiting categories. Intersex people may benefit from a non-binary understanding of sex and gender that moves beyond male/female or masculine/feminine binaries.
- Primary research exploring the mental health needs of intersex people appears to be relatively limited and there is a need for large-scale research into the psychological and emotional wellbeing of intersex people, as well as the long-term impact of ‘normalising’ treatments for older intersex people.
- Specialist long-term follow up services for intersex people should include psychological support to address psychosexual, emotional and social wellbeing.

3.3.5 Summary

This Section has explored the issues pertaining to the health and healthcare for LGBTI people. LGB people report significantly worse physical health compared to the general population. Of LGB groups, the general health of bisexual people is poorer compared to lesbian and gay counterparts partly due to bi-phobia that exists in both heterosexual and lesbian and gay communities. Additionally, health inequalities are visible in the incidence of cancer as international research trends suggest that LGB people are at a higher risk of developing certain cancers like anal cancer in gay and bisexual men, with those who are HIV-positive at highest risk. In order to ensure early detection and treatment of cancer, research suggests anal screening programmes for gay and bisexual men and cervical screening for lesbian and bisexual women are needed. For those who survived cancer, access to psychological and emotional support services should be increased and geared around their specific needs that may differ from mainstream populations. Research identified a gap in high quality international research to address the cancer burden, general health profile and care needs of trans people and similarly there is a lack of research on health inequalities and healthcare for intersex people beyond surgical intervention.

LGBTI people are more likely to report an enduring psychological or emotional problems compared to the general population with raised incidence of suicide attempts, suicidal ideation, depression, and anxiety disorders. Mental distress appears most pronounced for young people under the age of 35, gay men living in rural areas, and those over the age of 55. Gay and bisexual men are at an increased risk of drug dependence, with illicit drug use most prevalent for those aged 25-45. Whilst accessing treatment and care, LGB people are more likely to report unfavourable experiences including concerns regarding communication with health professionals, and overall dissatisfaction with the treatment and care provided. Lesbian and bisexual people show a greater need for specialist mental health services and counselling support, as do trans people to help them overcome discrimination, marginalisation and minority stress that may or may not be linked to gender transitioning; or in some cases long periods of waiting for surgery. Like trans people, some intersex people may have experienced isolation due to stigma compounded by adversity where many have experienced ‘normalising’ surgery at a young age. For intersex people satisfaction with ‘treatment’ outcomes vary markedly ranging from satisfied with treatment outcomes after surgical intervention to significant dissatisfaction including (as examples) prolonged sexual anxiety, dyspareunia, and dissatisfaction with genital function. Research suggests that any treatment

of intersex people should occur in the context of open dialogue between practitioners, the intersex person and their family with full informed consent prior to any surgical intervention and increased access to psychological support services.

3.4 What is known about the health inequalities of LGBTI people focusing on vulnerable intersections as it relates to healthcare?

Intersectionality can be understood as the intersections between a range of dimensions associated with social and cultural difference that people experience, and this is consistent with contemporary European health and social care literature. Markers of difference such as gender, sexual orientation, gender identity, gender expression, sex characteristics, age, ethnicity, race, disability and social class (as well as others) can be used to differentiate and hierarchise people. These markers are interdependent and intersect to create and sustain health inequalities, for example trans people from a minority ethnic background may have high rates of depression due to (amongst other things) the intersections of their gender identity and ethnicity. This section explores some of the intersections of LGBT(I) identities within specific populations and settings. In doing so it pays attention to rural or geographically remote areas; older and younger LGBTI people; refugee, asylum seekers, and migrant LGBTI people; those who live in poverty or are socio-economically disadvantaged, and disabled LGBTI people. For ease of reading, the text that follows explores each of these in turn, but each section is brief because there is a dearth of research that accounts for the health inequalities of intersectional subjectivities.

3.4.1 People in rural areas

People in rural areas
<ul style="list-style-type: none"> □ LGBT people who live in rural areas can experience high rates of depression, smoking and binge drinking (Whitehead <i>et al.</i>, 2016). □ In terms of depression, in rural areas trans people report significantly higher rates of depression (65%) compared to cisgender men (41%) and cisgender women (54%; Whitehead <i>et al.</i>, 2016). Trans and non-binary people report higher levels of internalised, enacted and anticipated stigma. Stigma may decrease health-seeking behaviour amongst trans and non-binary people due to fear of future discrimination for those who lived in rural areas (Whitehead <i>et al.</i>, 2016). □ Compared to those who lived in urban areas, gay men aged 18–39 experience higher rates of psychological distress, lower self-esteem and lower life satisfaction due to greater acceptance from others, less emotional support and a reduced sense of belonging (Lyons A., Hosking, & Rozbroj, 2015). □ Living in rural areas may be a source of ‘risk’ for some LGBT people, and living in an urban area can act as a protective factor against mental health problems for some gay and bisexual men. (Bourne <i>et al.</i>, 2016; Hickson <i>et al.</i>, 2016; Lyons A. <i>et al.</i>, 2015; Whitehead <i>et al.</i>, 2016).

3.4.2 Refugees and asylum seekers

Migrants, refugees and asylum seekers
<ul style="list-style-type: none"> □ LGBT asylum seekers and refugees may have experienced abuse by parents, caregivers or peers and a low level of connectedness to these prior to seeking asylum or refuge. Experiences of abuse correlated to negative mental health outcomes (Alessi, Kahn, & Chatterji, 2016). □ In one study, LGBT asylum seekers and refugees who disclosed their sexual orientation, gender identity or who engaged in same-sex activity, faced significant consequences in their countries of origin including public shaming, withdrawal of emotional and social support, and pressure to seek a 'cure' from talking therapists or so-called religious leaders (Alessi <i>et al.</i>, 2016). □ LGBT people who are migrants/asylum seekers can be blamed for their gender non-conformity leading to social exclusion. In evangelical Christian communities, some LGBT people were led to believe that they were sick or demonically possessed (Alessi <i>et al.</i>, 2016).

Example from rapid-reviews: Migrants, refugees and asylum seekers

Rapid-reviews from Belgium, Finland, Luxembourg, and the UK drew attention to grey literature that highlighted how some LGBT asylum seekers and refugees experience disproportionate trans/bi and homophobia combined with overt racism [x4 MS: Belgium, Finland, Luxembourg, UK]. Moreover, additional reviews also highlighted how LGBT people are fearful of 'coming-out' or acknowledging their sexual orientation or gender identity [x3 MS: Croatia, Finland, France]. Fear of 'coming-out' placed individuals in difficult positions as a result of expectations to provide supporting evidence of their LGBT identity to qualify for asylum in Europe. In many instances, this evidence is non-existent and the cycle of marginalisation may be perpetuated in the countries where they seek refuge.

3.4.3 People with disabilities

People with disabilities
<ul style="list-style-type: none"> □ Population-based data from the U.S. (n=82,531) reveal that LGB adults show a high prevalence of disability with 36% of lesbian and 36% of bisexual women having disabilities due to chronic health conditions or poor physical or mental health, compared to 25% of heterosexual women (Fredriksen-Goldsen <i>et al.</i>, 2012b). □ LGB people with disabilities were often significantly younger compared to heterosexual adults with disabilities. The authors suggest that inequalities in chronic health conditions (e.g. lifetime asthma arthritis, obesity), health risk behaviours, and poor physical and mental health amongst LGB adults may contribute to the heightened prevalence of disability (Fredriksen-Goldsen <i>et al.</i>, 2012b).

Example from rapid-reviews: People with disabilities

Data from four rapid-reviews suggest that some disabled LGBT people are particularly marginalised at the intersections of disability, their gender identity and/or sexual orientation [x4 MS: Austria, Belgium, Germany, Poland]. The Belgian rapid-review drew attention to grey literature highlighting how LGBT people with disabilities may face two minority positions as they are more dependent on others regarding care due to chronic illness, and also have less privacy in exploring and developing sexual and gendered identities. Due to double marginalisation, LGBT people with disabilities may have a greater need to access health services for physical and psychological support (Germany) and to help them gain an understanding of their gender and/or sexual identities (Austria). A review from Austria highlighted how psychological support services for disabled people often did not emphasise inclusion of LGBTI people.

"NGOs focus on disability OR homosexuality and when we wanted to launch a support group for disabled LGBTIs and asked [name] for support they answered "we don't need that". (Austria)

(Source: Report – Qwien 2011 Final report "Disability is queer culture". Zentrum für schwul/lesbische Kultur und Geschichte)

The Austrian rapid-review indicated that professionals may be unaware of the need for inclusion of disabled LGBT people, which reduces the prevalence of much needed treatment and therapy.

3.4.4 People in socio-economic poverty

People in socio-economic poverty

- Little research in this review was found to focus on socio-economic issues for LGBTI people although some studies do include elements of socio-economic difference. More research is needed.
- In a systematic review of the literature examining risk factors and correlates of cigarette smoking amongst LGB populations, Blosnich and colleagues (2013) reports that LGB people in socio-economic poverty or low income situations appear to be at greater risk of smoking. Factors that precipitated higher rates of smoking were stress, depression, alcohol consumption and exposure to victimisation over time (Blosnich, Lee, & Horn, 2013).
- For gay and bisexual men higher educational background and higher income are associated with lower levels of mental health problems. These patterns reflect the importance of both literacy and material circumstances in determining mental health (Hickson *et al.*, 2016).

3.4.5 Younger people/Older people

Younger people	Older people
<ul style="list-style-type: none"> □ There are substantial health inequalities related to substance misuse, smoking, mental health problems for young LGB people with a growing awareness of the impact of these factors on educational attainment (Blosnich <i>et al.</i>, 2013). □ Findings from the UK Stonewall Gay & Bisexual Men's Health Survey (n=5,799 suggest that young gay and bisexual men are at significantly higher risk of poor mental health compared to older men with very high levels of depression (29%), anxiety (24%), suicide attempts (6%) and self-harm (14%) (Hickson <i>et al.</i>, 2016). □ LGB people up to the age of 25 show higher rates (almost three times) of substance use for tobacco, alcohol, marijuana, cocaine and ecstasy compared to youth in general (Goldbach <i>et al.</i>, 2014). □ Factors associated with higher rates of substance use (cigarette smoking) include victimisation, discrimination and abuse or negative experiences linked to LGB identity disclosure for LGB youth (Blosnich <i>et al.</i>, 2013). □ For trans youth, additional risk factors include homophobic and transphobic harassment, bullying ranging from verbal harassment and intimidation to physical violence, and parental disapproval of their child's gender expression (Bauer <i>et al.</i>, 2015; Sherriff, Hamilton, Wigmore & Giambrone, 2011). □ Resilience and emotional well-being of trans youth has to be a collective responsibility with wider support urgently needed from schools, practitioners, and others in the community as well as at systems level, to ensure health and other services are able to address specific care needs of trans youth (Zeeman, Aranda, Sherriff, & Cocking, 2016). 	<ul style="list-style-type: none"> □ Older LGB people have an elevated risk for disability, poor mental health, and smoking and excessive drinking compared to heterosexual people (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ell, 2013). □ For older LGB people victimisation, financial barriers to healthcare, obesity and limited physical activity account for poor general health, disability and depression in later life. Protective factors decreasing the odds of poor general health, disability, and depression included social support and social network size (Fredriksen-Goldsen <i>et al.</i>, 2012a) □ For some LGBT people in remote areas, loneliness and isolation can be a significant challenge as they age specially for those living in remote areas or for those who have not 'come out' to friends and neighbours (Sharek, McCann, Sheerin, Glacken, & Higgins, 2015). □ The housing status of older LGBT people is associated with their health and wellbeing. One study showed that the preference of some older LGBT people was living independently in their own home, followed by shared accommodation with other LGBT people. This same study also showed that a quarter of LGBT older adults did not reveal their sexual orientation or gender identity to healthcare practitioners due to fear of discrimination and fear that it might impact on the quality of care (Sharek <i>et al.</i>, 2015)

Example from rapid-reviews: Older LGBT people

Grey literature from the rapid-reviews suggest that health services appear to be limited or not available/accessible for older LGBT people [x8 MS: Czech Republic, Finland, France, Germany, Lithuania, Netherlands, Spain, UK]. For example, in the Czech Republic review, attention is drawn to literature that suggests that the managers of some health and social care institutions are not always aware that LGBT older people are in their facilities and therefore, their needs are not necessarily considered in the context of care for older people.

"Actually, so far, I haven't thought there could be a LGBT senior. I thought that only the young ones are ..." (Manager of a health and social care institution, Czech Republic)

(Source: Report - Špatenková & Olecká 2016 LGBT elderly people. PROUD)

Questions to consider

1. LGBT people are more likely to be single over the age of 50. Loneliness and isolation for LGBT(I) people as they age can be a significant challenge, specifically for those who lived in geographically isolated areas or for those who have not 'come out'. How might health promotion initiatives target older LGBT(I) people to help prevent social isolation and loneliness?
2. Older LGBT people in residential care facilities feared 'being trapped in a heterosexual world' or 'having to return to the closet'. Trans people feared they may not be able to be themselves in predominantly heterosexual (cisgender) care environments. How might practitioners in care facilities acknowledge the specific needs of older LGBT(I) people?
3. Instead of addressing the emotional wellbeing and resilience of trans youth at an individual level, how might schools, practitioners and others in community settings work in collaboration with trans youth themselves to address their needs?

Learning points

- Rural populations often have reduced access to high quality primary care compared to those who live in more urban areas. When addressing this for rural LGBT groups, outreach clinics and telemedicine with specialist consultations and primary care practitioner training have been found to be effective.
- Mental health practitioners will benefit from increased awareness of the social and psychological impact of childhood and adolescent abuse experiences on LGBT(I) migrants. For policy, there is a need to strengthen the protection and inclusion of LGBT(I) people worldwide via national/regional child policies and laws particularly for those who are migrants, refugees and asylum seekers.
- Older LGBTI people live with the legacy of historic discrimination, marginalisation and social exclusion. They have endured a historical and social context where same-sex relationships were criminalised, their lives were stigmatised and their gender and sexual identities were often invisible. Thus, for older LGB people victimisation, financial barriers to healthcare, obesity and limited physical activity may account for poor general health, disability and depression in later life. However, social support and a comprehensive social network appears to act a protective factor against poor health, disability and depression later in life. With regards to older intersex people, further research is needed to understand the impact of 'normalising' treatments and their related health needs later in life.
- There are substantial health inequalities related to substance misuse and mental health problems for young LGBT(I) people associated with factors such as victimisation, discrimination, and abuse or negative experiences linked to identity disclosure. Support is urgently needed from youth settings such as schools, youth clubs, and others in community settings to ensure health and other services are able to address specific care needs of LGBTI youth.
- Research is needed to understand the mechanisms through which LGB(TI) adults have an increased risk of disability.

3.4.6 Summary

This Section has explored some of the intersections of LGBT(I) identities within specific populations and settings. Research suggests that living in rural areas can create further health inequalities and have important implications for access to services, particularly for gay men and trans people. Older LGBT(I) people can also experience both physical and mental health difficulties as they age and become more dependent, however social support can act as a protective factor. Conversely younger people can be at risk of health inequalities, including mental distress and substance misuse, in ways that can impact on their educational attainment; however targeted resources have been shown to have positive outcomes. Refugees and asylum seekers are likely to be at risk of physical and mental health problems due to experiences of abuse and victimisation, though further research is needed to fully explore this grouping. The research suggests that LGBT(I) people who are on lower incomes are at risk of mental health problems and are more likely to smoke (linked to other factors such as lack of social support and discrimination), but data is limited. In addition, LGB(TI) people are more likely to be disabled and to be younger when experiencing disabilities and further research into the implications for healthcare is needed.

3.5 What are the potential barriers faced by: 1) LGBTI people when using or trying to access healthcare and; 2) health professionals when providing care for LGBTI people?

Health professionals face a range of challenges when caring for LGBTI people including negative cultural and social norms that have become engrained over time, their own discomfort and unease in addressing gender and sexuality in conversations with their patients, uncertainty about the use of language/terminology, and not knowing whether people are LGBTI. Research and grey literature from rapid-reviews of MS indicate that healthcare professionals may not always be aware of key health related issues facing LGBTI people nor specific health conditions, and may well (un)knowingly or (un)intentionally engage in discriminatory behaviour themselves. This Section explores both the interchange between barriers that health professionals face when providing care and the barriers faced by LGBTI people when accessing healthcare. It is important to note that research exploring the barriers that prevents access to care focused mainly on LGBT people with hardly any research on barriers that health professionals face when providing care for intersex people.

3.5.1 Cultural and social norms

Examples of barriers faced by health professionals when providing care	Examples of barriers faced by LGBTI people when accessing care
Cultural and social norms	
<p>Health professionals commonly accept heterosexuality as the norm (e.g. Fish & Williamson, 2016; Katz-Wise & Hyde, 2012; Marques <i>et al.</i>, 2015).</p> <p>Health professionals often assume their patients are heterosexual, and express surprise when they learn people are LGB (Pennant, Bayliss, & Meads, 2009).</p> <p>Health professionals lack cultural awareness relating to specific groups such as black and ethnic minority gay and bisexual men. Lack of such lack cultural awareness may be a key structural barrier to HIV testing (Wao <i>et al.</i>, 2016).</p>	<p>LGBT people commonly experience homophobia, biphobia and transphobia in healthcare settings (Bauer <i>et al.</i>, 2014; Pennant <i>et al.</i>, 2009; Sharek <i>et al.</i>, 2015; Utamsingh <i>et al.</i>, 2016).</p> <p>Some LGB people perceive health professionals as judgemental or describe them as 'rude' or asking 'intrusive' questions (Pennant <i>et al.</i>, 2009).</p> <p>Half of trans people who presented at emergency departments in their felt gender had negative experiences including being refused care, hurtful or insulting language, being belittled or ridiculed for being trans and refusal to examine parts of the body etc. (Bauer <i>et al.</i>, 2014).</p>

Example from rapid-reviews: Cultural and social norms

Across almost all MS, the rapid-reviews showed that LGBT(I) people commonly experience the impacts of cultural and social norms that privilege heterosexuality and cisgenderism in the form of individual or institutional transphobia/biphobia/homophobia [x20] when accessing treatment and care. In the French rapid-review, it was reported that some trans people fear that they will be refused treatment, fear being exposed as trans in the doctor’s waiting room, or fear humiliation or feeling uncomfortable due to uncommon body/scars. Some experienced verbal harassment, inappropriate curiosity and/or negative attitudes ending ultimately in feelings of humiliation:

“I was consulting in [name] at the Gynaecology Clinic about genital reconstruction surgery and asked to take off my clothes because they did not see a woman with a penis before. Then they called in some 4-5 medical students and they surveyed my naked body.” (Trans person, Hungary)

(Source: Report - Hidasi, B. 2014 Transcare documentation of discrimination in the field of health of trans* people in Hungary. Transvanilla Transgender Association)

3.5.2 Language

Examples of barriers faced by health professionals when providing care	Examples of barriers faced by LGBTI people when accessing care
Language	
<p>In settings where LGBT(I) people access health services, practitioners often assume they are heterosexual (and cisgender) and use language accordingly (Bauer <i>et al.</i>, 2014; Hill & Holborn, 2015; Pennant <i>et al.</i>, 2009).</p> <p>Practitioners can be hesitant to discuss issues related to gender and sexuality with trans young people which results in the wrong pronouns being used when addressing them (Zeeman <i>et al.</i>, 2016).</p>	<p>Assumed heterosexuality reinforces the invisibility of LGB people, and may create barriers in communication between LGB people and health professionals. For example where a gay man is asked ‘Do you have a wife?’ or where a gay man speaks of himself as gay but the doctor uses the term ‘homosexual’ (Pennant <i>et al.</i>, 2009; Sharek <i>et al.</i>, 2015).</p>

Example from rapid-reviews:

Some trans people feared being addressed with the wrong pronoun and being asked too many questions:

“[name] must explain her situation every time she asks for an appointment because she is mis-gendered due to her deep voice.” (Trans woman, France)

(Source: Leaflet - Chrysalide 2012 L'accueil médical des personnes transidentitaires. Chrysalide)

3.5.3 Not knowing and 'coming out'

Examples of barriers faced by health professionals when providing care	Examples of barriers faced by LGBTI people when accessing care
Not knowing	'Coming out'
<p>Health practitioners are not always aware of the LGBT status of their patients and commonly assume people are heterosexual and cisgender (Sharek <i>et al.</i>, 2015).</p> <p>Non-disclosure may lead to inappropriate questioning and diagnoses based on partial information (Fish & Bewley, 2010).</p> <p>Reluctance of LGB(TI) people to 'come out' means that health professionals are often unaware of the identity of LGB(TI) people in healthcare settings and as a result cannot mobilise the necessary resources to address their specific health needs (Pennant <i>et al.</i>, 2009).</p> <p>Where LGBT people were out in health environments their visibility was correlated to better rapport between providers and service users (Whitehead <i>et al.</i>, 2016).</p>	<p>Some LGBT people opt not to reveal their LGBT status for fear of rejection and discrimination whereas some believed disclosure would have a negative impact on their healthcare (Hill & Holborn, 2015).</p> <p>Some LGBT people thought their sexual orientation or gender identity had no bearing on their health (Whitehead <i>et al.</i>, 2016).</p> <p>Consequences of disclosure included potential embarrassment, silence or fear of refusal of care (Fish & Bewley, 2010).</p> <p>Reasons for non-disclosure included lack of opportunity or the assumption that disclosure was irrelevant to treatment and care with some describing limited emotional and psychological resources to deal with potential negative attitudes of health professionals (Fish & Bewley, 2010).</p> <p>Some had safety concerns or didn't 'come out' due to their need for privacy and confidentiality (Fish & Bewley, 2010).</p>

Example of Non-Disclosure from rapid-reviews of MS:

Some LGBT people did not reveal their identities for fear of discrimination or fear that their disclosure might have a negative impact, for example lead to a referral for so-called 'conversion therapy'. 'Conversion therapies' are based upon the assumption that lesbian/gay/bisexual/trans identities are per se a mental disorder and should be treated. Rapid-reviews from MS [x11] reported that people were offered treatment or counselling to help them 'convert'.

"The psychologist that I visited the last time is religious – she is a Christian. I am too, but not so much... When I opened up to her regarding my sexual orientation, she agreed to counsel me but only if I agreed to change my life and my orientation. She tried to send me to [name of a pilgrimage site], told me that they will cure me there of this compulsion... But I don't want to give this up, I was very sad". (Quote from survey with LGBT people, Slovakia)

(Source: Guidebook - Smitková & Kuruc, 2012 Recommendations and incentives for psychologists working with lesbian, gay, bisexual and trans (LGBT) clients. Inicijativa Inakosť)

3.5.4 Documentation, health information and protocols

Examples of barriers faced by health professionals when providing care	Examples of barriers faced by LGBTI people when accessing care
Documentation, health information and protocols (environment)	
<p>One study drew attention to how documentation and protocols used by practitioners had clearly been developed around assumed heterosexuality and were therefore not geared towards the needs of LGB people's (e.g. midwifery data recording forms and protocols) nor towards clear messages of inclusivity (Pennant <i>et al.</i>, 2009).</p> <p>Whilst lesbian and bisexual women are more likely to receive unsuitable advice or encounter inappropriate behaviour (e.g. during the course of sexual history taking, contraceptive services and cervical screening), little attention is paid to lesbian and bisexual women's health issues in either undergraduate or post-qualification medical curricula (Fish & Bewley, 2010).</p>	<p>There is a lack of relevant documentation like leaflets, flyers, information, marketing materials and processes for recording patient information and care pathways that are appropriate for lesbian and gay patients (Pennant <i>et al.</i>, 2009).</p> <p>Trans people may have very particular needs with regards to the recording of demographic information and health records (Deutsch, Green, Keatley, Mayer, Hastings <i>et al.</i>, 2013).</p>

Example of reducing fear in accessing healthcare from rapid-reviews:

A rapid-review from the UK presented a study which included an interview with a lesbian woman who drew attention to how the creation of LGBT(I) friendly environments may help reduce fear of accessing health services.

"If health workers made it obvious, for example, through posters or direct contact with me, that patient's sexuality was not an issue for them and that lesbians were welcome, I might feel easier about visiting the GP for things like smears". (Lesbian woman, UK)

(Source: Guidelines – Ashworth, A. 2012 Sexual orientation: A guide for the NHS. Stonewall UK)

3.5.5 Continuity of care

Examples of barriers faced by health professionals when providing care	Examples of barriers faced by LGBTI people when accessing care
Continuity of care	
<p>When lesbian and bisexual women access health services they are often seen by a range of different health professionals resulting in health professionals not always being aware if a person identifies as lesbian/bisexual (Fish & Bewley, 2010; Pennant <i>et al.</i>, 2009).</p>	<p>Lesbian and bisexual women patients saw a range of different health professionals. As a result, there was no consistency or continuity in care (Fish & Bewley, 2010; Pennant <i>et al.</i>, 2009).</p>

3.5.6 Knowledge and training

Examples of barriers faced by health professionals when providing care	Examples of barriers faced by LGBTI people when accessing care
Knowledge and training	
<p>Many generic and specialist health professional lack the appropriate knowledge regarding lives and related health(care) needs of LGBTI people as well as lack the appropriate culturally competent skills necessary to meet the needs of LGBT(I) people (Alessi <i>et al.</i>, 2016; Bailey <i>et al.</i>, 2014; Budge <i>et al.</i>, 2013; Chakraborty <i>et al.</i>, 2011; Elliott <i>et al.</i>, 2015; Gonzales & Henning-Smith, 2015; Jones, 2016; Moe & Sparkman, 2015; Pennant <i>et al.</i>, 2009; Sanders, Carter, & Lwin, 2015; Sharek <i>et al.</i>, 2015; Sherriff <i>et al.</i>, 2011; Utamsingh <i>et al.</i>, 2016; Zeeman <i>et al.</i>, 2016).</p>	<p>In a mixed-methods research design combining quantitative survey and qualitative interview methods (n=144 and n=36 respectively), only 41% of older LGBT people in healthcare thought health professionals had sufficient knowledge of LGBT issues leaving a staggering 59% who did not (Sharek <i>et al.</i>, 2015).</p> <p>Appropriate training is required to redress these key gaps in the knowledge of health professionals (Moe & Sparkman, 2015).</p>

Example of limited knowledge from rapid-reviews:

Rapid-reviews overwhelmingly drew attention to literature highlighting the seemingly limited education and training opportunities available for health professionals to address the specific health needs of LGBTI people in Member States. In Finland according to a survey conducted by American Psychiatric Association, only 30% of psychologists and psychology students were familiar with issues concerning gender variance and trans people meaning that 70% did not have the relevant knowledge. Several rapid-reviews from MS provided examples of quotes from the grey literature showing the need to increase knowledge to tackle ignorance around LGBTI issues.

Some reviews highlighted specifically literature showing that some health professionals have limited knowledge of how to support LGB youth who might be struggling with their sexual orientation:

"I think you have to be very precise and I personally think that I do not have sufficient knowledge, information, ideas on how to deal with it. How to guide a young person who is in an identity crisis? What am I? Am I gay, lesbian, bisexual? What does that mean? How do I bring it out or how do I do that? How do I find it?" (Health professional, Netherlands)

(Source: Report – Emmen *et al.*, 2014 Jong & anders. Nederlands Jeugdinstituut en Movisie)

Rapid-reviews highlighted that in some MS, state funded specialist services to support gender transitioning were reported as being difficult to access or not provided by a range of MS [x9 MS: Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Portugal, Romania, Slovakia]. Some practitioners did not have the relevant training to provide treatment for trans people.

"I have contacted 16 doctors from [name] and local towns. Most of them wrote back to me explaining that they do not work with people like me and they have no information [about the options of transitioning in Slovakia]. They know nothing, they are not trained or they simply wrote to me that they are not interested in meeting me." (Anonymous, 20 year-old, Slovakia)

(Source: Guidebook - Transfúzia 2015 The standards of trans-inclusive environment in the healthcare system. Transfúzia)

Questions to consider

1. LGBT(I) people are more likely to come out if they know health professionals will uphold their confidentiality and privacy. How could practitioners work in partnership with LGBTI people to reassure and protect their confidentiality and privacy in healthcare settings?
2. What kind of documentation, pathways, and protocols can be developed to specifically target the health needs of LGBTI people?

Learning points

- Health professionals should show greater cultural awareness and sensitivity towards gender and sexual plurality, and recognise that people might identify as LGBTI. In this way, health professionals can foster better holistic care and greater social inclusion in health settings.
- Where LGBT(I) people are informed of who has access to their information and are asked to provide consent prior to information being shared with other professionals or related agencies, they are more likely to 'come out'.
- Disclosure of sexual orientation *can* (but not always) bring health benefits and greater levels of satisfaction with care received due to better communication between health professionals and LGB people. Where health professionals hold positive attitudes towards LGBT people, 'coming out' is more likely.
- Where health professionals accept LGBTI people unconditionally without making judgements and show respect in their interactions with LGBTI people, they are more likely to open up and in return trust health professionals.
- Practitioners should use affirmative language that acknowledge the LGBTI status of patients without judgement, for example by using the same terms that patient uses to describe themselves or by using language appropriate to the gender identity of trans people.
- Trans (and intersex) people may have particular needs for recording demographic information and health status for example where their chosen name and gender identity differs from their legal designated name and sex. This may need including both legal name, preferred name, gender identity and pronoun.
- Greater consistency in care provided, including by one practitioner, could offer the opportunity needed to provide person centred care allowing for mutual respect and trust to develop over time.
- Training is needed to develop knowledge of the intersecting needs of LGBTI people relating to sexual orientation, gender identity, sex characteristics, ethnicity, age, disability and socio-economic status is required.

3.5.7 Summary

This section has explored how healthcare providers can both knowingly and unknowingly perpetuate homophobia, bi-phobia, interphobia and transphobia. LGBTI people may not disclose their sexual orientation, or gender identity or sex characteristics, but can be encouraged to do so, through ensuring confidentiality, and by health professionals refraining from making judgements and not presuming people are heterosexual and cisgender. Health workers have an ethical responsibility and duty of care to provide high quality health services, regardless of the sexual orientation, gender identity or sex characteristics of their patients. They could play an important role in accepting LGBTI people without judgement and acknowledge any feelings of fear that may accompany treatment to facilitate greater uptake health services. LGBTI people can be encouraged to work in partnership with health professionals to provide appropriate treatment and care by verbalising their specific health needs or by 'coming out' in health settings (when relevant) that offer a safe environment. Institutional issues, such as literature that assumes heterosexuality, overlooks specific health needs related to other sexual orientations. Furthermore, where there are numerous health providers this can lead to a lack of consistency in care for LGBTI people, and mitigate against positive experiences of healthcare. Research suggests that healthcare providers require better knowledge of LGBTI healthcare and that training can be beneficial to reducing health inequities. In order to provide access to healthcare, more knowledge is needed to understand the barriers that both health professionals face when providing care, as well as the barriers LGBTI people face when accessing health services and knowledge of how these barriers can be overcome.

3.6 What examples of promising practice exist to address the health needs of LGBTI people?

The rapid-review template for Member States (see Appendix B) included a section on examples of promising practice (if they existed) regarding addressing the specific health needs of LGBTI people in their country. Examples provided spanned a broad range of settings for example: HIV testing and support centres where free, anonymous and voluntary HIV testing and consulting centres were provided; centres providing assistance and support for people living with HIV; peer mentoring for LGBT people in crises; a queer social group to interact with refugees and thereby foster mutual understanding; information leaflets for health professionals to address LGBTI health; queer leadership development, counselling and psychological support; and a suicide prevention strategy for LGBT people. This section presents specific examples of promising practice reported by MS¹¹.

Country: Austria

Target Group: Trans* and inter* people

Promising Practice: Tabera founded in 2015, is an advice centre for trans* and inter* people providing psychotherapy, support groups or support during the coming out process. In addition, Tabera provides public lectures, workshops, and seminars.

Country: The Netherlands

Target Group: Lesbian and gay seniors over 65

Promising Practice: "Als u begrijpt wat ik bedoel..." (in English, 'if you understand what I mean') is a project for 'Pink Seniors over 65' that provides a story telling space to keep older lesbian and gay people engaged, optimistic and less isolated.

Country: Italy

Target Group: Men who have Sex with Men

Promising Practice: Deliberazione P.G.84587/2014 – CONVENZIONE TRA IL COMUNE DI BOLOGNA, L'AZIENDA U.S.L. DI BOLOGNA E L'ASSOCIAZIONE is an agreement between municipal and local health authorities with the LGBTI association PLUS to provide access to HIV prevention and testing for MSM.

Country: Latvia

Target Group: LBT women

Promising Practice: 10 dalykų apie LBT moterų sveikatą (in English "10 Things About LBT Women's Health") is a brochure to address LBT women's health covering topics such as "Coming Out in Healthcare Setting", "Sexual Health", "Risk Factors for Cancer", "Risk Factors for Heart Disease", "Mental Health", "Addictions" "Eating Disorders", "Violence", "Motherhood", "Health of Trans Women" and further recommendations for health professionals.

Country: Romania

Target Group: LGBTI people

Promising Practice: The Romanian Association for Mental Health had a program for personal development of LGBTI people, designed to cater for their particular needs, especially when faced with a largely heteronormative society.

Country: Slovakia

Target Group: Queer people (LGBT)

Promising Practice: Q-Centrum is a community centre established by the non-governmental organisation Queer Leaders Forum in Bratislava. The aim of the centre is to provide social, legal and psychological counselling to LGBT clients.

Country: Luxembourg

Target Group: LGBTI refugees / Queer people

¹¹ See Appendix B for rapid-review summaries for each MS containing further detail of promising practice.

Promising Practice: CIGALE Centre LGBTI refugee support group meets every week providing social support to reduce social isolation and offers pedagogic counselling when needed. Additionally, the centre offers a Queer get-together as an inclusive socialising event for queer people to get in touch with LGBT refugees in order to increase wellbeing and provide a wider sense of understanding and acceptance by locals.

Country: Germany

Target Group: Intersex and Trans people

Promising Practice: Queer leben / Schulenberatung is an independent counselling centre in Berlin for Inter* and Trans* people offering a professional peer-counselling service provided by professional therapists who are intersex themselves and employed to support intersex people.

SECTION FOUR: Limitations and conclusions

4.1 Introduction

In this Section, we draw attention to some of the limitations of the existing research explored in this State of the Art Synthesis Report (SSR) and end with some broad conclusions. The present report is a synthesis of findings from the 1) [Scientific Review \(SR\)](#) and the 2) [Comprehensive Scoping Review \(CSR\)](#) of grey literature in Europe and rapid-reviews of literature in MS. Conducted within the context of Task 1 for the [Health4LGBTI pilot project](#) and bringing together a range of sources from both scientific and grey literatures, this review provides new and valuable insights into the root causes of health inequalities experienced by LGBTI people as well as what is known about the inequalities faced by LGBTI people in relation to healthcare, including potential barriers faced by health professionals when providing care. However, it is nevertheless important to acknowledge some limitations of this SSR.

4.2 Limitations

First, findings of the SR indicated that there is an extensive lack of high quality international research published in peer reviewed journals on the general health profile, cancer burden and care needs of trans and intersex people; a situation that needs to be rectified. Furthermore, biomedical terminology utilised by health professionals such as 'gender dysphoria' and 'disorders of sex development' are contested and not universally embraced. However, these terms can be useful as they identify and categorise people according to specific health needs. In order to gain access to treatment trans and intersex people have to employ these diagnoses (sometimes unwillingly), resulting in medicalisation of their lives and bodies. For some medicalisation offers access to much needed treatment to align their body with their gender identity and gender expression, whereas for others (intersex people) 'normalising treatments' at a young age without full informed consent may have detrimental implications later in life. These complex ethical dilemmas impact on the health research that the SR could draw on, as some people may be ambivalent towards biomedicine and its related treatment technologies, whilst the respite that these interventions offer may be embraced by others.

Second, in the CSR the data presented from the rapid-reviews were the work of key contributors from each respective MS which meant some reviews included translated summaries of texts only available in national languages. Whilst this is a key strength of the CSR in being able to access literature that might otherwise be inaccessible, it also meant we were not able to verify translations for accuracy. Consequently, at various points all three documents (SSR, SR and CSR) we have added specific caveats and/or made amendments where terminology, language, or otherwise unclear statements were present.

Third, both the SR and CSR did not attempt to evaluate the quality of the primary research included, nor evaluate the quality of grey literature reviewed. Therefore, examples from rapid-reviews should be read against the backdrop of reports produced by MS. Therefore, some caution must be applied in the interpretation of study findings as well as the recommendations elicited.

Finally, research reported in the SR often combined health profiles for lesbian and bisexual women, or gay and bisexual men without considering the health inequalities for each individual group. Representations of data combining the health inequalities for these groups were consequences of research design that fed into data extraction when attempting to represent the health inequalities for distinct groups (lesbian, gay, bisexual). Equally for the CSR in some cases, it was unclear which L.G.B.T.I. group(s) the literature reported were referring to. Analysis revealed that studies commonly collapse sexual minority people into a single group. Although combining data together in this way can be useful for research and analytical purposes, it does blur important issues which may be very specific to each group and may also merit specific attention. Therefore, in the SR, SCR and SSR it has not always been possible to tease out precisely which issues are most pertinent to which group if the source did not differentiate. As a result, we propose that future research that seeks to differentiate between LGBTI people is designed specifically to ensure analysis can be conducted by 'sexual orientation, gender identity or sex characteristics'¹² separately, thus maximising relevancy for each group. This should be undertaken without essentialising each group and presuming their issues are the same in ways that neglect intersectional differences.

4.3 Conclusions

The aim of Task 1 of the Health4LGBTI project to produce a state-of-the-art review study carried out in the context of the EU funded pilot project [Health4LGBTI \(SANTE/2015/C4/035\)](#). The study comprised two key review activities including a SR and a CSR. Together, these activities were designed to provide the data underpinning this SSR and to complement each other by allowing access not only to primary research literature but also to gain access to grey literature through Member State rapid-reviews that might not otherwise be accessible via the 'usual' review methodologies (e.g. systematic and narrative reviews).

The results of the SR of published research, the CSR comprising of a European review and rapid-reviews of MS were consistent in demonstrating the existence of key health inequalities for LGBTI people in Europe. From our analysis it became clear that health inequalities stem from cultural and social norms upholding gender and sexual binaries. Perpetuation of these binaries lead to minority stress for LGBTI people associated with discrimination and victimisation based on their sexual orientation, gender identity and sex characteristics. Many inequalities stemming from such origins are arguably avoidable and thus may be reduced via health services. Whilst this may require specific effort by health systems including health professionals to ensure such services are specifically attuned to the needs of LGBTI people, it is also essential action in line with European efforts to abolish discrimination on any grounds and to uphold and promote the human rights of LGBTI people.

Research identified a range of barriers that health professionals face in addressing the health needs of LGBTI people, often linked to a lack of knowledge and understanding of the lives, partnerships, and health concerns of LGBTI people. Personal values, beliefs and behaviours may knowingly or unknowingly continue to marginalise LGBTI people, and render their lives invisible. The challenge for health professionals and health systems therefore is to develop

¹² Terminology utilised in accordance with ILGA-Europe recommendations.

the structures for both specialist and universal health service provision that are truly inclusive and equally accessible to all regardless of gender identity, sexual orientation, or sex characteristics.

Although some encouraging promising practices in various health settings and contexts were evident in the CSR, there is nevertheless still much to be done to ensure LGBTI people are included in service design, service delivery and training, as well as ensuring the fundamental human rights of LGBTI people are universally upheld and promoted. Appropriate and mandatory training for health professionals across all European Member States' health systems is an important step in this direction.

SECTION FIVE: Recommendations

5.1 Introduction

The previous Sections of this SSR report have presented a synthesis of findings from the SR and CSR (see Appendices) to explore: 1) the root causes of health inequalities experienced by LGBTI people including what is known about such inequalities in relation to healthcare settings; 2) the potential barriers faced by health professionals when providing care for LGBTI people, and; 3) barriers faced by LGBTI people when using or trying to access healthcare have also been explored.

As noted in the introduction, one of the key benefits of such a state-of-the-art review is that it can help not only to consider and synthesise some of the most current research in a given area(s) and establish 'what is known', but it can also assist in identifying where further research and priorities are needed and thus can be of significant value for health policy making.

In this final Section, synthesised recommendations drawing once again on the SR and CSR are presented. These are structured in terms of general recommendations (including research, policy, and practice) and recommendations for the training of health professionals. They should be read alongside the extended recommendations in the SR and CSR.

5.2 General recommendations

Research and policy

- 1) There is very limited research with Intersex people that addresses health inequalities and healthcare. Further research is needed with Intersex people to explore health beyond gendered based surgical intervention. This should:
 - a. Consider the general health profile and health outcomes of intersex people. This research can include determining the longer-term impact of hormone treatment and surgical interventions beyond surgical intervention, but it cannot be limited to this; and
 - b. Develop understandings of how to improve and/or ensure appropriate access to health services.
 - c. Intersex people should be included in research, policy and decisions about healthcare delivery to represent their own health related concerns.

- 2) Limited literature was identified within the scope of these reviews which considers where more than one marker of difference intersects and the implications of such intersectionality for health. LGBTI people who are older, younger, disabled, migrants, living in rural areas and those in socio-economic poverty may experience multiple marginalisations. Consequently, further research should be conducted with these LGBTI groups to investigate their needs:
 - To consider the impact of intersectionality on health outcomes; and

- To understand how to improve and/or ensure appropriate access to health services.
 - LGBTI people should be included in research, policy and decisions about healthcare delivery to represent their own health related concerns.
- 3) Similarly, research and much of the literature from the rapid-reviews of European MS focused on lesbian, gay, bisexual and trans people with the health profile of gay men gaining most attention. Both research and rapid-reviews indicate a need for better understanding of the general health profile, health outcomes, and cancer burden of lesbian women, bisexual people and trans people. Even less information was available for intersex people via research and rapid-reviews.
- A dedicated research and policy focus is required to increase understanding of the specific health inequalities and cancer burden of lesbian, bisexual, trans and intersex people, and;
 - How to improve and/or ensure suitable access to health services.
- 3) The European review and rapid-reviews showed that many LGBTI people across European countries experience 'fear' when accessing healthcare settings and disclosing their sexual orientation, gender identity or sex characteristics (e.g. due to concerns of discrimination, lack of privacy and confidentiality and so on). Fear associated with discrimination can stem from minority stress and past experiences of discrimination. Research found the physical and mental health outcomes of those with prolonged exposure to minority stress are poorer.
- Direct policy action is needed to ensure that health professionals and the health systems gain an understanding of the fear LGBTI people may experience due to minority stress and discrimination they are subjected to, and;
 - Structural and individual inequalities that contribute to generation of such fear should be addressed.
- 4) Research and rapid-reviews of EU Member States found that mental distress including depression, anxiety and suicide attempts were raised for lesbian, gay and bisexual people. Trans people globally show considerably higher rates of mental distress with gender transitioning improving emotional wellbeing for some. Even less is known about the longer-term impact of 'normalising treatments' on the mental and physical health of intersex people.
- Alongside research on the health profile of intersex people, further research is needed on Intersex people's mental health experiences and needs.

Practice

- 1) Whilst LGBTI people accessed treatment for mental distress, gender transitioning or medical interventions related to a range of intersex variations, research and rapid-reviews overwhelmingly found:

- There is a need for improved access to psychological support services and talking therapies that are not heteronormative.
- Mental health services should accommodate gender and sexual variance and help LGBTI people overcome their experiences of adversity.

5.3 Recommendations for training

We recommend that higher education institutions and training centres for health practitioners undertake the following:

- 1) Provide training in all settings to develop LGBTI awareness and cultural competence to help ensure all LGBTI people have equal access to healthcare services and that their specific needs are recognised and addressed.
 - Specific resources including training for health professionals across MS are therefore required to ensure that they are aware of the specific health needs of LGBTI people.
 - To develop or re-design services to then address these needs.
 - Given the ostensibly significant gaps in grey literature regarding intersex people's healthcare needs, particular attention should be paid to this population.

- 2) Even though LGBTI people may have equal rights including the protected nature of sexual orientation, gender identity and sex characteristics in some MS, rapid-reviews indicated in many EU Member States, heteronormativity persists for LGBTI people. Fear that stems from these experiences for LGBTI people may impact on access to treatment and screening (for example treatment may be avoided, or treatment may be ended prematurely). Training initiatives for health professionals should include:
 - Opportunities to understand the impact of persistent gender and sexual norms and how upholding these norms may be in tension with the equal rights afforded to LGBTI people in many MS.
 - Increase knowledge of historic events that may have marginalised LGBT people resulting in some (particularly older people) being invisible or avoiding disclosure of their sexual orientation or gender identity.
 - Help to facilitate LGBTI identity disclosure where appropriate in health settings and approach LGBTI people without judgement.
 - Help practitioners understand the significance of inclusion of same-sex partners in decision-making about care pathways and treatment options, and how linking to the broader LGBTI community can aid the mental health and wellbeing for these groups.

- 3) To gain an understanding of unnecessary medicalisation and pathologisation of the lives and bodies of trans and intersex people. This is often (but not only) conveyed through systems of diagnosis and classification, medical pathways and the related

terminology used and embraced by many health professionals. Training should include:

- Acknowledging the diversity and plurality of language needed to describe and understand the lives, bodies, and experiences of trans and intersex people in terms of gender expression, gender identity and sex characteristics.
 - Developing opportunities to question heteronormativity¹³ (in language and practice) by including scope for a range of sexual orientations and gender expressions.
 - Practitioners could use non-binary language taking account of a spectrum of gender identities and sex characteristics spanning beyond reductionist male/female binaries.
 - Ensuring practitioners use inclusive language by asking open questions for example 'What pronoun do you use?' or 'What is your chosen name?'
- 4) To consider as noted in point 2 above, for some LGBTI people their gender and/or sexuality intersect with other markers of difference leading to multiple marginalisations, for example LGBTI people who are younger, older, disabled, an ethnic minority, asylum seeker, refugee etc.
- Training for health professionals should include an attention to such potential multiple marginalisations (for example asylum seekers, migrant and refugee LGBT people may have experienced abuse in their country of origin linked to their sexual orientation or gender identity).
 - Including opportunities to become aware of LGBTI health needs at these intersections (for example access to health screening, mental health services and counselling support may be needed).
 - Being inclusive of particular needs which may require specific adaptations and specialist support.

¹³ Heteronormativity is applicable to trans and intersex people because it refers to both gender norms (i.e. cisgender male/female) that are meant to come together within heterosexual norms.

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Appendices

Appendix A: Scientific Review (SR)

Appendix B: Comprehensive Scoping Review (CSR)



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HEALTH LGBTI

REDUCING HEALTH INEQUALITIES EXPERIENCED BY LGBTI PEOPLE

A review of health inequalities experienced by LGBTI people and the barriers faced by health professionals in providing healthcare for LGBTI people

Scientific Review

June, 2017

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Executive summary

AIMS

This Scientific Review (SR) was carried out in the context of the EU funded pilot project *Health4LGBTI* (SANTE/2015/C4/035). The aim of the SR, was to determine **what is known** about the health inequalities faced by Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) people with a focus on individuals in **vulnerable situations**. A further aim was to explore the **potential barriers** faced by health professionals when providing care for LGBTI people.

METHODS

Using a narrative review and synthesis design via a systematic literature search strategy, 57 relevant papers comprising either primary research, systematic reviews, or meta-analyses of primary research studies were extracted, reviewed, and synthesised. Searches were conducted using Web of Science, CINAHL, PsychINFO, MEDLINE, Cochrane Library, Google Scholar, and additional hand searching to identify: 1) What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings? 2) What is known about the health inequalities of LGBTI people focusing on vulnerable intersections (e.g. rural, older, refugee, immigrant, disability, poverty) as it relates to healthcare? and; 3) What are the potential barriers faced by health professionals when providing care for LGBTI people? A narrative synthesis was then performed to address the review questions.

RESULTS

Root causes of health inequalities experienced by LGBTI people

In general, health inequalities occur due to the consequences of a complex interaction of environmental, social, cultural and political factors. Findings in this SR revealed a number of such root causes likely to contribute to the experience of health inequalities by LGBTI people including: i) cultural and social norms that preference and prioritise heterosexuality; ii) minority stress associated with sexual orientation, gender identity and sex characteristics; iii) victimisation; iv) discrimination (individual and institutional), and; v) stigma.

What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Results of the SR revealed that in terms of **physical health**, LGB people report significantly worse health outcomes and healthcare experiences compared to heterosexual populations (e.g. Elliot *et al.*, 2015). For example, findings revealed that not only are LGB people at a higher risk of developing certain types of cancer (e.g. anal cancer in gay and bisexual men) compared to heterosexual people, but they are also commonly diagnosed with cancer at a younger age. Few studies were extracted focusing on the cancer burden and general health profile of trans and intersex people suggesting a need for further research with this population. With regards to **mental health**, research suggest that LGBT people are at significantly higher risk of experiencing mental health problems compared to the general population. For instance, LGB people are twice to three times more likely to report an enduring psychological or emotional problem compared to the general population. Moreover, LGBT people are at higher risk of mental disorders, suicidal ideation and suicide, substance misuse, and deliberate self-harm compared to the general population. There is scant primary research

exploring the mental health needs of intersex people, and thus there is a need for further research into the psychological and emotional wellbeing of intersex people.

With regards access to **treatment and care**, research suggests that LGBTI people are more likely than the general population to report unfavourable experiences of primary care provision including poor communication from health professionals, and overall dissatisfaction with the treatment and care provided. For example, findings showed that for some intersex people, adversity appears linked to the medicalisation of their bodies, where some may be subjected to ‘normalising’ surgery at a young age. Dissatisfaction with accessing medical procedures was linked to health professionals not communicating appropriately leading to a lack of informed consent. Similarly, trans people who experienced enacted stigma when accessing care were more likely to leave treatment prematurely due to social isolation. With a notable lack of primary research studies regarding trans and intersex people, there is a need for further research with these populations to ensure their experiences and needs are fully reflected and taken into account with regards the provision of, and access to, health services.

What is known about the health inequalities of LGBTI people focusing on vulnerable intersections as it relates to healthcare?

Analysis and synthesis of primary research focused specifically on some of the **intersections of LGBT(I) identities** within specific populations and settings including: rural/urban settings; older/younger LGBT people; refugee, asylum seekers, and/or migrant LGBTI people; those who are socio-economically disadvantaged, and; LGBTI people with disabilities. Living in **rural areas** appears to contribute to health inequalities and have implications for access to services, particularly for trans people. **Older LGB** people can also experience both physical and mental health difficulties as they age and become more dependent, however social support can act as a protective factor (no research on ageing and health was evident for intersex people). For young LGBT people, many experience mental health difficulties and substance misuse, in ways that can affect educational attainment. Although limited research exists on the health of LGBT(I) people whom may also **be migrants, refugees, and/or asylum seekers**, findings suggest that many may have experienced abuse in their country of origin (by parents, caregivers or peers) which is correlated with negative mental health outcomes. Similarly, little research was extracted which focused specifically on **socio-economic issues** for LGBTI people. However, of those that included elements, the findings showed that LGB people on lower incomes may be at a high risk of mental health problems and substance (mis)use. Finally, and once again with little research focusing on LGBTI people with **disabilities**, findings showed that LGB people are more likely to be disabled and to be younger when experiencing disabilities. In general, there appears to be very little research exploring issues of intersectionality for LGBTI people but particularly so for trans and intersex people which needs to be addressed.

What are the potential barriers faced by health professionals when providing care for LGBTI people?

Findings show that health professionals face a range of challenges/barriers when caring for LGBTI people in healthcare settings including cultural and social norms; language; not knowing and coming ‘out’; institutional barriers, and; lack of knowledge and training. With

regards **cultural and social norms**, in contexts where gender and sexual norms are upheld (such as heteronormativity), health professionals may (un)knowingly and often (un)intentionally subject LGBTI people to heterosexism, homophobia, biphobia, interphobia or transphobia resulting in significant barriers to healthcare. With regards to **language**, when LGB people access health services, practitioners often assume heterosexuality and use language accordingly, meaning that LGB people experience exclusion and invisibility. For trans and intersex people, health professionals using pathologising language and incorrect pronouns can (amongst other things) result in avoidance of healthcare. Findings from the research revealed that many health practitioners are not always **aware of the LGBTI status** of their patients nor that their patients *could* be LGBTI. Reasons for non-discourse include perceptions of irrelevancy to treatment and care, concerns over the negative attitudes of health professionals including fear of impact on healthcare. For **institutional issues**, research showed a lack of relevant documentation (e.g. leaflets, flyers, information, marketing materials) and protocols (e.g. processes for recording patient information and care pathways) appropriate for heterosexual patients as well as lesbian and gay patients can mitigate against positive experiences of healthcare. Although no research was evident for trans or intersex people in this respect, it is important to acknowledge that trans and intersex people may have very particular needs with regards to the recording of demographic information and health records which need to be addressed. Finally, for **knowledge and training**, the research is overwhelmingly clear; many generic and specialist health professionals lack the appropriate knowledge regarding the lives and related health(care) needs of LGBTI people as well as lack the appropriate culturally competent skills necessary to meet their needs. Appropriate training is required to redress these key gaps in the knowledge of health professionals.

CONCLUSIONS

The review provides valuable insights into what is known about the inequalities faced by LGBTI people in relation to healthcare including potential barriers faced by health professionals when providing care. It is clear from our analysis that LGBTI people in Europe experience significant health inequalities and that many such inequalities are arguably avoidable and thus preventable. Inequalities can potentially be reduced via health services. Whilst this may require specific efforts by health systems including health professionals to ensure such services are specifically attuned to the needs of LGBTI people, it is also essential action and in line with European efforts to abolish discrimination on any grounds and to uphold and promote the human rights of LGBTI people. The challenge for health professionals and health systems is to develop the structures for both specialist and universal health service provision that are truly inclusive and equally accessible to all regardless of gender identity, sexual orientation, or sex characteristics.

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List of abbreviations

AIDS	Acquired immune deficiency syndrome
CAIS	Complete Androgen Insensitivity Syndrome
CoE	Council of Europe
CSR	Comprehensive Scoping Review
DSD	Disorders of Sex Development
DSM-5	Diagnostic and Statistical Manual of Mental Disorders V5
EC	European Commission
EP	European Parliament
EU	European Union
FGR	Focus Group Report
FRA	Fundamental Rights Agency
HCP	Healthcare Professional
HIV	Human Immunodeficiency Virus
ICD-11	International Classification of Diseases V11 R
LGBTI	Lesbian, Gay, Bisexual, Trans, and Intersex
MS	Member State
MSM	Men who have Sex with Men
RR	Rapid-Review
SOGI	Sexual Orientation and Gender Identity
STI	Sexually Transmitted Infection
SR	Scientific Review (this report)
SSR	State of the Art Synthesis Report
TGEU	Transgender Europe
UN	United Nations
UNDP	United Nations Development Programme
UNPFA	United Nations Populations Fund
WHO	World Health Organisation
WSW	Women who have Sex with Women
PACE	Parliamentary Assembly Council of Europe

Glossary of key terms

Here we provide some of the most commonly terms used throughout this report and in the two companion reports (see Appendices). They are taken directly from ILGA-Europe's most commonly used phrases and acronyms which can be found here: www.ilga-europe.org/resources/glossary.

Cisgender	A term referring to those people whose gender identity and gender expression match the sex they were assigned at birth.
Gay	Refers to a person who is sexually and/or emotionally attracted to people of the same gender. It traditionally refers to men, but other people who are attracted to the same gender or multiple genders may also define themselves as gay.
Gender	Refers to a social construct which places cultural and social expectations on individuals based on their assigned sex.
Gender expression	Refers to people's manifestation of their gender identity to others, by for instance, dress, speech and mannerisms. People's gender expression may or may not match their gender identity/identities, or the gender they were assigned at birth.
Gender identity	Refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms. Some persons' gender identity falls outside the gender binary and related norms.
Gender reassignment surgery (GRS)	Medical term for what trans people often call gender confirmation/affirmation surgery, which is sometimes (but not always) part of a person's transition.
Homosexual	People are classified as homosexual on the basis of their gender and the gender of their sexual partner(s). When the partner's gender is the same as the individual's, then the person is categorised as homosexual. The term focuses on sexuality rather than on identity and may, in some contexts, have a negative and pathologising connotation.
Intersex	Relates to a range of physical traits or variation that lie between binary ideals of male and female. Intersex people are born with physical, hormonal or genetic features that are neither wholly female nor wholly male; or a combination of female and male; or neither female nor male. Many forms of intersex exist; it is a spectrum or umbrella term, rather than a single category.
Heteronormativity	Refers to the set of beliefs and practices that gender is an absolute and unquestionable binary, therefore describing and reinforcing heterosexuality as a norm. It implies that people's gender and sex characteristics are by nature and should always be aligned, and therefore heterosexuality is the only conceivable sexuality and the only way of being 'normal'.
Heterosexism	Heterosexism is a set of discriminatory attitudes, bias and behaviours relying on gender as a binary to favour heterosexuality and heterosexual relationships.
Queer	Previously used as a derogatory term to refer to LGBTI individuals in the English language, queer has been reclaimed by people who identify beyond traditional gender categories and heteronormative social norms. However, depending on the context, some people may still find it offensive. Also refers to queer theory, an academic field that challenges heteronormative social norms concerning gender and sexuality
Sex	The classification of a person as male or female. Sex is assigned at birth and written on a birth certificate, usually based on the appearance of their external anatomy and on a binary vision of sex which excludes intersex people. A person's sex however, is actually a combination of bodily characteristics including: chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics.

<p>Sex characteristics</p>	<p>A term that refers to a person's chromosomes, anatomy, hormonal structure and reproductive organs. OII Europe and its member organisations recommend protecting intersex individuals by including sex characteristics as a protected ground in anti-discrimination legislation. This is because many of the issues that intersex people face are not covered by existing laws that only refer to sexual orientation and gender identity. This is seen as being a more inclusive term than 'intersex status' by many intersex activists, as it refers to a spectrum of possible characteristics instead of a single homogenous status or experience of being intersex.</p>
<p>Sexual orientation</p>	<p>Refers to each person's capacity for profound affection, emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender.</p>
<p>Trans</p>	<p>Is an inclusive umbrella term referring to people whose gender identity and/or gender expression differ from the sex/gender they were assigned at birth. It may include, but is not limited to: people who identify as transsexual, transgender, transvestite/cross-dressing, androgynous, polygender, genderqueer, agender, gender variant, gender non-conforming or with any other gender identity and/or expression which does not meet the societal and cultural expectations placed on gender identity.</p>
<p>Transsexual</p>	<p>An older and medicalised term used to refer to people who identify and live in a different gender. The term is still preferred by some people who intend to undergo, are undergoing or have undergone gender reassignment treatment (which may or may not involve hormone therapy or surgery).</p>
<p>Transition</p>	<p>Refers to a series of steps people may take to live in the gender they identify with. Transition can be social and/or medical. Steps may include: coming out to family, friends and colleagues; dressing and acting according to one's gender; changing one's name and/or sex/gender on legal documents; medical treatments including hormone therapies and possibly one or more types of surgery.</p>

SECTION ONE: Background

1.1 Introduction

Since the inception of the European Union (EU) and 1997 Amsterdam Treaty, slow but steady progress has been made to secure the fundamental rights of LGBTI people. However developments have not been consistent throughout Member States (MS). Both the human rights and health outcomes of people across the EU differ markedly across MS. Even though general populations are healthier than at any time, there are established and growing inequalities in health between, and within most European MS as well as within and between, specific population groups (Gugglberger, Sherriff, Davies, & Van den Broucke, 2016; Sherriff, Gugglberger & Davies, 2014). Reducing health inequalities therefore, is regarded as one of the most important public health challenges facing the EU and its Member States (EC, 2009, 2010, 2014).

There is increasing acknowledgement that lesbian, gay, bisexual, trans, and intersex (LGBTI) people experience significant health inequalities including access to health services which impacts both on their health outcomes and on their experiences of healthcare systems (Fish & Williamson, 2016; Williams, Varney, Taylor, Fish, Durr, *et al.*, 2015). For example, with regards to health and social care settings, LGBTI people continue to experience stigma and discrimination combined with social isolation and limited understanding of their lives by others, leading to significant barriers in terms of accessing health and social care services (Pennant, Bayliss, & Meads, 2009; see also Blondeel, Say, Chou, Toskin, Khosla, Scolaro, & Temmerman, 2016). These experiences can translate into a range of physical and mental health conditions (e.g. King, Semleyn, Tai, Killaspy, Osborn, Popelyuk, & Nazareth, 2008).

Set within this backdrop, this current report examines some of the peer reviewed primary research literature relating to LGBTI people and health inequalities, including access to healthcare, to develop understanding of these key issues.

1.2 About Task 1

Task 1 of the Health4LGBTI project was a state-of-the-art review study focusing on the health inequalities faced by LGBTI people (especially those in vulnerable situations) and the potential barriers faced by health professionals when providing care for LGBTI people. Co-led by the University of Brighton (UoB) with ILGA-Europe in collaboration with all Consortium partners, the review study comprised two key activities:

- 1) A **Scientific Review** (SR) of relevant International/European primary research literature published in academic peer reviewed journals (in English only).
- 2) A **Comprehensive Scoping Review** (CSR) of relevant grey literature from (where possible) all 28 European Member States (MS).

Together, these two key activities informed the production of the key Deliverable for Task 1: State-of-the-art synthesis report (D1.1; see Figure 1, next page).

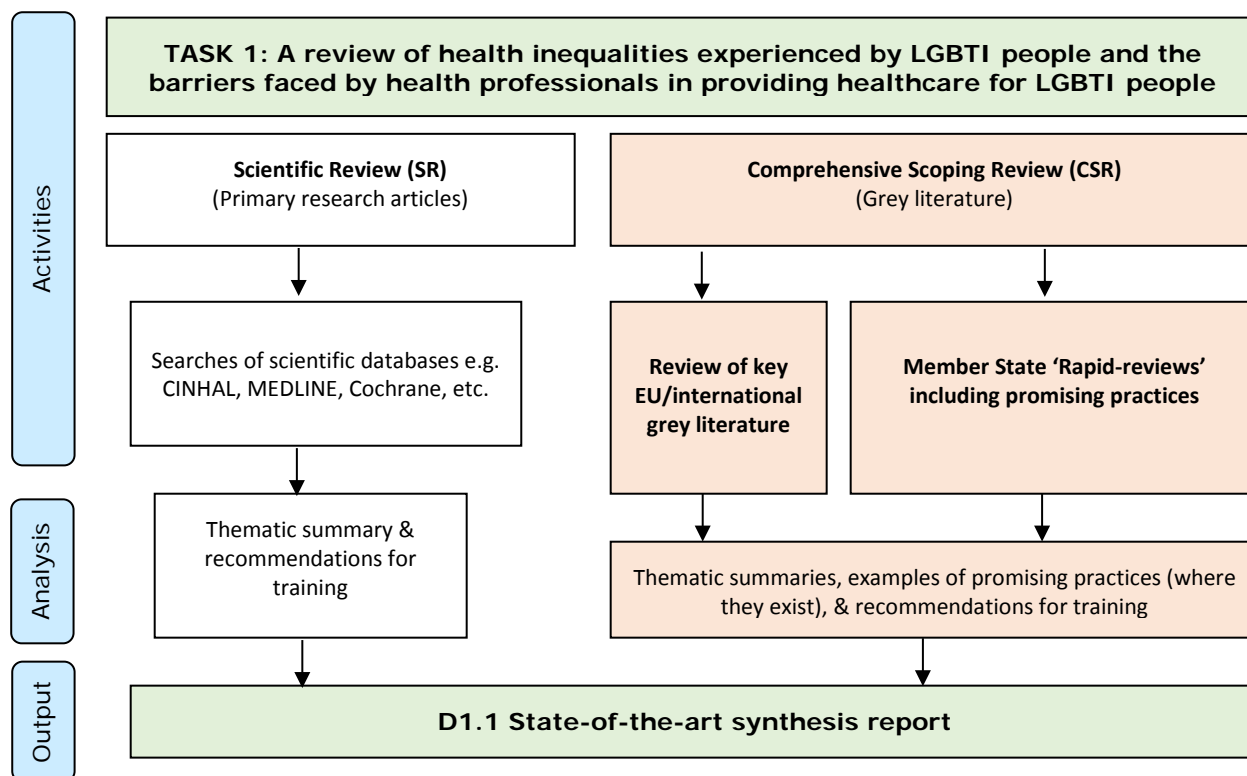


Figure 1. Overview of Task 1

1.3 Aims of the Scientific Review

The aim of this Scientific Review (SR; Figure 2 next page) was to determine what is known about the health inequalities faced by LGBTI people with a focus on LGBTI individuals in vulnerable situations (e.g. LGBTI people living in rural areas, older LGBTI people, LGBTI people from lower socioeconomic backgrounds, LGBTI people with disabilities, etc.). A further aim was to explore the potential barriers faced by health professionals when providing care for LGBTI people. Consequently, the SR review questions were as follows:

1. **What is known** about the health inequalities faced by LGBTI people as it relates to healthcare settings?
2. What is known about the health inequalities of LGBTI people focusing on **vulnerable intersections** (e.g. rural, older, younger, refugee, immigrant, disability, poverty) as it relates to healthcare?
3. What are the **potential barriers** faced by health professionals when providing care for LGBTI people?

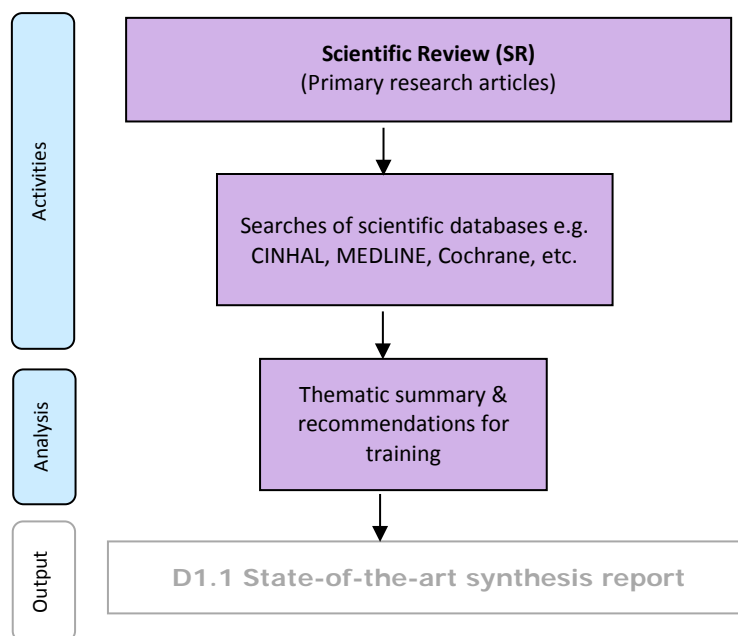


Figure 2. Overview of the Scientific Review (SR)

1.4 About this report

This current report represents the **Scientific Review (SR)** as set out in Task 1 (findings from the Comprehensive Scoping review and the overall State-of-the art Synthesis Report are presented elsewhere; see Zeeman *et al.*, 2017a, 2017b). The report is divided into seven key Sections as follows:

Following this first section which sets the context for the review, **Section Two** details the scientific review protocol and methods used. **Section Three** draws briefly on the research literature relating to the root causes of health inequalities. In **Section Four**, what is known about the health inequalities facing LGBTI people as it relates to healthcare settings is explored. **Section Five**, considers intersectionality in terms of overlapping inequalities stemming from (intentional and unintentional) discrimination and unfair treatment on other grounds. In **Section Six**, barriers faced by health professionals when providing care for LGBTI people are explored. Finally, **Section Seven** presents the main recommendations emerging from the primary research literature, as well as identifying some limitations and drawing overall conclusions from the review.

1.5 A note on context and terminology

It is important to note that this Scientific Review (SR) along with the companion Comprehensive Scoping Review (CSR; Zeeman *et al.*, 2017a) provides the base-line information to inform the key deliverable for Task 1 (D1.1 State-of-the-art Synthesis Report). The State-of-the-art Synthesis Report (SRR; Zeeman *et al.*, 2017b) is a summary document bringing together this present SR as well as the CSR. Thus, the present SR is only one part of Task 1 and should only be read and contextualised within the overarching SSR.

In the course of conducting this SR, it became clear that in some of the published articles language is used which is at odds with contemporary usage. Language is a living thing and its usage changes over time. However, it is nevertheless important for reviews, research, and other reports to not perpetuate misunderstandings and inaccuracies through inappropriate or careless language. Consequently, although this SR uses an established scientific method (protocol) for conducting searches and analysing and presenting findings, it has at various points been necessary to add specific caveats and/or make amendments where terminology, language, or otherwise problematic statements were present. Whilst this might be a relatively unusual step for a SR, it was deemed as necessary by both the Task 1 partners and the wider Health4LGBTI Consortium.

Throughout this report therefore, the terms sexual orientation, gender identity and sex characteristics are used where relevant in line with commonly accepted language reflected in European policy directives, national guidelines, and third sector recommendations (e.g. see FRA, ILGA-Europe and ONS)¹. Certain sections in this report refer specifically and precisely to LGB or LGBT people instead of LGBTI people; this is done to acknowledge the original research participants in the particular referenced study in question. In doing so, this frequently highlights the dearth of research including trans or intersex people (or both) as research participants compared to LGB people more broadly.

It is important however to acknowledge that recruitment for research with LGBTI people can be challenging due to an understandable unwillingness for some to participate in research (e.g. due to fear of disclosure; see King *et al.*, 2008) or due to the various identities that people may have or acquire and the language they use to describe themselves. For example, Elliott and colleagues (see Elliott, Kanouse, Burkhart, Gary, Lyratzopoulos, Beckett, Schuster, Roland, 2015) asked 2,169,718 people to identify themselves as either 'heterosexual', 'gay', 'lesbian', 'bisexual', 'other' or 'prefer not to say'. 27,497 participants identified as lesbian, gay or bisexual with around 4% preferring not to name their identity and 0.6% identified as 'other'. What this demonstrated is that although these terms can provide an indication of the diversity of ways LGB people identify, they also demonstrate how some people may resist labels which are historically associated with marginalisation.

Whether LGBTI people are hesitant to participate in research due to fear of disclosure, or whether they resist fixed identity categories such as lesbian, gay, bisexual, trans and intersex, the need to address the related health inequalities remain pertinent. This present SR has been conducted with an awareness of the potential constraints and divisive use of identity categories; however, we also acknowledge that such categories can be useful when aiming to understand the health inequalities associated with LGBTI people's lives, in order to inform future healthcare training, practice and policy initiatives and it is within this context, that we use these terms.

¹ See www.ilga-europe.org/resources/glossary

FRA (2012) Handbook on European non-discrimination law: Case-law update. Austria: European Union Agency for Fundamental Rights.

Haseldon & Joloza (2009) Measuring sexual identity. A guide for researchers. Newport UK: Office for National Statistics.

ILGA-Europe (2015) Annual review of the human rights situation of lesbian, gay bisexual trans and intersex people in Europe. Brussels: ILGA.

SECTION TWO: Scientific Review Protocol and Methods

2.1 Introduction

This Section presents the methods and process used to conduct this Scientific Review. In doing so, details of the search strategies used, inclusion/exclusion criteria as well as literature extraction and final literature included, are provided.

2.2 Methods

A qualitative state-of-the-art narrative review and synthesis design was used due to the complex exploratory nature of this study. Such a review considers the most current research in a given area(s) or topic and commonly summarises current and emerging trends reflected in the literature helping to establish 'what is known' as well as identify research priorities. Moreover, a state-of-the-art narrative review can assist in producing a synthesis of current thinking that cuts across the field offering new perspectives on an issue and/or highlight new areas for further research, training, and policy development.

The outcome of state-of-the-art narrative reviews is typically a summary of review results. However, given that the findings of the SR feed into other components of the wider research project including the qualitative focus groups with LGBTI people and health professionals (Task 2), and the development of the training modules (Task 3 and 4), an additional outcome of the current SR is to provide emerging recommendations on the training of health professionals in overcoming barriers to care provision for LGBTI people to ultimately contribute to the reduction of health inequalities. The detailed protocol containing the steps undertaken for this review is available on request from the first author.

2.2.1 Search Strategy

Database management software (EndNote) was used to allow storage of the primary research citations identified in the searches, to keep track of them, to identify exclusions, and to detect duplicates. The SR was conducted drawing on (where relevant) principles of the PRISMA statement (Moher, Liberati, Tetzlaff, & Altman, 2009). CINAHL, PsychINFO, MEDLINE (including PubMed), Web of Science, Cochrane Database of Systematic Reviews and the Campbell Collaboration Library of Systematic Reviews was searched. Additional databases were considered including SCOPUS, EMBASE, AMED, OVID, British Education Index (BIE), and ERIC but were excluded due to non-relevance. Google and Google Scholar was searched in English and references of included papers were checked to identify further relevant articles.

2.2.2 Inclusion/exclusion

Language (English only), time (2010 onwards)² except for the inclusion of pivotal systematic reviews in the field published from 2008 onwards (King *et al.*, 2008; Pennant *et al.*, 2009), and some geographical restrictions (European primary focus, wider international focus where directly relevant) were applied. Precise inclusion/exclusion criteria for paper extraction were agreed amongst Consortium partners. Initial searches generated in excess of 2961 publications that included 17 narrative reviews/systematic reviews. As this SR has (in real

² Literature from 2010 onwards was included to ensure the review covered the most current research findings available.

terms), three separate questions to address (2 closely related, and one distinct), specific search strategies were adopted for each of the different questions:

Question 1: What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

The following search terms were utilised for question 1 with the related inclusion and exclusion criteria:³

Lesbian / gay / homosexual* / bisexual / trans* / transgender / transsexual* / intersex / hermaphroditism / disorders of sex development / queer / transvest* / gender identity / questioning / unsure / LGBTI / GLBT / LGB / LGBT / LGBTQ / LGBTU / LGBT & I / same sex / same-sex / sexual minority / sexual orientation

Health inequality* / disparity* / gradient / disadvantage* / determinant*

Inclusion Criteria	Exclusion Criteria
Peer reviewed primary research articles published in academic journals or systematic reviews	Grey literature
Published in English	Non-English
Published between 2010-2016	Prior to 2010
Social determinants	Biological and genetic factors
Physical and mental health	Sexual health
Homosexual, bi, trans and intersex	Sexual practices (e.g. WSW [women who have sex with women] and MSM [men who have sex with men] and sex work) ⁴
Physical and mental conditions i.e. suicide, depression, mental distress, self-harm, substance misuse, unique medical inequalities, cancer, fertility, obesity etc.	HIV/AIDS and other STIs ⁵

Table 1. Inclusion and exclusion criteria for question 1

Number	Terms	CINAHL	PsychINFO	MEDLINE	Web of Science	Cochrane, Campbell etc.
	Question 1					
1	Lesbian / gay / homosexual* / bisexual / trans* / intersex / queer / gender identity	19383	9340	112036	88863	
2	LGBTI / GLBT / LGB / LGBT / LGBTQ / LGBTU / LGBT & I	13986	1661	1268	1744	
3	health* n3 (inequalit* or disparit* or inequit* or disadvantage* or gradient* or determinant*)	89121	6937	276089	34667	
Total	Term 1 or 2 and 3	38	1139	98	385	16

Table 2. Number of hits per database for question 1

³ These search terms are consistent with the terms identified in databases such as CINAHL. We appreciate that some of the terms inappropriately medicalise sexualities, gender identities, and sex characteristics. However, to ensure the broadest coverage and maximise retrieval, we opted to include such terms for the purposes of the searches.

⁴ Research focusing on MSM and WSW were excluded as this review focused on sexual orientation/identities instead of sexual practices.

⁵ HIV/AIDS and other STIs are excluded from the current SR due to being an already over-researched area and the resulting large and diverse literature available. Although clearly a pertinent literature for LGBTI population, it was beyond the scope and resources of this current Task 1 to review again literature that has been widely reviewed before. For a selection of relevant publications on HIV and other STIs, see: Baral *et al.*, 2012; Diaz *et al.*, 2015; Dubois-Arber, 2010; EC, 2009; ECDC, 2015; Giami, A. & Bail, 2011; Logie *et al.*, 2012; Mirandola *et al.*, 2016; Scheim *et al.*, 2016).

Question 2: What is known about the health inequalities of LGBTI people focusing on vulnerable intersections (e.g. rural, older, refugee, immigrant, disability, poverty) as it relates to healthcare?

The search terms in question 1 were combined with these terms for question 2 with the following inclusion and exclusion criteria:

Intersection* / rural areas / rural population / rural health / aged / old* / young / disab*/ poverty / migrants* / immigrants/ asylum*/ refugee / displaced

Inclusion Criteria	Exclusion Criteria
Rural, geographically remote areas	Urban areas
Over the age of 18 as per age of consent in EU MS ⁵	Under the age of 18 ⁶
Older LGBTI people	LGBTI war veterans (USA)
Socioeconomic disadvantage or poverty	High income settings
Disabilities	Able bodied
Migrants, immigrants, asylum seekers, refugees	Native citizens
Health	Occupational health

Table 3. Inclusion and exclusion criteria for question 2

Number	Terms	CINAHL	PsychINFO	MEDLINE	Web of Science	Cochrane, Campbell etc.
	Question 2					
4	Intersection*	2013	6937	5302448	74363	
5	Rural areas / rural population / rural health / aged / old* / young / disabled / disab*/ poverty / migrants* / immigrants/ asylum*/ refugee / displaced	932	160025	2237154	250086	
Total	Term 1 or 2 and 3 and 4 and 5	5	268	20	86	3

Table 4. Number of hits per database for question 2

Question 3: What are the potential barriers faced by health professionals when providing care for LGBTI people?

The following search terms were utilised for question 3 with the related inclusion and exclusion criteria:

Lesbian / gay / homosexual* / bisexual / trans* / transgender / transsexual* / intersex / hermaphroditism / disorders of sex development / queer / transvest* / gender identity / questioning / unsure / LGBTI / GLBT / LGB / LGBT / LGBTQ / LGBTU / LGBT & I / same sex / same-sex / sexual minority / sexual orientation
Barrier*/ gap / beliefs / attitudes / values / norms / perspective / opinion / heteronormative* / perception

Health service accessibility / healthcare accessibility / health profession* / staff / nurs* / doctor / clinician*

⁶ Intersex research with participants under the age of 18 will be included due to a peak in health service access during puberty and prior to the age of 18.

Inclusion Criteria	Exclusion Criteria
Acute care, community, hospitals, health promotion, surgeries, mental health services	Occupational health
Health professionals including gynaecologist, obstetrician, GP, psychologist, psychiatrist, mental health practitioners, nurse, midwife, surgeons, paediatrician, endocrinologist	Lay workers
Human care, treatment, practice	Animal care

Table 5. Inclusion and exclusion criteria for question 3

Number	Terms	CINAHL	PsychINFO	MEDLINE	Web of Science	Cochrane, Campbell etc.
	Question 3					
8	Barrier* / gap / beliefs / attitudes / values / norms / perspective / opinion / heteronormative* / perception	54848	214544	1541605	8760301	
9	Health profession* / staff / nurs* / doctor / clinician*	41819	73953	26977280	1717606	
10	Health services accessibility* / healthcare inequalities / healthcare delivery /	89121	4472	1946	112011	
Total	Term 1 or 2 and 8 and 9 and 10	15	335	502	49	2

Table 6. Number of hits per database for question 3

2.2.3 Literature extraction

During data extraction, each question generated a range of papers. Papers identified for Question 1 also covered Question 2. The search to answer Question 3 generated an additional set of papers. The number of papers identified is therefore divided in Q1 and Q2=n1, and Q3=n2. The following databases were searched comprehensively, each contributing the following number of papers: Web of Science (520), CINAHL (58), PsychINFO (1742), MEDLINE (620), Cochrane, Campbell and other systematic reviews (21).

The combined number of papers identified across databases were: 2961 that included 21 narrative or systematic reviews. Based on a review of the abstracts, the following exclusions were made: duplicates (n1=467) / (n2=362), publication lacking a full text (n1=267) / (n2=64), protocols of a systematic reviews (n1=48 / n2=8), systematic reviews not meeting the inclusion criteria (n=5), not primary research (n1=505) (n2=260) and overly small sample size (n1=62) / (n2=25). Papers that were theoretical or discussion papers were excluded (n1=348) / (n2=102). The full text of remaining publications were then retrieved and read (n1=358) / (n2=82) with publications focusing on sexual practices (MSM/WSW) instead of identities, HIV/AIDS or STI etc. excluded (n=403). A total of 57 papers were included in the synthesis.

Figure 3 (below) shows how publications were selected for review.

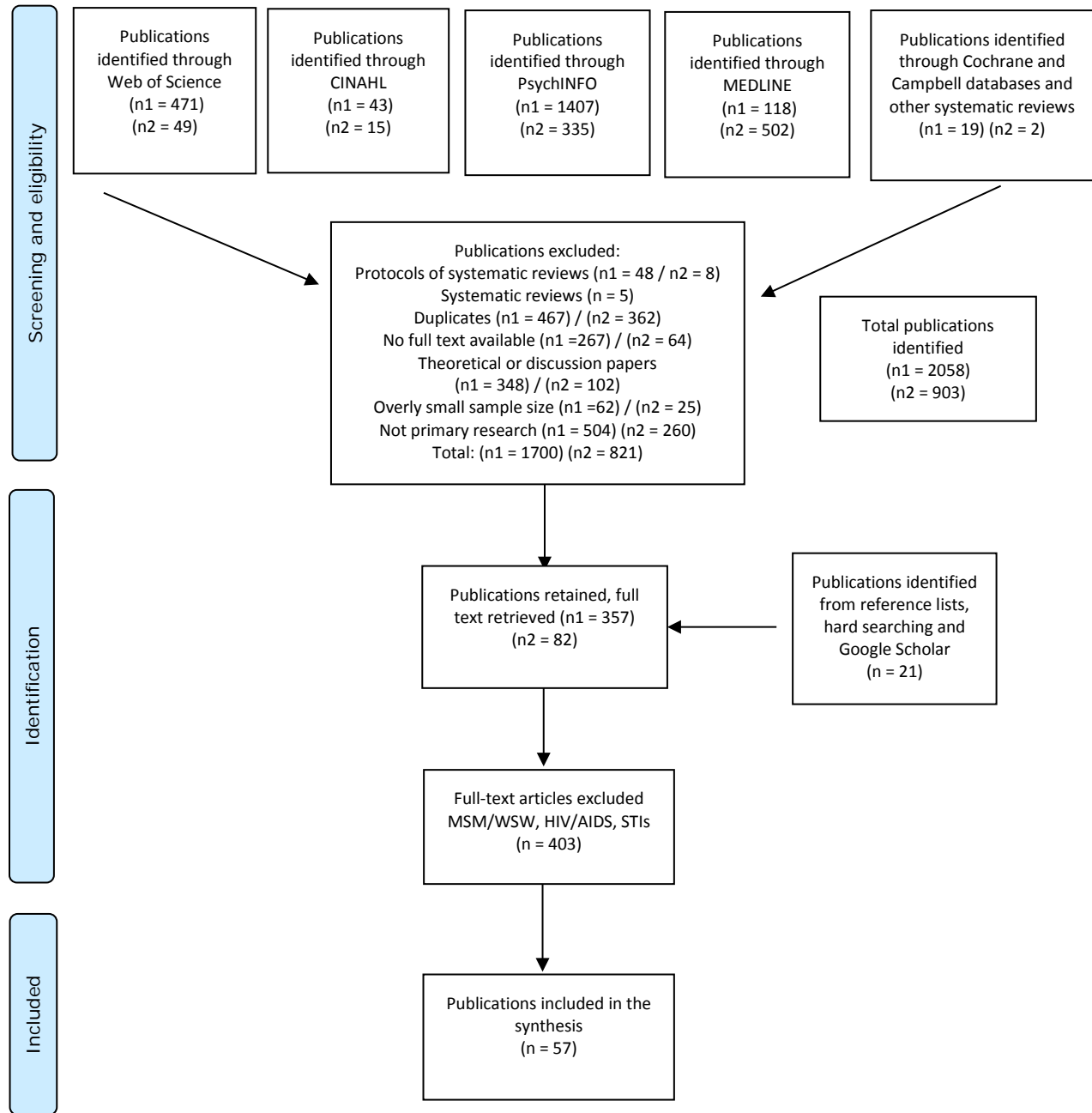


Figure 3. Flowchart for inclusion of publications

2.3 Literature included

A master table was created in Endnote and Excel containing key information from each of the selected studies including: health topic, time range of the search, year published, geographical scope, the LGBTI subpopulation, methods employed, scientific journal etc. (see Appendix). The following 16 systematic reviews and/or meta-analyses and narrative reviews were included (Blondeel, Say, Chou, Toskin, Khosla, Scolaro, & Temmerman, 2016; Blosnich, Lee, & Horn, 2013; Eliason, Ingraham, Fogel, McElroy, Lorvick, Mauery, & Haynes, 2015; Fredriksen-Goldsen & Muraco, 2010; Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014; Haas, Eliason, Mays, Mathy, Cochran, & D'Augelli, 2010; Hill & Holborn, 2015; Katz-Wise & Hyde, 2012; King, Semleyn, Tai, Killaspy, Osborn, Popelyuk, & Nazareth, 2008⁷; Lee, Schober, Nordenstrom, Hoebeke, Houk, Reiner & Woodhouse, 2012; Meads, Carmona, & Kelly, 2012; Meads & Moore, 2013; Pennant, Bayliss, & Meads, 2009⁸; Reisner, Poteat, Keatley, Cabral, Mothopeng, Dunham, Holland, Max & Baral, 2016; Semleyn, King, Varney, & Hagger-Johnson, 2016; Wao, Aluoch, Odondi, Tenge, & Iznaga, 2016). Each systematic review appraised in the region of 25 research studies or more (16 systematic reviews x 25 papers each) meant in excess of 400 research studies were explored in this Scientific Review. Moreover, papers that were published in addition to these systematic reviews or following these reviews, that met the inclusion/exclusion criteria, were also included. Due to the broad scope of the SR database searches were revisited a number of times to address gaps in the identified papers for specific subpopulations for example the health outcomes of intersex people and their experiences of accessing healthcare. These iterative search measures were utilised to ensure each of the three questions were covered in sufficient depth.

7 Although the King *et al.*, (2008) review falls outside the timeframe for the SR as set by the inclusion/exclusion criteria, it is included as an exception as the study provides the first comprehensive global overview of LGB mental health research undertaken and is considered to be an excellent and highly relevant article.

8 Similarly, the Pennant *et al.*, (2009) review on improving LGB healthcare was included as an exception due to its relevance.

SECTION THREE: Root causes of health inequalities experienced by LGBTI people

3.1 Introduction

This Section explores some of the root causes of health inequalities experienced by LGBTI people based on the research papers extracted via the review protocol (Section 2). It is not intended to be a comprehensive account but instead is presented in order to gain a brief understanding of how these inequalities come about and are maintained.

In general, research suggests that inequalities occur due to the consequences of a complex interaction of environmental, social, cultural and political factors. The causes of health inequalities for LGBTI people which have been documented in the research reviewed as part of this SR and are presented here include: heteronormativity; heterosexism; minority stress; victimisation; discrimination (individual and institutional), and; stigma. Each of these root causes are addressed briefly below.

3.2 Root causes of health inequalities

3.2.1 Heteronormativity

Heteronormativity refers to the set of beliefs and practices that gender is an absolute and unquestionable binary, and therefore describe and reinforce opposite sex attraction with heterosexuality as a norm. It implies that people's gender and sex characteristics are by nature and should always be aligned, and therefore heterosexuality is the only conceivable sexual orientation and the only way of being 'normal' (e.g. Fish & Williamson, 2016; Katz-Wise & Hyde, 2012; Marques *et al.*, 2015; Pennant *et al.*, 2009).

In most European Member States, health inequalities occur in contexts where heteronormativity is at play and heterosexuality is upheld as the social and cultural norm. In mainstream healthcare settings where LGBTI people access treatment and care, being heterosexual (as well as cisgender and non-intersex) is often assumed and accepted as the status quo (Marques, Nogueira, & De Oliveira, 2015; Utamsingh, Richman, Martin, Lattanner, & Chaikind, 2016). LGBTI people are marginalised due to heteronormative assumptions conveyed in communication between health professionals and their patients where language is infused with subtle meaning (Fish & Williamson, 2016; Utamsingh *et al.*, 2016). These assumptions are heard in verbal communication and seen in written communication where case notes and multidisciplinary forms often fail to recognise the lives and partnerships of LGBTI people. The actions of health professionals may be (un)intentionally disrespectful and insensitive towards LGBTI people (Utamsingh *et al.*, 2016; see also Sharek *et al.*, 2015). When LGBTI people are rendered invisible, or their lives are overlooked due to assumed heterosexuality, cisgenderism, binary gender identities and normative sex characteristics, the relationship between health providers and people who access care is adversely affected. In these instances, LGBTI people who access healthcare and other support services are less likely to be open and disclose their sexual orientation, gender identities or sex characteristics, and/or information relevant to their specific needs (Utamsingh *et al.*, 2016). Research has found that less than half of lesbian women reveal their orientation to health professionals in

the first few consultations (Marques *et al.*, 2015). Consequently, health professionals may not have all the relevant information needed to make a full assessment of health needs in order to suggest appropriate treatment options (Rose, Ussher, & Perz, 2016; see also Pennant *et al.*, 2009). In one study, consultations based on heteronormative assumptions where the health needs of LGBTI people were overlooked, were found to lead to poorer health outcomes one-year post consultation (Utamsingh *et al.*, 2016).

3.2.2 Heterosexism

Heterosexism can be understood as a set of discriminatory attitudes, bias and behaviours relying on gender as a binary to favour heterosexuality and heterosexual relationships. Research indicates that LGB people are subjected to various heterosexist practices of power such as rejection by families, friends, and peers resulting in social exclusion and stress. For some LGB people this can lead to an internalised sense of guilt or shame, also known as internalised homophobia (Van Beusekom, Bos, Kuyper, Overbeek & Sandfort, 2016). These effects of power are also visible in institutionalised stigma, prejudice, and discrimination. Indeed, in a systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people, King *et al.*, (2008) note how social hostility, stigma, and discrimination that most LGB people experience is in part responsible for higher rates of mental health problems.⁹

A qualitative study by Fish & Williamson (2016) on LGB cancer patients' accounts of accessing cancer care (diagnosed with different forms of the disease), described experiences of less than optimal care due to the heterosexism where some LGB people experienced discrimination from health professionals such as micro-aggressions. Participants were reported by the authors as being unsure how to interpret the behaviour of abrupt clinicians and were baffled by interactions that were perceived as unkind, not knowing if the behaviour of clinicians was due to their (the patient's) sexual orientation or alternatively if that was the clinician's default way of interacting with those who access treatment and care. Here participants mentioned practitioners' body language when experiencing overt disapproval linked to heterosexist attitudes (Fish & Williamson, 2016). In addition, the authors reported how LGB people noticed the heterosexist attitudes of health providers during consultations about the inclusion of same-sex partners or gaining acknowledgement of the status of their partner as a legitimate next of kin. Various LGB people described instances where their partners were either not acknowledged or were dismissed due to health professionals failing to recognise their importance in providing care and support (Fish & Williamson, 2016).

3.2.3 Minority stress

Minority stress theory is presently the leading narrative that explains the health inequalities experienced by LGBTI people (see Bourne, Davey, Hickson, Reid, & Weatherburn, 2016). In an attempt to define minority stress, researchers have argued that stigma, prejudice, and discrimination create a hostile environment where people are subject to stressful social exchange (Elliott *et al.*, 2015). Population groups who experience minority stress often show a greater incidence of mental health problems (Chakraborty, McManus, Brugha, Bebbington, & King, 2011), and higher rates of smoking (Blosnich *et al.*, 2013) that eventually lead to

⁹ Although King *et al.*, (2012) only focus on LGB people, it is perhaps reasonable to extend this proposition to include trans and intersex people.

poor physical health (Elliott *et al.*, 2015). Minority stress operates where marginalised groups display specific risk factors (Lyons, Hosking, & Rozbroj, 2015). Whilst the entire population may display a particular risk factor, the incidence and effects of these risk factors may be more pronounced in smaller subsections of the larger population (Goldbach, Tanner-Smith, Bagwell & Dunlap, 2014; Semleyn *et al.*, 2016). Victimization can be experienced by both LGBTI and any other young people, but for LGBTI youth their victimization is often a direct consequence of their sexual orientation, gender identity, and/or sex characteristics.

In a recent meta-analysis of research exploring minority stress and substance use amongst sexual minority young people, LGB young people up to the age of 25 were found to have almost three times higher rates of substance use, compared to non-LGB people (Goldbach *et al.*, 2014). Results from 12 unique studies of LGB youth identified risk factors associated with these inequalities in substance (mis)use including: victimization, psychological stress, the absence of supportive environments, internalising/externalising problem behaviour, adversity LGB young people experienced following negative disclosure experiences, and housing status (Goldbach *et al.*, 2014).

The stress and loss of wellbeing LGB youth experienced related to negative reactions of family, friends and peers after they 'came out' or disclosed their orientation were significantly correlated to substance use. A further correlation was found between perceived parental support and support from other adults to mitigate against substance use amongst LGB young people. Therefore, LGB young people who perceived less support from parents and other adults showed higher levels of substance use, compared to lower rates of substance use in LGB peers who perceived that they had experienced good social support (Goldbach *et al.*, 2014).

A further risk factor the Goldbach *et al.*, review identified was the length of time it took LGB young people to come 'out' or disclose their sexual orientation. The length of time taken was positively correlated to rates of substance use. Aligned to minority stress theory, those with increased internal homophobia or those who experienced resistance or rejection when they 'came out', are likely to experience more stress and therefore have a higher incidence of substance use (Goldbach *et al.*, 2014).

3.2.4 Victimization

Katz-Wise & Hyde (2012) conducted a meta-analysis to appraise and synthesise findings from 138 research studies on LGB individuals' experiences of victimization, and a further 65 studies on heterosexual people involving over 500,000 participants across the USA and 18 additional countries across six continents. The review found accounts of self-reported victimization of LGB individuals were substantial with 55% experiencing verbal harassment, 45% experiencing sexual harassment, 44% experiencing relational victimization, and 43% general victimization. Victimization in this context included discrimination and physical assault. Gender differences were minor, for example some LGB males experienced slightly raised levels of weapon assault, being robbed, and sexual harassment (Katz-Wise & Hyde, 2012).

The review concluded that LGB people continue to experience significant levels of victimization and no types of victimization has decreased compared to earlier research undertaken. Encouragingly however, is that the authors reported how many LGB people appear to be

increasingly willing to report experiences of victimisation to appropriate authorities, and that greater tolerance and acceptance of sexual diversity is resulting in a small to moderate difference in victimisation rates of LGB people (Katz-Wise & Hyde, 2012).

In addition, the Goldbach *et al.*, (2014) meta-analytic review of research exploring minority stress and substance use amongst sexual minority young people which included five studies on LGB victimisation of young people, found that homophobic taunting and general victimisation, had a significant correlation to an increased prevalence of substance use amongst LGB youth. Consequently, the authors argue that targeted initiatives are needed for LGB youth to help them learn how to avoid and cope with victimisation by peers, and to make options available for mentoring that will enhance perceived support from adults. Support from parents and other community elders may well act as a protective factor for LGB youth (Goldbach *et al.*, 2014) and should be considered in the design of targeted initiatives.

3.2.5 Individual discrimination

Across the lifespan, research has found that most LGBT people have experienced discrimination ranging from hostility, personal rejection, harassment, bullying and personal violence (Haas *et al.*, 2010). Personal rejection by parents has been found not only to be linked to higher rates of substance misuse in LGBT youth, but also to a higher risk of suicide attempts (Haas *et al.*, 2010). LGBT young people who had experienced rejection from parents were eight times more likely to attempt suicide compared to those who had accepting and supportive parents (Haas *et al.*, 2010).

In a large-scale representative survey of the UK population living in private households (n=7,403) research by Chakraborty *et al.*, (2011) found that discrimination based on sexual orientation was frequently reported by LGB people. 4.9% of LGB people who responded to the survey, said that they had experienced discrimination based on their sexual orientation in the past year, compared to 1.6% of heterosexuals. (Individual) discrimination contributed to the higher incidence of mental health problems such as anxiety, depression and other stress related mental health problems amongst in LGB people resulting in a greater need for access to mental health services (Chakraborty *et al.*, 2011).

During the last two decades, consensus has increased amongst scholars and researchers that discrimination, social stigma and prejudice associated with LGBT sexual orientation and gender identity is in part responsible for the raised levels of suicide attempts and mental health problems found in LGBT people (Haas *et al.*, 2010; King *et al.*, 2008). Furthermore, research attributes higher levels of disability and poor physical health amongst older LGB adults due to the effects of discrimination across the lifespan (Fredriksen-Goldsen & Muraco, 2010; Fredriksen-Goldsen, Emler, Kim, Muraco, Erosheva, Goldsen, & Hoy-Ellis, 2012a; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013)

3.2.6 Institutional discrimination

Institutional discrimination occurs where laws and policies in the public domain generates and/or sustains inequalities, for example such as the prohibition of same-sex marriage or where laws do not protect against discrimination based on sexual orientation and gender

identity (Meads *et al.*, 2012)¹⁰. In a review of suicide and suicide risk in LGBT populations, Haas *et al.*, (2010) reports on primary research by Hatzenbuehler and colleagues (2009) which demonstrated that where LGB people are not protected against discrimination in employment, there is an increased incidence of mental health problems relating to mood, anxiety and increased substance use compared to the general population who lived in the same areas. Similarly, for LGB people living in areas where there are no protective policies, mental health problems can be about five times higher (Hatzenbuehler, Keyes, & Hasin, 2009).

Aligned to these findings, further research by Hatzenbuehler and reported by Haas *et al.*, (2010) found that in American States¹¹ where same-sex marriage was banned, the incidence of mental health problems in LGB people increased over time. Mood disorders increased from 23% to 31% amongst LGB participants, anxiety disorders increased from 3% to 9%, and alcohol misuse changed from 22% to 31%. Thus, in American States where LGB people experienced institutional discrimination due to lack of protection and respect of their fundamental rights, higher rates of mental health problems were evident (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010).

3.2.7 Stigma

Stigma comprises three different but related elements: anticipated stigma where LGBTI people show apprehension due to potential future occurrences of stigmatisation; internalised stigma where people devalue themselves as a result of their sexual orientation, gender identity or sex characteristics; and enacted stigma where people experience real instances of discrimination (Whitehead, Shaver, & Stephenson, 2016). Each strand of stigma may affect health-seeking behaviour in a specific way. For instance, anticipated stigma may create an environment where LGBTI people evade or postpone gaining access to treatment and care settings, as they may experience discrimination in these settings. Indeed, in systematic review and meta-synthesis comparing the perceptions of men who have sex with men (MSM) and healthcare providers on the barriers to uptake of HIV/AIDS-related interventions, the authors report how in all the qualitative studies reviewed and a large proportion of the quantitative studies reviewed (43%), stigma and discrimination emerged as the most frequently and intensely cited barrier to healthcare; for instance, some MSM and trans people reported being deterred from seeking HIV testing and treatment as they feared discrimination or encountering the stigmatising attitudes of health professionals (Wao *et al.*, 2016).

Similarly, in a study examining the relationship between stigma, disclosure and 'outness' and the utilisation of primary care services, Whitehead *et al.*, (2016) recruited LGBT participants residing in rural areas of the United States (U.S.). Amongst other things, the authors found that higher scores on stigma scales were associated with lower use of health services for trans (including non-binary) people. Moreover, high levels of disclosure of sexual orientation were associated with greater utilisation of health services for cisgender men. The authors concluded that these findings demonstrate the role of stigma in shaping access to primary healthcare amongst LGBT people. Furthermore, such findings indicate the need for interventions which

¹⁰ Although discrimination on the grounds of sex characteristics was not mentioned in this paper, it nevertheless represents a further example of how inequalities can be generated and sustained due to a lack of protection by law and policy.

¹¹ We recognise that the cultural contexts vary between US and EU.

focus on tackling and reducing stigma in healthcare settings as well as interventions or systems which can facilitate LGBT people's disclosure of sexual orientation and/or gender identity (Whitehead *et al.*, 2016).

SECTION FOUR: What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

4.1 Introduction

Following on from the brief exploration of some of the main root causes of health inequalities, this Section presents some of the known health inequalities experienced by LGBTI people in the context of healthcare settings. As with Section 3, the paragraphs that follow are drawn from the research papers extracted via the review protocol (Section 2). It is therefore not intended to be a comprehensive account of what is known about health inequalities experienced by LGBTI people. However, where issues are particularly pertinent but not evident in the research papers extracted due to (for example) a dearth of research in the field, we draw attention to alternative sources that we have not reviewed as they sit outside the protocol, but that might provide useful sources of further information (such as grey literature).

This Section begins by providing a brief and broad overview of research that draws attention to some of the health inequalities experienced by LGBTI people addressing issues relating firstly to physical health, and then mental health. Following sub-sections then explore health issues for lesbian, gay, bisexual, trans and intersex people in more depth, by providing a summary of the most pertinent health inequalities for each population group as it relates to healthcare settings.

4.2 Physical health

Physical health includes general perceptions of health. One of the largest studies worldwide conducted used observational data from the 2009-10 English General Practice Patient Survey (Elliott *et al.*, 2015), involved over 2 million participants (n=2,169,718) including 27,497 LGB people. The study compared the health and healthcare experiences of LGB participants to heterosexual participants. Findings suggested that people self-identifying as LGB were more likely to report fair/poor health compared to people identifying as heterosexual although the differences were small (see also Fredriksen-Goldsen *et al.*, 2013). For example, although relatively small differences via weighted analyses, of the heterosexual men in the sample, 19.6% reported health problems whereas 21.8% of gay men in the sample and 26.4% bisexual men reported poor health. For heterosexual women, 20.5% had fair/poor health compared to 24.9% of lesbian women and 31.6% of bisexual women. As a result, the authors concluded that LGB people report significantly worse physical health and healthcare experiences than heterosexual people (Elliott *et al.*, 2015; see also Gonzales & Henning-Smith, 2015).

In this current section (4.2), we only outline briefly the research findings in relation to one physical health issue, cancer. For pragmatic and presentational reasons including reducing unnecessary repetition, further examples of physical health inequalities experienced are presented later under L.G.B.T.I. specific headings.

4.2.1 Cancer

International research trends suggest that LGB people are at a higher risk of developing certain types of cancer compared to the general population. Moreover, LGB people are commonly diagnosed with cancer at a younger age (Boehmer, Miao, & Ozonoff, 2011a; Boehmer, Ozonoff, & Miao, 2011b). A synthesis of four systematic reviews showed that gay and bisexual men are twice as likely to report a diagnosis of anal cancer with those who are HIV-positive being at the highest risk (Blondeel *et al.*, 2016). Rates of anal cancer in gay and bisexual men are similar to the prevalence of cervical cancer in general female populations prior to the introduction of cervical screening programmes (Blondeel *et al.*, 2016). This evidence supports the need for anal screening programmes for gay and bisexual men. As for breast cancer in lesbian and bisexual women, research findings have been contradictory and contested. However, a systematic review by Meads & Moore (2013) on the incidence of breast cancer in lesbian and bisexual women concluded that there is no convincing evidence of higher rates of breast cancer in these women. More recent reviews of cancer have identified a significant gap in high quality international research to address the cancer burden and care needs of trans people (Blondeel *et al.*, 2016). Further detail of cancer prevalence in lesbian women, gay men and bisexual people are presented for each subgroup in the sections that follow.

4.3 Mental health

International research findings suggest that LGBTI people are at significantly higher risk of experiencing mental health problems compared to the general population (Bauer, Scheim, Pyne, Travers, & Hammond, 2015; Elliott *et al.*, 2015; King *et al.*, 2008; see also Gonzales, Przedworski & Henning-Smith, 2016; Mead *et al.*, 2012). Mental health inequalities follow on from discrimination and marginalisation experienced by LGBTI people, and is not inherent to sexual orientations, gender identities or sex characteristics as discussed in the previous section.

A pivotal systematic review on the incidence of mental disorder, substance misuse, suicide, suicidal ideation and deliberate self-harm in LGB people by King *et al.*, (2008) reviewed international research (25 studies) and extracted data on 214,344 heterosexual people and 11,971 lesbian, gay, and bisexual people. Results indicated significant inequalities with LGB people being at higher risk of mental disorders, suicidal ideation, substance misuse and deliberate self-harm compared to heterosexual people. The main findings revealed that the risk of lifetime suicide attempts in LGB people were 2.47 times higher, more than double compared to heterosexual people; suicidal ideation was twice as high in LGB people compared to heterosexual people; depression and anxiety disorders for the previous 12 months or over a lifetime were 1.5 times higher for LGB compared to heterosexual people; and alcohol or related substance dependence over the previous 12 months was 1.5 times more common in LGB people than heterosexual people (King *et al.*, 2008).

Deliberate self-harm is a major cause of acute medical admissions in the UK. The prevalence of self-harm increased steadily during the 1990s to peak at a rate of 400 per 100,000 people per year in the UK, one of the highest rates in Europe (King *et al.*, 2008). Research estimates that over 50% of all people who self-harm in the UK are LGB (Meads *et al.*, 2012).

In Elliott *et al.*'s (2015) large scale analysis of observational data from the English General Practice Patient Survey (n=2,169,718), the authors found that LGB people (n=27,497) are twice to three times more likely to report an enduring psychological or emotional problem compared to heterosexual people. Of heterosexual men in the sample, 5.2% reported a psychological or emotional problem compared to 10.9% and 15% for gay and bisexual men respectively. Similarly, for heterosexual women 6% reported psychological or emotional problems compared to 12.3% and 18.8% for lesbian and bisexual women respectively.

Such findings that demonstrate the existence of mental health inequalities for LGB people were confirmed by a very recent systematic review that pooled data from 12 population surveys in the UK and undertaken between 2011-2013 (Semleyn *et al.*, 2016). In total, the surveys involved 94,818 participants including heterosexual, gay, lesbian, and those who self-identified as 'other than heterosexual'. Findings from this review showed that lesbian and gay participants had a higher incidence of common mental disorder when compared to heterosexual participants. These research outcomes are consistent with the King *et al.*'s (2008) systematic review and other studies underpinning a dominant international narrative that significant inequalities exist when comparing the mental health and wellbeing of LGB groups to heterosexual populations (e.g. Chakraborty *et al.*, 2011; Meads *et al.*, 2012).

The next series of sub-sections provide brief overviews of the health inequalities of lesbian, gay, bisexual, trans and intersex people, specific to each group. The most pertinent health inequalities for each group, as revealed by the research papers included in this present review are discussed. Special reference will be made in terms of access to healthcare. For each group (L.G.B.T.I), findings are presented firstly in terms of general health (including physical health such as cancer and weight), mental health (e.g., depression, suicide ideation) and other issues including, as examples, stress, and substance (mis)use. Varying levels of detail, coverage, and topics reflect the research papers extracted.

4.4 Lesbian women¹²

Significant health inequalities exist for lesbian including bisexual women, often largely related amongst other things to experiences of stigma, discrimination, homophobia and heteronormativity in healthcare. Drawing on qualitative data collected via an online survey (n=5,909) with lesbian (and bisexual women), Fish & Bewley (2010) consider how these women's health should be considered as a health inequality. Lesbian and bisexual women can have very specific healthcare needs (e.g. sexual and cervical health, reproductive health and parenting, mental health, substance use, etc.) and such inequalities can ultimately lead to poor health outcomes (see also Fredriksen-Goldsen, Kim, Barkan, Balsam, & Mincer, 2010; Gonzales *et al.*, 2016). In the sections that follow, some of these specific aspects of lesbian women's health are explored reflecting the focus of the research papers extracted via the SR review protocol. These aspects include general/physical health such as polycystic ovaries, cancer prevalence with related cancer survival and support; suicidal attempts and substance misuse; and weight discrepancies.

¹² Trans and intersex people can identify as lesbian, gay, bisexual or heterosexual. Therefore these sections and the research they draw on might include trans and intersex people. However, the specific implications for trans lesbians, for example, cannot be read from these studies.

4.4.1 Polycystic ovaries

A systematic review by Meads *et al.*, (2012) reports on a study exploring causes of infertility in 254 lesbians, compared with 364 heterosexual women (see Agrawal *et al.*, (2004). The authors of the study found a higher rate of polycystic ovaries (80% vs. 32%) as well as higher rates of polycystic ovary syndrome (38% vs. 14%) in lesbian women compared to heterosexual women. Meads *et al.*, (2012) propose that there is a need for follow-up research to gain a better understanding of the prevalence of polycystic ovaries in lesbian women and underlying causes.

4.4.2 Cancer prevalence

A systematic review of breast cancer in lesbian and bisexual women (Meads & Moore, 2013), included nine research studies that assessed the incidence of breast cancer for these groups. Two studies indicated a higher prevalence of breast cancer in lesbian and bisexual women compared to women in general. Four studies indicated a negligible difference whereas one study showed mixed findings and two studies could not be equated. However, although the systematic review followed an established protocol for conducting such reviews, the appraised research contained small sample sizes and thus any conclusions should be tentative. Overall, the review found that evidence supporting higher prevalence of breast cancer amongst lesbian and bisexual women is inconclusive (Cochran & Mays, 2012; Meads & Moore, 2013).

With regards to cervical cancer, Meads *et al.*, (2012) note that it has been (wrongly) assumed previously that lesbian women and bisexual women are at lower risk of cervical cancer than the general population. The authors go on to that only around 50% of lesbian and bisexual women attend cervical screening programmes in the UK resulting in health professionals not always asking the right questions or offering routine screening due to such erroneous beliefs concerning risk. Given a high proportion of lesbian women and bisexual women report having heterosexual sex before the age of 16, it is possible these women could be at an increased risk of developing cervical cancer thereby substantiating the need for cervical screening programmes for lesbian and bisexual women to ensure early detection and access to treatment (Meads *et al.*, 2012).

4.4.3 Cancer survival and support

Research shows that cancer survivorship of lesbian and bisexual women in same-sex couples compared to women in heterosexual relationships is poorer. In Cochran & Mays' (2012) survey study utilising a large U.S. representative sample of married and cohabiting women who reported either a male (n = 136,174) or female (n = 693) co-residential relationship partner, women who lived with a same-sex partner showed a 3.2 times higher age-adjusted risk of dying from breast cancer. In terms of cancer survivorship, a recent systematic review from the UK by Hill & Holborn (2015) focused on studies researching LGB peoples' experiences of cancer care. In their review, the authors report on a mixed-methods study which found that lesbian and bisexual women who accessed treatment for breast cancer with partners, were more resilient and showed lower levels of emotional distress, whereas women without partners were more fatalistic (see Boehmer, Linde, & Freund, 2005). Hill & Holborn (2015) also draw on a small qualitative study of long-term breast cancer survivors. The authors describe how women with female partners, report that their female partner was a valuable

source of emotional and psychological support. Hill & Holborn (2015) comment that the support needs of sexual minorities are largely similar to that of heterosexual cancer patients but that sexual minority individuals may not have the same access to these mechanisms of support. The authors argue that further research is required on sexual minorities affected by cancer in order to not only increase the evidence base, but to identify support needs.

In a large study (n=122,345 comprising n=51,233 men and n=71,112 women) designed to address the cancer surveillance gap in lesbian, gay, and bisexual populations and thus also the dearth of information about the cancer survivorship, Boehmer and colleagues (2011a) examined the prevalence of cancer survivorship disaggregated by sexual orientation and cancer survivors' self-reported health also disaggregated by sexual orientation. Amongst women, although no significant differences were found in cancer prevalence by sexual orientation, lesbian and bisexual female cancer survivors were 2.0 and 2.3 times the odds of reporting fair or poor health compared with heterosexual female cancer survivors. The authors thus argue that lesbian and bisexual survivors of cancer may need additional support post treatment to help them regain their sense of health and wellbeing (Boehmer *et al.*, 2011a).

In their systematic review of sexual minority experiences of cancer care, Hill & Holborn (2015) report on a U.S. based study designed to determine factors that influence sexual minority women's coping responses and adjustment to breast cancer. Using a telephone-based questionnaire survey with participants recruited from a cancer registry, Boehmer and colleagues (Boehmer, Glickman, Winter, & Clark, 2014) compared the coping strategies of heterosexual people with lesbian and bisexual women with breast cancer. The authors found that women who self-identified as lesbian or bisexual had more adaptive coping strategies and were less fatalistic than heterosexual survivors. Coping strategies could have been developed over time due to other experiences of adversity such as discrimination and marginalisation where lesbian and bisexual women have developed the ability to persevere through adversity. However, the emotional and psychological support needs of these women remain pertinent during cancer survivorship. Specialist services are required to support these women (Hill & Holborn, 2015).

4.4.4 Suicidal attempts and substance mis(ue)

In their systematic review and meta-analysis of the prevalence of mental disorder, substance misuse, suicide, suicidal ideation, and deliberate self-harm in LGB people, King *et al.*, (2008) reported that lesbian and bisexual women were 1.82 times higher risk of suicide attempts compared to heterosexual women. These figures are supported by Meads *et al.*, (2012) who report on a study showing that in a sample of 6,178 lesbian and bisexual women, 5% had attempted suicide in the past year, and 20% had deliberately harmed themselves during the same period (see Hunt & Fish, 2008). King *et al.*, (2008) did not find any conclusive evidence to support higher prevalence of anxiety disorders for lesbian and bisexual women due to heterogeneity of the research methods used in the included studies. However, lesbian and bisexual women were reported as being at higher risk of developing alcohol and drug dependence compared to heterosexual women.

4.4.5 Weight discrepancies

A systematic review on weight discrepancies in lesbian and bisexual women included 20 population-based and 17 non-probability sample studies from the USA, UK and Australia (Eliason *et al.*, 2015; see also Fredriksen-Goldsen *et al.*, 2013). The bulk of the research appraised by the authors indicated that lesbian and bisexual women were at substantially higher risk of raised weight compared to heterosexual women. Lesbian and bisexual women showed significantly increased body mass index (BMI) or a higher ratio of BMI over 30. Across the lifespan the variance in BMI was reasonably consistent with the increase in weight beginning during puberty. However, the research reviewed by Eliason and colleagues (2015) found that raised weight might not be as closely linked to physical health problems and related negative health outcomes as previously thought. In other words, this unexpected finding suggested that a higher prevalence of physical disorders was not consistently associated with increased weight. The absence of a correlation between excess weight and physical conditions suggests that weight might not be a major driver of physical health inequalities amongst lesbian and bisexual women (Eliason *et al.*, 2015). This could be due to a range of protective factors in lesbian and bisexual women that may mitigate against the harmful effects of weight. Protective factors that helped to maintain health with increased weight were reported to be higher rates of physical activity amongst lesbian and bisexual women, and a reduced inclination to dieting resulting in less exposure to cyclical weight patterns, where weight is lost and regained in repetitive cycles over time (Eliason *et al.*, 2015).

4.5 Bisexual people

Recent research using observational data from the 2009-10 English General Practice Patient Survey (Elliott *et al.*, 2015) indicates that health inequalities based on sexual orientation are pronounced for bisexual people compared to heterosexual, gay, and lesbian participants (see also Meads *et al.*, 2012; Fredriksen-Goldsen *et al.*, 2010; Fredriksen-Goldsen *et al.*, 2012a; Fredriksen-Goldsen *et al.*, 2013; Gonzales *et al.*, 2016). In the following sub-sections, research relating to the health inequalities experienced by bisexual people is covered briefly based on the research papers extracted via the protocol (Section 2) and include aspects of general/physical health (cancer), mental health, substance (mis)use including stress.

However, worthy of note is that few of the papers reviewed for this SR focused specifically on issues relating to bisexual people. There are likely various reasons for this lack of focus relating to issues such as definition (e.g. behavioural or identity-related), challenges in recruitment (e.g. a behaviourally bisexual people may not necessarily self-identify as bisexual), as well as initial research design and analysis. For example, in terms of the latter Chakraborty *et al.*'s (2011) study on the prevalence of mental disorder, self-harm and suicide attempts to sexual orientation in England, only used binary categories of either heterosexual or non-heterosexual. Although the 'non-heterosexual' category included respondents describing their sexual identity as 'mostly heterosexual' and as 'other' as well as gay, lesbian and bisexual, the resulting analysis makes it impossible to draw out specific implications for bisexual people (or other sexual minorities) despite data on self-identity being collected¹³.

¹³ Sexual identity is used here rather than sexual orientation to reflect the original study which used a self-perceived sexual identity five-point response scale (see also Haseldon & Joloza, 2009).

4.5.1 General/physical health¹⁴

In Elliott *et al.*'s (2015) weighted analysis of observational data involving 2,169,718 people including 27,497 people identifying as LGB, the proportion of bisexual men that reported fair/poor general health was higher compared to heterosexual men although the differences were small (26.4% vs. 19.6% respectively). Similar patterns (albeit larger differences) were also observed for bisexual women with 31.6% reporting fair/poor general health compared to 20.5% of heterosexual women in the sample. Other research also notes significant differences in cancer prevalence between LGB and heterosexual populations. For example, Boehmer *et al.*, (2011a) reported that incidence of cervical cancer amongst bisexual women was more than twice that of other women.

4.5.2 Mental health

Research suggests that sexual minorities are two to three times more likely than the heterosexual population to experience enduring psychological and emotional difficulties (Elliott *et al.*, 2015; see also Gonzales *et al.*, 2016). For instance, data from the General Practice Patient Survey revealed bisexual men and women were more likely to report experiencing a longstanding psychological or emotional condition (15% and 18.8% respectively) compared to both other sexual minorities (10.9% gay, 12.3% lesbian) and heterosexual participants (6% heterosexual women, 5.2% heterosexual men; Elliott *et al.*, 2015; see also Fredriksen-Goldsen & Muraco 2010; Fredriksen-Goldsen *et al.*, 2013). Thus these results show the highest rates of enduring emotional and psychological conditions amongst LGB groups (Elliott *et al.*, 2015).

Similarly, in a self-completion survey with community-based, opportunistic sampling of 937 bisexual-identified and 4,769 lesbian-identified women, Colledge, Hickson, Reid, & Weatherburn (2015) reported that more bisexual women reported poor mental health or psychological distress than did lesbian women. The authors found that bisexuals were more likely to report an eating problem, more likely to have deliberately self-harmed in the past year, more likely to have felt sad/miserable or depressed in the last year, and more likely to have felt anxious or nervous in the last year, compared with lesbian women. The authors proposed that these findings may be due to bisexual women being more likely to experience social stress due to the 'double discrimination' of homophobia and biphobia.

In a national cohort study in the U.S. (n=68,814) of LGB adults (including n=515 bisexual people), Gonzales *et al.*, (2016) found the highest prevalence and odds of psychological distress amongst bisexual adults. For instance, bisexual men were significantly more likely to report severe psychological distress compared to heterosexuals as were bisexual women. In line with Colledge *et al.*, (2015), the authors propose this may be because bisexual people are not only marginalised by the larger heterosexual population, but may also experience stigma and discrimination from gay and lesbian people leading to fewer social connections and social isolation which is a key risk factor for psychological distress (Gonzales *et al.*, 2016).

¹⁴ Although out of scope for this review, additional useful information on the health of lesbian and bisexual women can be found from the LGBT Foundation (see www.lgbt.foundation; see also LGBT, 2013).

Hickson and colleagues (Hickson, Davey, Reid, Weatherburn, & Bourne, 2016) also note that sexual minorities such as gay and bisexual men suffer worse mental health than heterosexual populations. Analysis of data from the Stonewall Gay & Bisexual Men's Health Survey (n=5,799) which was an online community-based survey commissioned by Stonewall¹⁵, the authors note how mental ill-health amongst gay and bisexual men was common. 21.3% were reported as being depressed and 17.1% anxious, whilst 3.0% had experienced attempted suicide and 6.5% had self-harmed within the last 12 months. However, the authors do not differentiate between issues for gay men and issues for bisexual men meaning caution must be applied in interpreting these data within this current context.

4.5.3 Substance (mis)use

Research suggests that bisexual women are at higher risk of smoking for weight control and substance dependence, whilst (gay and) bisexual men had nearly twice the odds of being current smokers than heterosexual men (Blosnich *et al.*, 2013; Meads *et al.*, 2012; Gonzales *et al.*, 2016) and being heavy drinkers (Gonzales *et al.*, 2016). Colledge *et al.*, (2015) found that bisexual women are significantly more likely to report poor physical health and use of marijuana or tranquilisers than lesbian women (see also Fredriksen-Goldsen *et al.*, 2013).

In a systematic review and meta-analysis on minority stress and substance use in sexual minority adolescents, Goldbach *et al.*, (2014) note how high rates of substance misuse exist amongst LGB adolescents, at almost three times the rate of their heterosexual adolescents. The authors found negative disclosure reactions were rated to higher rates of substance misuse amongst LGB youth. However, as with other studies the authors did not disaggregate the data by sexual orientation meaning it is difficult to draw conclusions about bisexual people specifically.

Similarly, although the search protocol for this current SR did not include MSM (or HIV) specifically due to being an already over-researched area, it is important to acknowledge that there is a great deal of primary literature on substance misuse (e.g. Chemsex and injecting drug use, smoking, and alcohol) and MSM which includes bisexual men.¹⁶

4.6 Gay men

Research confirms that gay and bisexual men experience disproportionate health inequalities compared to the general male population (Bourne *et al.*, 2016; see also Blondeel *et al.*, 2016; Boehmer, Miao, Maxwell, & Ozonoff, 2014; Elliott *et al.*, 2015; Hill & Holborn, 2015; Meads *et al.*, 2012). As noted in this present SR literature exclusion criteria (see Section 2.2.2), abundant research (and reviews of research) is available on the HIV/AIDS and other STIs focusing on gay, bisexual and other MSM and thus is not included as part of the scope of this current task. Instead, as relatively less is known about the general health of gay men, it was decided to focus instead on less 'well-rehearsed' aspects of gay men's health.

As with bisexual men, few of the papers reviewed for this SR focused solely on issues relating to gay men and instead commonly aggregate gay, bisexual men, and other men who have

¹⁵ A UK charity promoting the rights of lesbian, gay, bisexual and since 2014, trans men and women.

¹⁶ For examples, see Heath *et al.*, (2012); Mirandola *et al.*, (2016); Vosburgh *et al.*, (2012).

sex with men (e.g. including men whom may also have sex with women; MSMW) in the design and analysis. In the sub-sections that follow, the health of gay men are discussed in more detail relating to physical health, weight, cancer, and mental health including substance (mis)use. Where bisexual or other MSM are included this is noted.

4.6.1 Physical health

In one large scale study designed to compare the health and healthcare experiences of sexual minorities with heterosexual people of the same gender, adjusting for age, race/ethnicity, and socioeconomic status, Elliott *et al.*, (2015) found that in general, sexual minorities (in this case, defined as LGB) were more likely to report fair/poor general health than heterosexuals although the differences were small (see also Gonzales *et al.*, 2016). Such findings are aligned to a systematic review conducted by Meads *et al.*, (2012). In their review, Meads and colleagues report on the findings from the Gay Men's Sex Survey (see Weatherburn *et al.*, 2005) which revealed that 10.2% of gay men in the sample had long-term conditions or a disability that restricted their activities of daily living and their ability to work (n=1632/16002). Most prevalent health problems in the total sample (n=16,002) included musculoskeletal problems such as arthritis, spinal problems, and nerve damage or chronic fatigue syndrome in 3.4% of gay male participants. Moreover, in a further study reported by Meads *et al.*, (2012) up to 5% of gay and bisexual men (n=1,754) had gastrointestinal problems, cancers, liver and kidney problems (see Reid *et al.*, 2002). Incidents of cancer in gay men are explored below.

4.6.2 Cancer prevalence

Amongst gay men, most research reports a higher prevalence of some forms of cancer compared to heterosexual men. Large-scale country-level health surveillance in the USA (n=122,345) found that gay men were almost twice as likely to report a cancer diagnosis compared to heterosexual men; Boehmer *et al.*, 2011b; Hill & Holborn, 2015). A narrative synthesis of 30 systematic reviews spanning international research on the disease burden in gender and sexual minority people, found that in MSM (including gay men) anal human papilloma virus (HPV) is common, as is hepatitis B (HBV) and human herpesvirus 8 (HHV-8) infections. Such viruses can lead to anal cancer, liver cancer and Kaposi sarcoma, respectively (Blondeel *et al.*, 2016). Reporting on Machalek *et al.*'s (2012) systematic review and meta-analysis, Blondeel and colleagues note how the HPV virus was not only common in HIV-negative MSM but alarmingly so in HIV-positive MSM (pooled prevalence of 53.6% vs. 89% respectively). This means that many MSM including gay men are generally at a high risk of anal cancer, but gay men who are HIV-positive are at the highest risk of developing anal cancer (Blondeel *et al.*, 2016).

In a systematic review of worldwide literature with the aim of ascertaining the experiences of sexual minority cancer patients and identify specific needs required, Hill & Holborn (2015) report that some gay men with prostate cancer experience significant body changes such as surgical scars, loss of sexual function, and weight gain leading to changes in physical appearance that resulted in a negative body image. Moreover, Hill & Holborn report on research that demonstrates how some gay men experienced negative attitudes from their communities impacting on their relationships, and in a further study the body image of gay

men was more closely associated with wellbeing compared to heterosexual men (Hill & Holborn, 2015).

4.6.3 Weight discrepancies

A systematic review by Meads *et al.*, (2012) found that the rate of eating disorders in gay (and bisexual) men was approximately 7% extrapolating that in the English context, this could mean that there are 875,000 gay and bisexual men with an eating disorder.

In a cross-sectional study with gay and bisexual men, Bourne *et al.*, (2016) found that 44% of gay and bisexual men in the sample were overweight (n=2498/5694). The ratio increased sequentially with age where gay men over the age of 45 years were more than twice likely to be overweight, compared to those under 25 years. Thus older gay and bisexual men were more likely to be overweight (Bourne *et al.*, 2016). Moreover, educational status showed a correlation to weight where gay and bisexual men with an upward level of education, showed lower rates of being overweight (Bourne *et al.*, 2016). Compared to all UK adult males, 62% had low levels of physical activity (n=3547/5761).

4.6.4 Mental health

Continuing with the same cross-sectional survey as Bourne *et al.*, (2016) but reporting this time on England, Scotland and Wales (n=5,799) Hickson *et al.*, (2016) report that that gay (and bisexual) men experience worse mental health compared to heterosexual men. This research found that 21.3% (n=1155/5416) of the gay and bisexual men in the sample were depressed. Rates of depression were higher for those who are a member of a visible ethnic minority group and bisexual people (Hickson *et al.*, 2016). Furthermore 17.1% (n=949/5556) of gay and bisexual men reported being anxious.

In research from the U.S., Gonzales *et al.*, (2016) drew on data from the nationally representative National Health Interview Survey in order to compare health outcomes amongst lesbian (n=525), gay (n=624), and bisexual (n=515) adults who were 18 years or older with heterosexual adults (n=67,150). The authors found that gay men were significantly more likely than heterosexual men to report severe psychological distress.

4.6.5 Suicidality

In general, research appears to suggest that LGB people are at the highest risk of attempted suicide compared to the general population. Indeed, gay and bisexual men in particular show disproportionate higher rates of completed suicide when compared with suicidal death rates found in the general population (Haas *et al.*, 2010).

In their systematic review of LGB people's health Meads *et al.*, (2012) report on a study by Bolding and colleagues (2002; n=772) which found that 13% of gay and bisexual men attending gyms had had suicidal thoughts in the previous six months. Similarly, in a meta-analytic study, King *et al.*, (2008) indicate that gay and bisexual men are at two-fold higher risk of suicide attempts in the preceding year compared to heterosexual men, and four times higher risk of suicide attempts over a lifetime. Thus, in comparison to heterosexual men, gay

men show a higher risk of lifetime prevalence for attempted suicide and deliberate self-harm (King *et al.*, 2008).

In Hickson *et al.*'s (2016) cross-sectional survey, the authors found that up to 3% (n=171/5739) of gay and bisexual men had attempted suicide. However, cohabiting with a same-sex male partner appeared to be a protective factor for some against depression, anxiety and attempted suicide (Hickson *et al.*, 2016). Cohabitation and marriage has been shown to contain health benefits due to the companionship and related psycho-social support that has a buffering effect against emotional distress and mental illness (Hickson *et al.*, 2016). Findings in this study also revealed that suicidal risk was raised for younger gay and bisexual men and for those with lower education and lower income leading the authors to propose that community interventions to increase mental health amongst gay and bisexual men should be designed to disproportionately benefit younger men and those living on lower incomes.

4.6.6 Substance (mis)use

Gonzales *et al.*'s, (2016) large cohort study from the U.S. found that gay men were significantly more likely than heterosexual men to report heavy drinking (OR, 1.97), and moderate smoking (OR, 1.98).

Bourne *et al.*'s (2016) survey found more than 43% of a sample of gay and bisexual men in England (n=2505/5770) drank alcohol on four days per week or more during the previous week. Of those men, alcohol consumption was highest for those over the age of 45 and lowest for men aged 16 to 35. Findings suggest that alcohol consumption increased with raised income (Bourne *et al.*, 2016). Around 25% of gay and bisexual men who participated in the Bourne *et al.*, study smoked tobacco (n=1469/5755). Smoking decreased with age and the incidence of smoking was lowest for men aged 45 and over. A strong association was found between lower income and smoking, whereas those with higher education smoked less (Bourne *et al.*, 2016; see also Fredriksen-Goldsen *et al.*, 2013). In a systematic review of the literature examining risk factors and correlates of cigarette smoking amongst LGB populations, Blosnich *et al.*, (2013) report on a study showing that gay men who attended gay bars more frequently were considerably more likely to smoke than those attending infrequently (see Stall *et al.*, 1999).

In their systematic review and meta-analysis of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people, King and colleagues (2008) report gay and bisexual men are at 2.4 times higher risk of developing drug dependence compared to heterosexual men. These findings corresponded to research by Bourne *et al.*, (2016) that found 19% of gay and bisexual men had used illicit drugs during the past month (n=1103/5755). Illicit drug use was highest in gay and bisexual men aged 25 to 45, and lower in those aged 45 and beyond. Thus, older gay and bisexual men were less likely to use illicit drugs, but more likely to drink alcohol frequently. Overall substance use figures suggested that health inequalities exist with highest rates of substance use by gay and bisexual men aged 25 to 45 (Bourne *et al.*, 2016)¹⁷.

17 'Chemsex' as a type of substance (mis)use is increasing in prevalence among gay, bisexual, and other MSM who use crystal methamphetamine and other drugs in the context of sexual activity, leading to an increased risk of STIs and HIV, but also the risk for psychosis

4.7 Lesbian, gay, and bisexual access to healthcare¹⁸

4.7.1 Primary Care

In Elliott *et al.*'s (2015) large-scale analysis of observational data from the English General Practice Patient Survey, the authors compared the health and healthcare experiences of heterosexual people and LGB people. Findings suggested that LGB people are 1.5 times more likely to report unfavourable experiences of primary care provision compared to heterosexual people (for example, 5.6 % of gay men vs. 3.6 % of heterosexual reported having no confidence or trust in their doctor). These differences between LGB people and heterosexual people were statistically significant across all four domains for lesbian and gay respondents and three out of four domains for bisexual people. These domains included: i) trust and confidence in the doctor; ii) doctor communication; iii) nurse communication; and iv) overall satisfaction. The results showed that the largest differences were apparent for gay men.

4.7.2 Mental health services

In a representative survey of the UK population living in private households (n=7,403) research by Chakraborty *et al.*, (2011) found that bisexual and lesbian women are more likely to seek support and treatment for mental health problems compared to other groups; possibly indicating that there is a greater need for access to mental health services amongst these women (see also Fredriksen-Goldsen *et al.*, 2013). However, the care responses from mental health professionals were not always perceived as appropriate or optimal. As lesbian and bisexual women showed an increased uptake of mental health services and talking therapies¹⁹, their mental health needs are acknowledged and should be accommodated via dedicated services (Chakraborty *et al.*, 2011).

4.7.3 Cancer care

A systematic review of international research examining the needs of LGB cancer patients found that lesbian and gay people have different cancer care needs compared to heterosexual people (Hill & Holborn 2015). The review revealed that some LGB people experience discriminatory attitudes from health professionals for example, lesbian women who were recovering from breast or gynaecological cancer were not offered reconstructive surgery due to the belief that lesbian women would be less likely to access this form of treatment. Here some health professionals asked participants to discuss reconstructive surgery with their 'husbands' not taking into account those who may be lesbian or bisexual (Hill & Holborn, 2015). Discrimination in access to and treatment of LGB cancer care contributed towards the anxiety and depression of cancer survivors. The research reviewed by the authors suggest that LGB support groups may be useful for people who feel isolated after diagnosis, where people can speak about their experiences and gain support from other LGB people in similar circumstances to promote their emotional and psychological wellbeing (Hill & Holborn, 2015).

and other drug induced paranoid. This group of drug users are currently overlooked by drug counselling services as they do not fall into the typical categories of injecting drug users. Therefore, there is a gap in access to healthcare and counselling; however, this gap was not explicitly covered in any of the papers identified via this scientific review.

¹⁸ Note trans and intersex access differs significantly and is explored in Sections 4.8-4.9.

¹⁹ Also referred to as talking treatments or psychological therapies.

Primary research with gay and bisexual men (n=124) recovering from prostate cancer and their partners (n=21) in Australia examined experiences of communication with health professionals. Gay and bisexual men were reported as perceiving a number of deficits in communication with health care professionals. These included: medical support dominating sexual and psychological support; heterosexuality of gay and bisexual patients being assumed; sexual orientation disclosure being problematic, and; perceptions of rejection or lack of interest and knowledge from a majority of health professionals with regard to gay sexuality and the impact of prostate cancer on gay and bisexual men (Rose *et al.*, 2016). The authors argue that emotional support needs to be included in post-treatment that takes into account the emotional vulnerabilities of gay and bisexual men and in doing so, question discourses of hegemonic masculinity within men's health. Health professionals could gain greater awareness of how representations of men as strong and competent may silence some gay and bisexual men, whilst not facilitating conversations in which men can be supported to make meaning of their adversity in emotional or psychological terms (Rose *et al.*, 2016).

Likewise, Rose and colleagues found that disclosure of sexual orientation was often perceived as problematic due to experiences of rejection or a perceived absence of interest and knowledge from many health professionals. Understanding of the impact of prostate cancer on sexuality and body image was limited amongst health providers. Some health professionals framed sexual dysfunction after treatment for prostate cancer as primarily a psychosocial event without acknowledging the impact of functional change. Health professionals should gain access to training to help facilitate sexual orientation disclosure and improve the capacity for conversations that could address the sexual, psychological and relational needs of gay and bisexual men recovering from cancer (Rose *et al.*, 2016).

4.8 Trans people

Trans is used as an inclusive umbrella term referring to those people whose gender identity and/or a gender expression differs from the sex they were assigned at birth, and includes those who define as transgender and transsexual. It includes, but is not limited to: men and women with transsexual pasts, and people who identify as transsexual, transgender, transvestite/cross-dressing, androgyne, polygender, genderqueer, agender, gender variant or with any other gender identity and/or expression which is not standard male or female and express their gender through their choice of clothes, presentation or body modifications, including undergoing multiple surgical procedures²⁰. As noted in Section 1.2 of this SR report, the terms used vary within the research literature. Where terminology, language, or otherwise problematic statements or poor design was present we have added specific caveats and/or made amendments/comments as it important for reviews, research, and other reports to not perpetuate misunderstandings and inaccuracies.

In the sub-sections that follow, a review of general health, mental health and impact of transitioning on trans people is presented below, followed by an overview of access to healthcare.

²⁰ Taken directly from ILGA-Europe's most commonly used phrases and acronyms which can be found here: www.ilga-europe.org/resources/glossary

4.8.1 General health²¹

A recent review of the health and needs of trans people, indicated that across low-income, middle-income and high-income settings globally, trans people experience significant health inequalities with the general health of trans people being the least researched aspect (Reisner, Poteat, Keatley, Cabral, Mothopeng, Dunham, Holland, Max & Baral, 2016). Reisner and colleagues' review considered 116 studies across 30 countries, including 16 projects undertaken in EU Member States. The review found higher rates of HIV and other STIs²², mental distress, substance use and abuse (violence and victimisation) amongst trans people compared to non-trans people. However, the authors point out that there are very few studies on the general health of trans people other than those addressing STIs, diabetes, cancer, and hormone use, and that many aspects of general health inequalities regarding trans people remain understudied (Reisner *et al.*, 2016).

Indeed, a recent narrative synthesis of systematic reviews spanning international research on the disease burden in gender and sexual minority people, found almost no research on the general health of trans men, whilst data on their experiences of accessing healthcare was reported as being sparse (Blondeel *et al.*, 2016). Moreover, Blondeel and colleagues noted that there is virtually no epidemiological data available on the burden of disease for the trans population. So, although there is excellent grey literature available via the World Professional Association for Transgender Health (www.wpath.org) as well as other resources such as the LGBTIreland report (Higgins *et al.*, 2016) published by the Gay+Lesbian Equality Network in Ireland (GLEN), limited primary research is available in peer reviewed journals regarding the general physical health of trans people (Meads *et al.*, 2012; Reisner *et al.*, 2016). Research therefore indicates there is a clear gap in data that supports the need to establish the general health profile of trans people (Meads *et al.*, 2012; Reisner *et al.*, 2016).

4.8.2 Mental health

Mental health is the most commonly studied area of trans health with aspects such as mood disorders, suicidal and non-suicidal self-injury and anxiety gaining the most attention (Reisner *et al.*, 2016). Research undertaken globally indicates considerably higher rates of mental health problems amongst trans people (Reisner *et al.*, 2016). As a result of social factors such as minority stress, discrimination and experiences of violence, trans people were significantly more likely to attempt suicide and experience suicidal ideation compared to non-trans people (Reisner, White, Bradford, & Mimiaga, 2014). Due to the substantial mental health inequalities of trans people that are consistently reported in research, the next section will focus predominantly on the mental wellbeing of this group, followed by a discussion of access to healthcare.

²¹ We are of course aware that other research papers on trans health exist that were not extracted by the search protocol. See the full reference list for the SR for examples of such papers including: Anders *et al.*, 2014; Budge *et al.*, 2013; Mizock & Fleming, 2011. In addition a range of discussion papers are available on trans issues, DSM-5 and ICD classifications and standards for care by: Coleman *et al.*, 2012; Drescher, 2013; Drescher *et al.*, 2012; Hendricks & Testa, 2012; Lev, 2013.

²² Although HIV and STIs were excluded from the search strategies for this review (see Section 2.2.2), it is acknowledged here briefly as limited research is available on the general health of trans people.

4.8.3 Depression

In a study investigating anxiety and depression in trans people, Budge, Adelson & Howard (2013) recruited a total of 351 trans people (n=226 trans women and n=125 trans men). The authors found that rates of depressive symptoms (51.4% for trans women; 48.3% for trans men) and anxiety (40.4% for trans women; 47.5% for trans men) were significantly higher than those for the general population. Similarly, Reisner *et al.*, (2016) report on data that consistently showed that trans adults are burdened by mental health such as depression citing estimates of depression prevalence as high as 64% in a sample of 573 trans women (see Nemoto, Bödeker, Iwamoto, & Sakata, 2014; see also Bauer *et al.*, 2014).

4.8.4 Suicidal ideation and suicide attempts

Studies from Europe, the U.S. and Canada indicate significantly raised levels of suicidal ideation and suicide attempts in trans populations with 22–43 % of trans people reporting a history of suicide attempts (Bauer, Scheim, Deutsch, & Massarella, 2014; Bauer *et al.*, 2015; see also Bailey *et al.*, 2014; Haas *et al.*, 2010; Maguen & Shipherd, 2010; Reisner *et al.*, 2014). Although Haas *et al.*, (2010) point out that in the U.S. there is little information about suicide rates within trans populations due to gender identity not routinely being recorded on death records.

In a research article presenting selected findings from the Trans Mental Health Study²³ which represents the largest survey of the UK trans population to date and the first to explore trans mental health and well-being within a UK context, Bailey and colleagues (2014) drew on a non-random sample of 889 trans people. The findings revealed an 84% lifetime prevalence of suicidal ideation. Up to 63% of trans people had thought about suicide in the last year, 27% had thought about it in the last week, whereas 4% thought about suicide on a daily basis (Bailey *et al.*, 2014). Of those who had thought about suicide, the authors report that 48% had made a suicide attempt.

In their analysis, Bailey *et al.*, (2014) draws attention to key risk factors identified in suicidal ideation and suicide attempts of trans people including 'gender dysphoria'²⁴; confusion/denial about gender identity; fears around transitioning; gender reassignment treatment delays and refusals; and social stigma. For example, the authors report on some participants experiencing confusion about their gender and did not know how to express this confusion or access the help needed to make sense of their emotional discomfort. Fear regarding the disruption and consequences of transitioning was another key risk factor of suicidal ideation and suicide attempts due to potential effects of gender reassignment treatments and the upheaval related to transitioning. In these circumstances suicide was reported as seeming like an option to escape such forms of adversity (Bailey *et al.*, 2014).

Maguen & Shipherd (2010) in a small survey study implemented at a trans conference in the U.S., found that of the 153 participants, 18% had reported a past suicide attempt with trans

23 McNeil, J., Bailey, L., Ellis, S., Morton, J. & Regan, M. (2012). Trans mental health study, the equality network. Available at: www.gires.org.uk/assets/Medpro-Assets/trans_mh_study.pdf (accessed 18th January 2017).

24 A contested term in the DSM-5 used to describe where trans people experienced distress and disassociation due to the incongruence felt between their gender identity and their assigned sex at birth.

men reporting the highest rate of suicide attempt at 41% followed by trans women (20%). These figures are considerably lower than those reported by Bailey *et al.*, (2014) and are likely to reflect the research design and sampling. For instance, Maguen & Shipherd note that their study was a small convenience sample which means findings are not generalisable, but also that participants were attending a conference on trans issues meaning the sample was potentially more 'connected' to the trans community. This considerable difference in both sample and sampling methodology as well as subsequent findings on suicide between Bailey *et al.*, (2014) and Maguen & Shipherd (2010) perhaps demonstrates the need for more high quality, large scale and representative research with and for trans people to improve comparability (including reliability and validity) of data.

Nevertheless, the authors do draw attention to a series of risk factors associated with those who reported having a past suicide attempt including being assigned female sex at birth, experience of psychiatric hospitalisations, and having experienced trans-related violence (Maguen & Shipherd, 2010).

In Bauer *et al.*'s (2015) research to identify intervenable factors associated with reduced risk of past-year suicide ideation or attempt (related to social inclusion, transphobia, or gender transition), the authors note a number of factors that seem to *protect* against suicidal ideation or reduced suicidal thoughts in trans people including: increased social support from professionals, family and friends; parental support for their gender identity; reduced transphobia, and having personal identification documents changed to reflect the appropriate gender.

4.8.5 Substance (mis)use

In their review of the health burden and needs of trans people across low-income, middle-income and high-income settings globally, Reisner *et al.*, (2016) note that data reporting on alcohol, illicit drug use and tobacco use amongst trans people globally are inconsistent and heterogeneous making comparison across a range of studies challenging. The authors note that although substance (mis)use is often described in the literature as a way of making minority stress manageable (a coping mechanism), further research is needed to gain a better understanding of the function of substances amongst trans people (Reisner *et al.*, 2016). Indeed, the relative lack of literature on trans people's use of substances and substance treatment may reflect the exclusion of trans people in research or perhaps a consequence of trans people commonly being grouped together in research design and analysis together with the LGB population.

4.8.6 Impact of transitioning on mental health

Comprehensive, large-scale research with trans people to explore the impact of transitioning appears to be sparse with more research being required. However, notable exceptions include Budge *et al.*, (2013) and Bailey *et al.*, (2014) reported below.

Budge *et al.*, (2013) in a study involving 351 trans people aimed to determine the relationship of transition status, perceptions of loss, social support, and coping on the mental health outcomes of depression and anxiety for trans people. Using structural equation modelling to

analyse the data, the authors found high rates of depressive symptoms and anxiety (see also Reisner *et al.*, 2016). Budge and colleagues reported that processes for trans women and trans men were primarily similar for depression and anxiety; namely that avoidant coping²⁵ serve as a mediator between transition status and distress. More specifically, transition status was negatively related to avoidant coping, suggesting that further along individuals were in transitioning, the less avoidant coping they used; but that the more avoidant coping individuals used, the more depression and anxiety they reported. The authors therefore argue that individuals in early stages of transitioning seem to use more avoidant coping, and consequently experience more distress. Subsequently, Budge *et al.*, (2013) conclude that individuals who are in the early stages of transitioning may use different coping strategies than those who are in the latter stages proposing as a consequence, that mental health interventions need to be tailored on the basis of the transition status of trans people.

A key finding from the Trans Mental Health Study reported by Bailey and colleagues (2014), was that transition was shown to greatly reduce rates of suicidal ideation and suicide attempt. Amongst the sample of n=889 trans participants, 67% of respondents reported thinking about suicide more before they transitioned with 3% reporting thinking about suicide post-transition. Indeed, their findings demonstrated the importance of timely access to gender reassignment treatment for those who required it. Transition had a positive impact on mental health and well-being. For instance, three quarters of participants reported that hormone therapy had led to changes in their emotional wellbeing or mental health. Participants described feeling more comfortable and confident in themselves since starting hormone treatment. They reported feeling more balanced and experienced more positive and less negative emotions on the whole. Though some participants reported greater 'mood swings', memory problems and reduced ability to concentrate after commencing hormone treatment. Of these participants, 85% were more satisfied with their body image after hormone therapy, and only 2% were less satisfied (Bailey *et al.*, 2014). Bailey *et al.*, (2014) propose that the processes of gender reassignment and social transition serve to reduce considerably rates of suicidal ideation and suicide attempt.

In terms of surgery, Bailey and colleagues report that for those participants who accessed it, surgical intervention had a significant impact with 88% of trans respondents being more satisfied with their lives after having non-genital surgery (n=182) and 83% after genital surgery (n=131). 74% reported that their mental health had improved as a result of transitioning.

Bauer *et al.*, (2014) report on findings from the Trans PULSE Project which was a survey conducted with trans people in Ontario, Canada (n=433) using respondent-driven sampling²⁶. The authors explored the experiences of trans people accessing medical treatment at emergency departments. 21% of trans patients in the sample reported avoiding medical care because of negative experiences that they feared may impact on their treatment. Trans people also feared being marginalised or stigmatised when accessing emergency care (Bauer *et al.*, 2014). Perhaps some of the most concerning experiences reported by trans participants

25 In psychology, avoidance coping is a maladaptive coping mechanism characterised by the effort to avoid dealing with a particular stressor.

26 An established network-based sampling method for studying 'hidden' or 'hard-to-reach' populations.

included: being belittled or ridiculed for being trans; health practitioners or admin staff using hurtful or insulting language; trans people being refused care or having their care ended prematurely; trans people being discouraged from exploring their gender; or practitioners not knowing enough to be able to provide care (Bauer *et al.*, 2014).

The same study reported a higher proportion of trans men accessed emergency departments compared to trans women (39% vs. 25% respectively). According to the authors, this may be due to trans women being less likely to perceive need for emergency department care. Alternatively, the authors propose that trans women may be more likely to not be living according to their gender identity (even part time), and may present as their birth assigned gender when attending emergency departments (Bauer *et al.*, 2014).

In a further article drawing on selected data from the Trans Mental Health Study in the UK (see also Bailey *et al.*, 2014), Ellis, Bailey, and McNeil (2015) report findings on the experiences of trans people in two healthcare settings: mental health services and gender identity clinics. Overall, the findings showed that trans people perceived mental health practitioners in particular to be poorly informed about trans issues and experiences. The authors point out that given that mental health practitioners are usually gatekeepers to gender identity treatment (i.e. hormones, surgery), this is extremely problematic. Ellis *et al.*, (2015) suggest that this means trans-awareness training to educate health practitioners and challenge prejudices in practice settings is required.

In a Canadian study, Lyons and colleagues (Lyons, Shannon, Pierre, Small, Krüsi, & Kerr, 2015) examined the experiences of trans people who accessed residential treatment for substance use (n=34). The authors found that most trans participants experienced enacted stigma (real instances of discrimination) in the form of social rejection and transphobia. Those who experienced these effects were more likely to leave treatment prematurely due to feeling isolated. In contrast, those who experienced trans friendly and inclusive treatment recounted more constructive care pathways and positive treatment outcomes (Lyons, T *et al.*, 2015).

4.9 Intersex people

Intersex relates to a range of physical traits or variation that lie between binary ideals of male and female. Intersex people are born with physical, hormonal or genetic features that are neither wholly female nor wholly male; or a combination of female and male; or neither female nor male. Many forms of intersex exist; it is a spectrum or umbrella term, rather than a single category²⁷. Research on intersex has focused on surgical interventions, with a dearth of research on general health profiles and healthcare experiences.

Primary and/or secondary sex characteristics of intersex people may be ambiguous and do not fit clearly defined anatomical male or female features (Köhler, Kleinemeier, Lux, Hiort, Grüters, & Thyen, 2012; Thyen, Lux, Jürgensen, Hiort, & Köhler, 2014). The lives of intersex people are often medicalised as seen in biomedical terms describing intersex variations as

²⁷ Taken directly from ILGA-Europe's most commonly used phrases and acronyms which can be found here: www.ilga-europe.org/resources/glossary

'disorders of sex development' (DSD), and in doing so, pathologising intersex people, and the related medical interventions, surgical technologies, and hormonal procedures that intersex people are subjected to²⁸. Research reporting on the health of intersex people is often small-scale with a focus on participants under the age of 19 years²⁹, when many intersex people present to health services due to the onset of puberty.

In the following sub-sections, research relating to intersex people within the context of health inequalities is covered briefly based on the research papers extracted via the protocol (Section 2) and include assigned sex, impact of surgery, ethical accountability, mental health, and specialist services.

4.9.1 Assigned sex

In an online Australian survey of 272 people with intersex variations that aimed to redress the gap in research on this groups' experiences and perspectives concerning educational contexts, 52% of participants reported having been assigned female sex at birth (Jones, 2016). Of these participants, the same proportion (52%) continued to use the same assignment at the time of the survey. Amongst participants, 41% were assigned male sex at birth, with 23% continuing to use the same male assignment at the time of the survey. The authors propose that the reduction in the use of male gender identity since birth could be due to the fact that some participants assigned male sex at birth, may over time have changed their gender identity when they were older. In this same study, 8% of participants identified as being trans due to disagreeing with medical practitioners about their assigned sex (Jones, 2016). This highlights how male/female binary categories for sex markers (and/or sex characteristics) and gender identity are not helpful and how intersex bodies can be 'trapped' in these limiting categories. Moreover, it raises important questions regarding potentially imposed and unnecessary medical intervention at birth³⁰.

4.9.2 Impact of surgery³¹

A range of intersex variations are diagnosed biomedically which unnecessarily medicalise intersex people based on biological difference and are often incongruous with how intersex people self-identify. Although it is beyond the scope of this study to explore these issues in any depth, here we examine briefly the research extracted via the study protocol demonstrating differential impacts of surgery for intersex people.

28 Thus, we use the term 'Disorders of Sex Development' or 'DSD' in quotes where it is used in the research literature to highlight that it is a contested term.

29 For intersex people, the protocol inclusion criteria for this SR were adjusted to include those between the age of 13 to 18 as hormonal and related physical changes are often accompanied by medical intervention during puberty. One exception to this was the inclusion of a recent study by Nokoff *et al.*, (in press) due to its relevance.

30 Although not meeting the review protocol inclusion criteria for this present SR, the following articles by Bastien Charlebois (in press, a, in press b) raise some important questions and issues regarding self-determination and medical intervention.

31 Discussion literature (i.e. non-primary research that didn't meet the SR inclusion criteria) is available for intersex people on the impact of medical intervention in infancy and childhood on physical health. Such literature draws attention to the commonality of complications following surgery including urethral healing failures, fistulae, stenosis and urine flow impairments (e.g. see Mouriquand *et al.*, 2016; see also Liao *et al.*, (2015).

Intersex people commonly report two types of medical intervention associated with their sex characteristics. These interventions are hormonal treatment and surgery aiming at either masculinisation or feminisation (Thyen *et al.*, 2014).

In a European study that included participants from Austria, Germany and Switzerland (n=110), surgical outcomes related to overall appearance and sexual functioning showed a significant correlation to patient satisfaction (Thyen *et al.*, 2014). The authors report that intersex people reported lower satisfaction with care compared to adult patients with other chronic conditions in rehabilitation services. Findings also showed that intersex people without access to psychosocial care were less satisfied with their healthcare. Whether participants received psychological counselling or not, did not affect their satisfaction with care, but unmet needs did.

In a review of recent publications on outcome data of 'disorders of sex development' (DSD), Lee *et al.*, (2012) report on a Finnish mailed questionnaire study (see Fagerholm *et al.*, 2013)³² which looked at the attitudes of intersex people following feminising surgery (genitoplasty). With a 53% response rate yielding 24 participants up to the age of 36 years, 17 of the 24 respondents reported satisfaction, and five participants reported being dissatisfied with genital function³³. Of the five dissatisfied patients, three experienced their vagina as being too tight or tender and two patients were dissatisfied because of poor clitoral sensation.

In a recent study from the U.S., Nokoff and colleagues assessed the outcome of cosmesis before and after genital surgery in a cohort of intersex children <2 years of age with no prior genitoplasty at the time of enrolment (Nokoff, Palmer, Mullins, Aston, Austin, *et al.*, in press). In doing so the authors aimed to 1) describe the frequency of sex assignment, and types of surgery performed; and 2) prospectively determine cosmesis ratings by parents and surgeons before and after genital surgery. Parents and surgeons all rated the appearance of the genitalia unfavourably before surgery, with surgeons giving worse ratings than parents. Cosmesis ratings improved significantly after surgery, with no between-group differences.

These findings are in stark contrast to a European study citing considerable dissatisfaction with treatment and surgical intervention (Köhler *et al.*, 2012). Here amongst 57 intersex people who had undergone genital surgery, as many as 47% were unhappy with the outcome of surgery, 44% experienced prolonged sexual anxiety, 70% had problems with sexual desire and 56% described symptoms of dyspareunia whilst 44% XY males feared sexual contact compared to 66% XY females (Köhler *et al.*, 2012; see also Jones, 2016). For those with complete androgen insensitivity (CAIS), 81% reported problems with desire and 70% experienced dyspareunia (Köhler *et al.*, 2012). As many as 62% of participants reported that they experienced sexual problems because of their intersex embodiment (Köhler *et al.*, 2012). It should be noted that these studies had small numbers and thus further research is needed to explore the impact of surgery longitudinally. The authors suggest that genital surgery should be minimised and performed mainly in adolescence or adulthood with the persons' (informed) consent.

32 2011 at the time of online publication and inclusion by Lee *et al.*, (2012). 2013 published in print.

33 The Lee *et al.*, (2012) paper does not mention whether satisfaction was measured with or without informed consent of the participants.

4.9.3 Ethical accountability

Assumptions that early surgery is in the best interest of intersex individuals have been widely challenged (Köhler *et al.*, 2012; Thyen *et al.*, 2014). Research findings conclude that early feminising surgery should be avoided at birth, and gonadectomy should only take place where there is a risk of gonadal malignancies and in consultation with parents along with the full consent of the child or young person. In addition, surgical intervention should be reduced to a minimum, and should only take place with full informed consent in accordance to patient's needs in puberty and adulthood (Köhler *et al.*, 2012)³⁴. Parents should be consulted and involved with their child in decision-making regarding care pathways. Poor communication between health professionals, the family and patient and secrecy or stigma related to intersex bodies adds to the psychological burden of these conditions (Thyen *et al.*, 2014). Furthermore, research recommends that young people's gender identity should be respected (including when it is non-binary) as they approach puberty and beyond (Köhler *et al.*, 2012).

4.9.4 Mental health

Primary research exploring the mental health needs of intersex people appears to be relatively limited and it is clear there is a need for large-scale research into the psychological and emotional wellbeing of intersex people.

In the online Australian survey of 272 people with intersex variations noted earlier (Jones, 2016), participants aged 16 to 87 reported that being diagnosed as 'DSD' or identified as intersex and the related medical intervention, had a range of both physical and psychological effects. With regards psychological effects, young people reported experiencing isolation due to stigma, bullying, discrimination or rejection from family or peers (Jones, 2016). Consequently, the incidence of suicide attempts amongst intersex participants in the sample were 19% with as many as 60% having considered suicide compared to under 3% in the general Australian population (Jones, 2016). Furthermore 26% of participants reported having self-harmed due to being intersex (Jones, 2016).

4.9.5 Specialist services

In the Thyen *et al.*, (2014) study with German, Austrian and Swiss participants (n=110), 28% experienced difficulties accessing specialist care. Participants who did not understand the diagnosis at the time of disclosure reported significantly lower levels of patient satisfaction at compared to the average satisfaction for all patients. Of the study sample, 11% of intersex participants reported being offered counselling or talking therapies to help them make sense of events in adulthood. 28% reported that they had been offered such services but that they had no need for them. However, the majority of participants had never been offered access to psychological support services. Those who had never been offered psychological support reported the lowest satisfaction with care (Thyen *et al.*, 2014). Thus access to psychosocial support services appears to significantly increase patients' satisfaction with healthcare. People with intersex characteristics should have access to medical staff specifically trained in intersex people's needs where they can access appropriate services and/or interventions to maintain

³⁴ In addition we would propose that any surgeries (which are not life-saving) be deferred until the 'patient' is able to give truly informed consent.

and promote positive mental health and wellbeing. Within these services, long-term follow up should include assessment of psychosexual, emotional and social wellbeing (Thyen *et al.*, 2014).

SECTION FIVE: What is known about the health inequalities of LGBT³⁵ people focusing on vulnerable intersections as it relates to healthcare?

5.1 An introduction to intersectionality

Within contemporary European health and social care literature, intersectionality can be understood as the intersections between a range of dimensions associated with social and cultural difference that people are subjected to (Meads *et al.*, 2012; Zeeman, Aranda, Sherriff & Cocking, 2016). People carry certain markers of difference such as gender, sexual orientation, gender identity, gender expression, sex characteristics, age, ethnicity, race, disability and social class (as examples). These markers intersect to create and sustain health inequalities, for example trans people from a minority ethnic background may have high rates of depression due to (amongst other things) the intersections of their gender identity, sexual orientation, and ethnicity. The response to such markers of difference varies amongst European MS and is influenced by (amongst other things) a range of legal, political and economic factors such as legislation that either prohibits LGBTI people from participation in mainstream cultural and social life, or fully includes LGBTI people (Meads *et al.*, 2012).

This Section explores some of the intersections of LGBT identities within specific populations and settings. In doing so it pays attention particularly to rural or geographically remote areas; older and younger LGBT people; refugee, asylum seekers, and migrant LGBT people; those who live in poverty or are socio-economically disadvantaged, and disabled LGBT people. This Section is shorter than the previous one as there is far less research undertaken that accounts for the health inequalities of intersectional subjectivities. Moreover, none of the research reviewed in this Section included a focus on intersex people highlighting a large gap in the current primary research literature. The use of LGBT in this Section is therefore deliberate to reflect this absence. It may be that these findings are relevant to intersex people, but more research is needed to identify these intersections.

5.2 Rural areas

In an online survey with LGBT individuals (n=1,014) residing in rural areas of the U.S. Whitehead *et al.*, (2016) examined the relationship between stigma, disclosure and 'outness' and the use of primary healthcare services. Findings revealed a range of risk factors for poor health including higher rates of depression, smoking, and binge drinking (Whitehead *et al.*, 2016). For instance, in terms of the former, 50% of the sample met criteria indicating possible clinical depression with trans and non-binary respondents reporting significantly higher rates (65%) than cisgender men (41%) and cisgender women (54%). Moreover, all groups studied (cisgender men, cisgender women, trans and non-binary respondents) reported experiencing stigma with trans and non-binary respondents reporting much higher levels of all three types of stigma (internalised, enacted, anticipated) compared to the other two groups. The authors go on to note that for trans and non-binary participants, enacted stigma scores were associated with lower self-reported health scores whilst there was no evidence of this relationship between stigma and health score for cisgender groups. Whitehead *et al.*, (2016)

³⁵ See note in paragraph 2 of this page regarding the research covered in this Section that does not include intersex people.

suggest that stigma may thus decrease health-seeking behaviours amongst trans and non-binary people (e.g. due to fear of future discrimination) living in rural areas, and that further research is required to explore this further to improve uptake of primary healthcare services. Moreover, the authors argue that methods of engagement that have already been found to be effective with rural LGBT groups such as outreach clinics, telemedicine with specialist consultations and primary care practitioner training to help health providers understand the needs of LGBT people living in rural areas, need to be implemented as they can contribute to reducing healthcare stigma and uncertainty, improving access to quality healthcare for LGBT people in rural areas (Whitehead *et al.*, 2016).

In an online survey (n=1,034) exploring the rural-urban differences in mental health, resilience, stigma, and social support amongst young Australian gay men, Lyons, A. *et al.*, (2015) found that gay men living in rural areas aged 18-39 were at significant disadvantage regarding their mental health and wellbeing compared to gay counterparts living in urban areas. This included a greater likelihood of psychological distress, lower self-esteem, lower life satisfaction, greater concerns around acceptance from others, less emotional support, and a lower sense of belonging (Lyons, A. *et al.*, 2015). The authors conclude that mental health prevention and treatment strategies in rural areas need to include a particular focus on young gay men, specifically improving access to forms of support.

The above studies (Lyons, A. *et al.*, 2015; Whitehead *et al.*, 2016) appear to demonstrate that living in rural areas may be a source of 'risk' for some LGBT people. In an analysis of data from the online Stonewall Gay & Bisexual Men's Health Survey (n=5,799; Hickson *et al.*, 2016; see also Bourne *et al.*, 2016), findings showed that living in London (an urban area) appeared to be associated with lower odds of depression, suicide attempt, and self-harm. In other words for this particular study, living in an urban area appeared to act as a protective factor against mental health problems for some gay and bisexual men.

5.3 Older people

Research documents a range of health inequalities experienced by older LGB people (e.g. see Fredriksen-Goldsen & Muraco, 2010; Fredriksen-Goldsen *et al.*, 2012a; Fredriksen-Goldsen *et al.*, 2013; see also Gonzales & Henning-Smith, 2015)³⁶, but the focus on LGB indicates a need for more research with trans and intersex people. In an analysis of data of the Washington State Behavioural Risk Factor Surveillance System in the U.S. (n=96,992) Fredriksen-Goldsen *et al.*, (2013) analysed risk factors for health outcomes, chronic conditions, health behaviour and access to care according to their sexual orientation and gender identity. The study found that older LGB people had an elevated risk for disability, poor mental health, and smoking and excessive drinking compared to heterosexuals.

Similarly, Fredriksen-Goldsen and colleagues (2012a) using a cross-sectional survey (n=2,349) investigated the influence of key health indicators and risk and protective factors on health outcomes (including general health, disability, and depression) amongst older LGB people in the U.S. The authors found that victimisation, financial barriers to healthcare,

³⁶ No research included in this SR considered issues for older intersex people. Clearly, research is needed to understand the impact of surgery and hormonal treatment for older intersex people and their related health needs as they age.

obesity, and limited physical activity accounted for poor general health, disability, and depression amongst LGB older adults. Protective factors decreasing the odds of poor general health, disability, and depression included social support and social network size (Fredriksen-Goldsen *et al.*, 2012a).

In a mixed-methods research design combining quantitative survey and qualitative interview methods (n=144 and n=36 respectively), Sharek, McCann, Sheerin, Glacken, & Higgins (2015) found that as LGBT people age, they are more likely to be single (43%) compared to 15% in heterosexual populations over 55 years. The authors found that loneliness and isolation of LGBT people as they aged became a significant challenge, specifically for those who lived in geographically isolated areas, or for those who have not come 'out' to friends and neighbours and as a result lost their connections with the LGBT community (Sharek *et al.*, 2015). Social isolation and loneliness may have implications for mental health as seen in the elevated incidence mental health problems mentioned above, for older LGB people.

Sharek *et al.*, (2015) also found the housing status of older LGBT people was associated with their health and wellbeing. The preferred option was to live independently in their own home, followed by shared accommodation with other LGBT people. Residential care facilities were regarded as the least favourable option as older LGBT people feared 'being entrapped in a heterosexual world' or having to 'return to the closet' (Sharek *et al.*, 2015). Trans people were concerned that they may not be able to be themselves in predominantly cisgender and heterosexual care environments. Concerns were raised that same sex partners would be rejected or that their role in providing care would not be respected by health professionals (Sharek *et al.*, 2015).

With regards to health professionals, Sharek and colleagues found that over a quarter of participants did not reveal their LGBT identity to healthcare practitioners due to fear of discrimination and fear that their sexual orientation or gender identity might impact on the quality of care provided (Sharek *et al.*, 2015). The authors conclude that given older LGBT people are a 'doubly invisible group', it is crucial that LGBT issues in educational training for health practitioners are implemented to ensure that groups of people who have historically experienced discrimination, do not face further discrimination as they age.

5.4 Young people³⁷

Central themes in primary research with LGBT youth (it is again important to note the need for further work with intersex young people) suggests that there are substantial health inequalities related to substance misuse, smoking, mental health problems with a growing awareness of the impact of these factors on educational attainment (Blosnich *et al.*, 2013). Findings from the Stonewall Gay & Bisexual Men's Health Survey (n=5,799) suggest that young gay and bisexual men are at significantly higher risk of poor mental health compared to older men with very high levels of depression (29%), anxiety (24%), suicide attempts (6%) and self-harm (14%) (Hickson *et al.*, 2016). These findings were explained by raised

37 A range of other information is available on the health of young LGBTI people that falls beyond the scope of this review due to publication date, not being primary research or falling under the remit of grey literature. See as examples: Allen, Glick, Beach, & Naylor (1998); D'Augelli (2004); Ellis & High (2004); IGLYO (2013).

levels of homophobic abuse and assault experienced by young gay and bisexual men (Hickson *et al.*, 2016; see also Zeeman *et al.*, 2016; Sherriff, Hamilton, Wigmore, Giambrone, 2011). Indeed, in a qualitative study with LGBT(Q) (Questioning) young people, Sherriff *et al.*, (2011) note how participants reported experiencing high levels of homophobic and transphobic bullying, ranging from verbal harassment and intimidation to physical violence in a range of contexts including school environments. The authors argued that there is a clear need for the development of holistic institutional-level interventions to address the needs of LGBTQ youth. In particular, Sherriff *et al.*, (2011) noted that practitioners themselves (including mental health, education, housing, social services, police, and youth practitioners) expressed desires for training on LGBT issues to meet young people's diverse needs and specifically for training to include real-world examples through the voices of young LGBTQ youth themselves.

With regards to substance misuse, in a recent systematic review of primary research on substance use amongst LGB young people up to the age of 25, Goldbach *et al.*, (2014) found higher rates of substance use (almost three times) for tobacco, alcohol, marijuana, cocaine and ecstasy by LGB youth were found compared to heterosexual young people. LGB youth were also more likely to increase their use of substances as they aged. The same review found that ethnic and minority gay and male bisexual youth had slightly raised levels of substance use compared to female and white counterparts respectively (Goldbach *et al.*, 2014; see also Blosnich *et al.*, 2013). Similarly, in a systematic review of the literature examining risk factors/correlates of cigarette smoking amongst LGBT populations, Blosnich and colleagues found that younger LGBT people who had experienced victimisation, discrimination, and abuse were more likely to smoke, in particular those young people who had negative experiences linked to LGBT identity disclosure (Blosnich *et al.*, 2013). However, the authors note that the body of research linking higher rates of smoking and risk factors/correlates in young LGBT people are inconclusive and requires further investigation. Specifically, Blosnich *et al.*, (2013) note that a major shortcoming in understanding better the aetiology of smoking inequalities and more conclusive evidence on the origins of the tobacco epidemic in LGB communities, is the failure of many large-scale surveillance studies to include sexual orientation and gender identity. The authors argue that a major step to address health inequalities experienced by LGBT people is to first know where such inequalities lie and this requires better research including epidemiological surveillance.

Research on and with LGBT young people has also identified important protective factors for LGBT youth that could promote mental health and reduce substance use, for example findings show that early intervention reduced instances of transphobia that prevented suicidal ideation, leading to a reduction in related suicide attempts (Bauer *et al.*, 2015). Further protective factors for LGBT youth were observed where smoking rates decreased with an increase in availability of resources specific to supporting sexual minority young women (Blosnich *et al.*, 2013). As part of a larger study with young people, Zeeman *et al.*, (2016) analysed a small subset of qualitative data of trans youth to explore their understanding and experiences of resilience and emotional well-being. Trans young people reported that resilience as an individual and collective capacity, allowed them to persevere through adversity, be that name-calling, bullying, marginalisation or social exclusion, making them feel more resourceful and stronger in the face of that adversity. The authors argued however, that resilience and emotional well-being has to be a collective responsibility with wider support urgently needed from schools, practitioners, and others in the community as well as at

systems level, to ensure health and other services are able to address the specific care needs of trans youth (Zeeman *et al.*, 2016).

5.5 Migrants, refugees, and asylum seekers

There is seemingly a dearth of research on the health of LGBTI people whom may also be migrants, refugees, and/or asylum seekers with few papers being extracted via the SR protocol that addressed this area.

One notable exception was a recent study exploring child and adolescent abuse experiences and their impact on the pre-migration mental health of LG&T asylum seekers and refugees. Alessi, Kahn, & Chatterji (2016) analysed data from 26 life-history interviews with LG&T participants aged 21-49 years who obtained refugee or asylum status in the U.S. or Canada on the basis of sexual orientation or gender identity. The findings indicated that many experienced abuse by parents, caregivers or peers and a low level of connectedness to these elders prior to seeking asylum or refuge that correlated to negative mental health outcomes. For some LGBT people experiences of abuse began as early as the age of 5 including humiliation, name-calling and beatings that intensified during puberty (Alessi *et al.*, 2016). In this study, Alessi and colleagues report how LGBT people who disclosed their sexual orientation or gender identity, or who engaged in same-sex activity or non-normative gender performances faced significant effects in their countries of origin, such as public shaming, withdrawal of emotional and social support and for some pressure to seek a 'cure' from talking therapists or religious leaders. The behaviours of some LGBT people were sanctioned across a range of settings such as at home, in the learning environment and in public places leaving nowhere to feel safe. Instead of elders, family and community leaders questioning heteronormative and cisnormative cultural and social assumptions, LGBT people were often blamed for their sexual and gender non-conformity leading to social exclusion. In certain evangelical Christian communities LGBT people were led to believe that they were sick or demonically possessed (Alessi *et al.*, 2016).

The authors pose a number of implications for policy and practice based on their research findings. In terms of practice, suggestions include the benefits of raised awareness for mental health practitioners whom may enrich their practice through increased awareness of the social and psychological impact of childhood and adolescent abuse experiences on LGBT asylum seekers or refugee adults. For primary healthcare professionals, LGBT asylum seekers or refugees may benefit from being assessed for PTSD at early consultations and also from receiving a trauma-informed approach which takes into accounts the impact of traumatic events on the current functioning and circumstances of clients (Alessi *et al.*, 2016). For policy, the authors focus on the need for the worldwide strengthening of protection and inclusion of LGBT people via national/regional child policies and laws. Importantly, Alessi and colleagues argue that as LGBT rights steadily advance, it is also necessary to draw attention to religious ideology which contributes to the persecution of LGBT people.

5.6 Socio-economic poverty

As with primary research on LGBTI people who are also migrants, refugees, and/or asylum seekers, few papers were extracted via the SR protocol that included a focus on socio-economic issues.

However, although no papers focused exclusively on socio-economic issues for LGBTI people, some studies did include elements. For instance, findings from the Stonewall Gay & Bisexual Men's Health Survey (Hickson *et al.*, 2016) showed that for gay and bisexual men higher educational background and higher income were associated with lower levels of mental health problems. The authors propose that these patterns reflect the importance of both literacy and material circumstances in determining mental health. Similarly, linking to Section 5.7 below, using population-based data to examine disability amongst LGB adults Fredriksen-Goldsen, Kim, & Barkan (2012b) found that bisexual men were more likely to be socio-economically disadvantaged compared to heterosexual people. Furthermore, in their review of literature examining risk factors and correlates of cigarette smoking amongst LGB populations, Blosnich *et al.*, (2013) report that LGBT people in socio-economic poverty or low-income situations are at greater risk of smoking than the general population. For these people, the factors that precipitated higher rates of smoking included stress, depression, alcohol consumption and exposure to victimisation over time (Blosnich, *et al.*, 2013).

5.7 People with disabilities

Once again similar to previous sections, few primary research papers focusing on LGBTI people with disabilities were extracted in the searches for this SR. Notable exceptions include the two papers summarised below.

Research by Fredriksen-Goldsen *et al.*, (2012b; see also Fredriksen-Goldsen & Muraco, 2010) using U.S. population-based data from the Washington State Behavioural Risk Factor Surveillance System (n=82,531) revealed high rates of disability amongst LGB adults compared to heterosexuals. 25% of heterosexual women, 36% of lesbian women and 36% of bisexual women had disabilities. Analysis of data showed that compared to heterosexual adults with disabilities, LGB adults with disabilities were often significantly younger. Fredriksen-Goldsen *et al.*, (2012b) argue that studying disability is important not only to target prevention efforts to the particular risks different population groups face but to be able to improve the quality of life for LGB adults with disabilities. The authors go on to argue that research is needed in order to understand better the mechanisms through which LGB adults have an increased risk of disability compared to heterosexual people. In this particular study, the authors suggest that inequalities in chronic health conditions (e.g. lifetime asthma arthritis, obesity), health risk behaviours, and poor physical and mental health among LGB adults may contribute to the heightened prevalence of disability.

In further research from the U.S., Gonzales & Henning-Smith (2015) analysed data from the National Health Interview Survey to explore health inequalities and disability amongst older adults in same-sex cohabiting relationships with men (n=698) and women (n=630) aged 50 and over, compared to cohabiting older adults in married opposite-sex relationships (n=131,841 men; n=114,945 women) and unmarried opposite-sex relationships (n=5,403 men; n=4,346 women). The authors found that compared to heterosexual adults in married opposite-sex relationships, older men in same-sex relationships exhibited greater odds of psychological distress, and older women in same-sex relationships experienced increased odds of poor/fair health, but also required assistance with daily living activities, experienced functional limitations, and experienced greater psychological distress (Gonzales & Henning-Smith, 2015).

SECTION SIX: What are the potential barriers faced by health professionals when providing care for LGBTI people?

6.1 Introduction

Health professionals commonly face a range of challenges when caring for LGBTI people in healthcare settings including (as examples), cultural and social norms that become engrained over time, personal discomfort and unease in addressing gender and sexuality in conversations with their patients, uncertainty about the use of language, and not knowing whether people are LGBTI. It should also be noted from the research reviewed in this SR, that some healthcare professionals may not only be unaware of some the key issues facing LGBTI people, but also may be unaware of specific health issues and needs for LGBTI people, as well as often (un)knowingly or (un)intentionally engage in discriminatory behaviour themselves (e.g. see Sharek *et al.*, 2014; Utamsingh *et al.*, 2016).

This Section explores some of the potential barriers faced by health professionals when providing care for LGBTI people. As noted in other parts of this SR, it is not intended to be a comprehensive account but instead is based on the research papers extracted. The potential barriers faced by health professionals which have been documented in the research reviewed and are presented here include: cultural and social norms; language; not knowing and coming 'out'; institutional barriers, and; knowledge and training.

6.2 Cultural and social norms

As noted in previous Sections, where gender and sexual norms are upheld (such as heteronormativity; see Section 3.2.1; Fish & Williamson, 2016; Marques *et al.*, 2015; see also Katz-Wise & Hyde, 2012), health professionals may subject LGBTI people to heterosexism, homophobia, biphobia, interphobia³⁸ or transphobia resulting in significant barriers to healthcare (Bauer *et al.*, 2014; Pennant *et al.*, 2009; Sharek *et al.*, 2014; Utamsingh *et al.*, 2016).

Research suggests that LGBTI people experiences of healthcare tend to be less favourable than the general population (e.g. Bauer *et al.*, 2014; Elliot *et al.*, 2015; Lyons, A. *et al.*, 2015; Pennant *et al.*, 2009; Thyen *et al.*, 2014; Utamsingh *et al.*, 2016). Indeed, in a limited (due to lack of literature) systematic review of individual qualitative research studies of LGB patients' experiences of healthcare in the UK, Pennant *et al.*, (2009) suggest that LGB people commonly experienced homophobia in healthcare settings³⁹. For instance, the authors report on research where LGB people described some health professionals as being 'rude', or asking 'intrusive' questions or they were perceived as 'judgemental' and did not show respect in their interactions with their LGB patients. Pennant *et al.*, (2009) note that other studies they reviewed also revealed examples of rough treatment, poor emotional support for a suicidal

38 Interphobia encompasses negative attitudes and feelings towards people who are born with, or develop in puberty, sex traits that are not typically male or female, known as intersex Traits whether they are actually born with them or simply exhibit non-binary gender identity or expression, which is commonly associated with having congenital Intersex Traits. See <http://oii-usa.org/2417/what-is-interphobia>.

39 As noted in Section 2, although this Pennant *et al.*, (2009) exceeds the inclusion criteria timeframe, the authors included this systematic review due to its pivotal contribution to the field.

patient, and frequent reports of unprofessional treatment on religious grounds. Due to prevailing social and cultural norms that sustain heterosexuality, health professionals often assumed patients were heterosexual, acting with surprise when they learned that people were LGB⁴⁰. Such examples are indicative of heteronormativity and constitute significant barriers to accessing healthcare.

Similarly, in a 433-patient study from Canada on avoidance of hospital emergency department use by trans people, Bauer *et al.*, (2014) found that half of all trans people in the research reported negative experiences in emergency department, and 21% stated that they had avoided visiting emergency departments because of this. Examples of these negative experiences included: being refused or ended care; hurtful or insulting language; refusal to discuss trans-related issues; being told 'you are not really trans'; being belittled or ridiculed for being trans; and refusal to examine parts of the body. The authors note that such negative experiences of trans-related discrimination and poor care may be significant barriers to access to healthcare, and that health practitioners should be trained in trans-related issues (Bauer *et al.*, 2014).

Furthermore, research demonstrates how some health providers lack cultural awareness related to specific groups such as black and ethnic minority gay and bisexual men. For instance, in a systematic review and meta-synthesis of qualitative and quantitative evidence regarding MSM's and healthcare providers' perceptions of barriers to uptake of HIV/AIDS-related interventions, Wao *et al.*, (2016) found that health professionals' lack of cultural awareness was an important structural barrier to HIV testing (Wao *et al.*, 2016). By showing greater cultural awareness with sensitivity towards gender and sexual plurality, and by recognising that people might identify as LGB(TI), health professionals could foster better holistic care and greater social inclusion in health settings (Pennant *et al.*, 2009; Wao *et al.*, 2016).

6.3 Language

In settings where LGB people access health services, practitioners often assume heterosexuality and use language accordingly (Bauer *et al.*, 2014; Hill & Holborn, 2015; Pennant *et al.*, 2009). As a result LGB people experience exclusion for example by health professionals asking a gay man 'Do you have a wife?' Such assumed heterosexuality reinforces the invisibility of LGB people (Sharek *et al.*, 2015), and creates (amongst other things) barriers in communication between LGB people and health professionals (Bauer *et al.*, 2014; Bauer *et al.*, 2015).

Language is also a barrier for trans and intersex people with, as examples, practitioners using pathologising language and using incorrect pronouns. For instance, in a study with trans young people, Zeeman *et al.*, (2016) found that practitioners were hesitant to discuss issues related to gender and sexuality which resulted in the wrong pronouns being used when

⁴⁰ Although these issues can also be seen as relevant for trans and intersex people, the research presented here only focused on LGB studies and thus that is all that can be reported in this report. See the accompanying CSR report (Zeeman *et al.*, 2017a) for additional examples relating to trans and intersex people.

addressing them. Trans young people therefore expressed a desire for practitioners to do more to understand their needs and provide accessible support⁴¹.

Further barriers in access to healthcare may emerge due to the use of language where health professionals and patients use different terms. For example, in their systematic review of individual qualitative studies exploring LGB people's experiences of healthcare, Pennant and colleagues (2009) report on a study (Mair, 2003) which highlighted how misunderstandings between patient and doctor may result from the use of differing terms to describe sexualities. In his study of gay men's experience therapy, Mair (2003) notes how whilst some gay men may choose to describe themselves as homosexual, others reject the term and prefer to describe themselves as 'gay' and that this can act as a barrier. He presents an example of a patient who spoke of himself as 'gay', but the doctor used the term 'homosexual'. The patient found this distracting and struggled to follow the conversation (Mair, 2003). According to Pennant *et al.*, (2009), practitioners should consider using the same terms the patient uses to describe themselves, and others propose practitioners should use gender neutral language when discussing partners (Bauer *et al.*, 2014; Hill & Holborn, 2015). However, each encounter between a LGBTI person and a health professional is individual and culturally specific. Language should therefore be fluid and reflect openness and sensitivity to create space for plurality and diversity (Marques *et al.*, 2015).

6.4 Not knowing and coming 'out'

As noted earlier, in research with 144 older LGBT people in Ireland, Sharek and colleagues found that over a quarter of participants (26%) did not reveal their LGBT identity to healthcare practitioners due to fear of discrimination and fear that their sexual orientation or gender identity might impact on the quality of care provided (Sharek *et al.*, 2015). Further research found that younger white women who accessed treatment were more likely to disclose their sexual orientation compared to older women and those who were from ethnic minority groups (Hill & Holborn, 2015). An American online sample of rural LGBT populations (n=1,014), Whitehead *et al.*, (2016) found that 37% of participants were not 'out' about their sexual orientation or gender identity to their health provider, whereas 28% thought that their provider may be uncomfortable with their disclosure. As much as 43% thought their sexual orientation or gender identity had no bearing on their health (Whitehead *et al.*, 2016). Thus, reasons for non-disclosure included lack of opportunity or the assumption that disclosure was irrelevant to treatment and care and some described limited emotional and psychological resources to deal with potential negative attitudes of health providers (Fish & Williamson, 2016; Fish & Bewley, 2010). Additional research found a third of lesbian women believed disclosure would have a negative impact on their healthcare (Pennant *et al.*, 2009). Consequences of disclosure included potential embarrassment, silence or fear of refusal of care (Fish & Bewley, 2010). For people living with HIV, disclosure of their HIV status and sexual orientation was often accompanied by fear of adverse effects such as maltreatment within the healthcare system (Wao *et al.*, 2016).

Disclosure of sexual orientation, sex characteristics, and/or gender identity can bring health benefits and greater levels of satisfaction with care received due to better communication

41 None of the papers extracted via the protocol discussed or presented issues relating to language for intersex people.

between health professionals and LGBTI people (e.g. Fish & Bewley, 2010; see also Hill & Holborn (2015, Whitehead *et al.*, 2016). For example, research found where LGBT people are 'out' in health environments, their visibility was correlated to better rapport between providers and service users (Whitehead *et al.*, 2016).

However, in some instances LGBTI people may not want to disclose their sexual orientation, gender identity or sex characteristics due to safety concerns, fear of discrimination or the need for privacy and confidentiality. For instance, in situations where lesbian and bisexual women were aware of negative attitudes held by health professionals, they were less likely to 'come-out'. Furthermore, non-disclosure may lead to inappropriate questioning and diagnoses based on partial information (Fish & Bewley, 2010)⁴².

6.4.1 What could health professionals do to help LGBT people to come 'out'?

By not assuming all patients or service users are heterosexual or cisgender, health professionals can create an environment conducive to LGBT people coming 'out' and disclosing their status (Baer *et al.*, 2014; Fish & Bewley, 2010; Fish & Williamson, 2016). According to Sharek and colleagues (2015), LGBT people are more likely to come 'out' to health professionals and those around them where they felt supported and know that they will be accepted by others (Sharek *et al.*, 2015). Pennant *et al.*'s (2009) systematic review revealed that whilst some LGB people feared confidential information would be leaked and end up in the public domain or in local communities at families and friends with damaging effects, LGB people were more likely to come 'out' if they knew health professionals would uphold their confidentiality and privacy (Pennant *et al.*, 2009). For lesbian and bisexual women, research findings showed that a clear commitment by health professionals to confidentiality made it easier to come 'out', where they were informed of who had access to their information, and were asked to provide consent prior to information being shared with other professionals or related agencies (Fish & Bewley, 2010).

6.5 Institutional barriers

6.5.1 Documentation, health information, and protocols

In Pennant and colleagues' (2009) review of LGB patients' experiences of healthcare in the UK, the authors report on studies which raise the issue of a lack of relevant documentation (e.g. leaflets, flyers, information, marketing materials) and protocols (e.g. processes for recording patient information and care pathways) that were appropriate for heterosexual patients as well as lesbian, gay, and bisexual patients⁴³. In some healthcare settings such documentation and protocols used by practitioners had clearly been developed around assumed heterosexuality and were therefore not geared towards the needs of LGB people's health needs (e.g. midwifery data recording forms and protocols) nor towards clear messages of inclusivity (Pennant *et al.*, 2009). Indeed, Fish & Bewley (2010) draw attention to the

⁴² Being 'out' to one's healthcare provider can be contextual. That is, the need to disclose may depend on the specific nature of the health care required. For example, going to the doctor for an insulin test may not require disclosure of sexual orientation, nor trans status or that one may have non-normative sex characteristics. Yet a trans or intersex person may nevertheless face a doctor who insists that it is absolutely necessary for them to know, regardless of the desires of the person themselves or the medically based information required, see the CSR and the report on the focus group study.

⁴³ Trans, and intersex people were not included in the studies identified by this scientific review.

dearth of health information for lesbian and bisexual women in comparison with materials available for heterosexual women and gay men. The authors argue that whilst lesbian and bisexual women are more likely to receive unsuitable advice or encounter inappropriate behaviour (e.g. during the course of sexual history taking, contraceptive services and cervical screening), little attention is paid to lesbian and bisexual women's health issues in either undergraduate or post-qualification medical curricula.

Although no articles were extracted from the SR protocol regarding trans (or intersex) people and documentation and protocols, it is important to acknowledge that trans people may have very particular needs with regards to the recording of demographic information and health records. For example, trans people may have a chosen name and gender identity that differs from their current legally designated name and sex. This may mean the need to include both legal name and preferred name, gender, and pronoun. Moreover, sex-specific health information such as a man with a cervix or a woman with a prostate for example, will require particular attention and documentation through accurate and appropriate data collection methods. For instance, a trans man who has accessed legal gender recognition (i.e. his legal sex is male) may still have their cervix, ovaries, and uterus, and thus require routine gynaecological screenings (Deutsch, Green, Keatley, Mayer, Hastings & Hall, 2013).

6.5.2 Continuity of care

A further institutional barrier health professionals' face found in the review of literature was the lack of continuity in care provided to LGB patients (e.g. Pennant *et al.*, 2009). Due to sensitivity around confidentiality and not knowing if a person identifies as LGBTI, greater consistency in care provided by one practitioner (rather than a different health professional each time) rather than would offer the opportunity needed to provide more person-centred care (Fish & Bewley, 2010; Pennant *et al.*, 2009). These arrangements would allow for mutual respect and trust to develop over time between LGBTI patients and a named health professional (Pennant *et al.*, 2009)⁴⁴.

6.6 Knowledge and training

Throughout this SR so far, the message from the primary research reviewed is both clear and consistent. Many generic and specialist health professionals lack the appropriate knowledge regarding the lives and related health(care) needs of LGBTI people as well as lack the appropriate culturally competent skills necessary to meet the needs of LGBTI people (Alessi *et al.*, 2016; Bailey *et al.*, 2014; Budge *et al.*, 2013; Chakraborty *et al.*, 2011; Elliot *et al.*, 2015; Fish & Bewley, 2010; Gonzales *et al.*, 2015; Lyons, T *et al.*, 2015; Moe & Sparkman, 2015; Pennant *et al.*, 2009; Sanders, Carter & Lwin, 2015; Sharek *et al.*, 2015; Utamsingh *et al.*, 2016; Zeeman *et al.*, 2016). As one of many examples, Sharek *et al.*, (2015) found that just 41% of older LGBT service users in healthcare thought health professionals had sufficient knowledge of LGBT issues leaving a staggering 59% who did not. Clearly, appropriate training is required to redress these key gaps in the knowledge of health professionals (e.g. Moe & Sparkman, 2015).

⁴⁴ It may be that LGBTI people select, where possible, medical personnel whom are known to them and/or their respective communities as being 'friendly'. However, whilst this may be done out of necessity, the issue remains for healthcare services to provide better, more competent and consistent care for LGBTI people in all settings and by all providers, not just the 'friendly-few'.

SECTION SEVEN: Recommendations from the research, limitations, and conclusions

7.1 Introduction

The previous Sections of this SR report have presented research extracted via the study protocol (Section 2) to explore: 1) What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings? 2) What is known about the health inequalities of LGBTI people focusing on vulnerable intersections (e.g. rural, older, younger, refugee, immigrant, disability, poverty) as it relates to healthcare? and; 3) What are the potential barriers faced by health professionals when providing care for LGBTI people?

The research papers reviewed as part of this current SR identified a number of recommendations. In this relatively brief Section, these recommendations (where relevant) are presented thematically with reference to the studies where they appeared. It is important to underline therefore that these recommendations/proposals are from the authors of the specific research papers included in this SR. They are therefore not exhaustive and do not necessarily reflect the position of the Consortium members. Consequently, some sub-sections are longer/shorter than others reflecting the content and/or focus of the papers included in the SR. As noted in Section 1.5, where possible we have tried to be precise in reporting primary research by referring specifically and deliberately to LGB or LGBT people instead of LGBTI people; this is done to acknowledge the original research participants in the study in question. However, in this Section where a study provided recommendations/proposals regarding only certain groups such as LGB, but the issues also appeared relevant for 'T' and 'I' people, then we have indicated this by including the latter in parenthesis e.g. LGB(TI), LGBT(I) etc.

Following the recommendations, brief limitations of the SR and conclusions are provided.

7.2 Overcoming barriers: general recommendations and recommendations for training from the research

7.2.1 General recommendations

- (L)GBT(I) services should be developed for younger people under the age of 25 and older people over the age of 55 by providing first line mental healthcare, treatment and social support (Bauer *et al.*, 2015, Hickson *et al.*, 2016).
- Targeted initiatives are needed for LGB(TI) youth to provide mentoring support that will help them learn how to avoid and cope with victimisation by peers. Support from parents and other community elders may act as a protective factor for LGB youth (Goldbach *et al.*, 2014).
- Bisexual and trans people are at high risk of mental disorder such as depression, anxiety and suicidal ideation. Greater visibility and tailor-made therapy services are required for trans and bisexual people (Hickson *et al.*, 2016).
- Trans and/or LGBT mental health specific treatment programmes are needed to ensure the psychological and emotional wellbeing of trans people is addressed (Lyons, T *et al.*, 2015), and that trans people are supported to deal with social stressors such as experiences of discrimination and victimisation (Reisner *et al.*, 2014).

- Intersex people should have access to specialist services where they can access talking therapies to maintain psychosexual, emotional and social wellbeing (Thyen *et al.*, 2014).
- Substance misuse services should take account of the raised prevalence of drug use amongst gay and bisexual men related to minority stress. Therapy services should be available to provide counselling and support (King *et al.*, 2008).
- Gay and bisexual men who are young, and those with lower education and lower income, are at higher risk of attempted suicide. Health promotion initiatives and mental health services are required to address these needs (Hickson *et al.*, 2016).
- Research suggests that stigma should be addressed in rural areas to improve uptake of primary care services. Approaches that have been found to be effective with rural LGBT groups were outreach clinics, telemedicine with specialist consultations and primary care practitioner training. These could help providers gain a better understanding of the health needs of LGBT(I) people (Whitehead *et al.*, 2016).
- In addition, the mental health of those who live in geographically remote areas may be affected by isolation and marginalisation which supports the need for mental health promotion programmes in these settings (Lyons, A. *et al.*, 2015).
- LGBT(I) asylum seekers and refugees may benefit from being assessed for post-traumatic stress disorder at early consultations and also from receiving a trauma-informed approach which takes into accounts the impact of traumatic events on the current functioning and circumstances of clients (Alessi *et al.*, 2016).

Cancer care

- Anal screening programmes for gay and bisexual men and cervical screening programmes for lesbian and bisexual women are needed to ensure early detection (Meads *et al.*, 2012).
- Given lesbian and bisexual cancer survivors more likely to report poor health after treatment and more likely to be single than other populations (Hill & Holborn, 2015), there is a need for additional support post treatment to help them regain their sense of health and wellbeing (Boehmer *et al.*, 2011a).
- LGBT(I) support groups may be useful for people who feel isolated after cancer diagnosis, where people can speak about their experiences and gain support from other people in similar circumstances, to promote emotional and psychological wellbeing (Hill & Holborn, 2015).

Research

- Research is needed to understand the reasons for increased rates of polycystic ovaries in lesbian women compared to heterosexual women (Meads *et al.*, 2012).
- A gap in data supports the need for future research to address the general health inequalities of trans people (Meads *et al.*, 2012) as well as further research to understand the impact of social transition, legal recognition and gender reassignment surgery for trans people (Bailey *et al.*, 2014).
- More recent reviews of cancer have identified a gap in high quality international research to address the cancer burden and care needs of trans people (Blondeel *et al.*, 2016).

- The impact of normalising interventions on intersex people later in life warrants research (Köhler *et al.*, 2012; Thyen *et al.*, 2014).

7.2.2 Recommendations for training

- Increased knowledge of LGBT(I) lives and historic events that may have marginalised LGBT(I) people, result in the need for safe and supportive care practices that are sensitive to the fear and anxieties of LGBT(I) people particularly for older adults (Meads *et al.*, 2012).
- Health professionals could show an understanding that connectedness of LGBT(I) people to the broader LGBT(I) community means greater mental health and wellbeing for some (Haas *et al.*, 2010).
- Health professionals should gain access to training that will help them facilitate sexual orientation disclosure, and improve their capacity for conversations to address the sexual and relational needs of gay and bisexual men recovering from prostate and other forms of cancer (Rose *et al.*, 2016).

Constructive communication

- Practitioners working in health settings should use language that is inclusive of LGB(TI) people, their lives and their partnerships (Fish & Williamson, 2016).
- Practitioners should avoid assumed heterosexuality, for example that people are heterosexual when they are married or have children (Sharek *et al.*, 2015).
- Practitioners should use gender-neutral language when discussing partners to include both heterosexual and same-sex partners (Hill & Holborn, 2015).
- Practitioners should ensure language is inclusive by asking open questions that do not assume people are heterosexual for example: 'Who do you live with?' or 'Do you have a partner?' (Pennant *et al.*, 2009).
- Practitioners should acknowledge the role and importance of same-sex partners and include them in decision-making about care pathways and treatment options (Sharek *et al.*, 2015).
- Opportunities should be created for LGB people to disclose their sexual orientation via inclusive, appreciative and non-judgemental communication that upholds professional values of mutual respect (Fish & Williamson, 2016).
- Health professionals should learn how to use non-binary language to ensure the plurality of the lives and bodies of trans and intersex people gain recognition (Reisner *et al.*, 2016; Köhler *et al.*, 2012; Thyen *et al.*, 2014).
- Asylum seeker, migrant and refugee LGBT people may have experienced abuse or trauma in their country of origin linked to their sexual orientation or gender identity. Health professionals should make additional efforts in communication to be non-judgemental and accepting (Alessi *et al.*, 2016).
- Practitioners should acknowledge the feelings of fear gay and bisexual men may experience prior to screening and treatment for HIV/AIDS and normalise these feelings in order to facilitate greater uptake of services (Wao *et al.*, 2016).

Healthcare providers

- Visibility of LGB(T) staff when working with LGB(T) patients may help (provided they can remain safe) to create an atmosphere where people feel more comfortable to 'come out' and discuss their specific health needs (Fish *et al.*, 2016).
- Health settings should provide information and leaflets that are LGBT(I) friendly by providing positive imagery to help promote the visibility of LGBT people (Sharek *et al.*, 2015).
- Health settings should make materials available for LGBT service users, particularly those in rural areas, to show the benefits of openly disclosing their sexual orientation and/or gender identity to health providers, and explaining the related benefits (Whitehead *et al.*, 2016).

Service user involvement

- L(G)B(TI) people should be included in decision-making about healthcare delivery and policy to represent their specific health concerns, and by helping to develop progressive services (Fish & Bewley, 2010).

7.3 Limitations and conclusions

The present report is a Scientific Review conducted within the context of Task 1 of the [Health4LGBTI pilot project](#). The review provides valuable insights into the root causes of health inequalities experienced by LGBTI people as well as what is known about the inequalities faced by LGBTI people in relation to healthcare including potential barriers faced by health professionals when providing care. However, it is nevertheless important to acknowledge some limitations of this SR.

7.3.1 Limitations

First, as a narrative review, literature is extracted from particular databases (with justifications) and therefore can never identify or extract all literature (nor is it intended to) that might be available on a particular topic. Consequently, the literature extracted and reported in this SR is based on precise inclusion/exclusion criteria agreed by Consortium partners. It will thus reflect these criteria and the specific databases used (not all journal papers are indexed in all databases meaning selective choices have to be made about which databases are likely to retrieve the most relevant data). The findings of the current review therefore, are limited by the defined query, search terms, and the selection criteria of primary studies.

Second, the review did not attempt to evaluate the quality of the primary research studies included as this was beyond the scope of the task. Consequently, some caution must be applied in the interpretation of study findings as well as the recommendations elicited.

Third, the literature extracted via the review protocol reflects a U.S. and U.K. bias (see Appendix) which is not surprising given the study was designed to only include articles published in English. Although this is commonly necessary within the limited resources and scope of research projects, it does mean that caution should be applied as the findings may miss key primary research published in peer reviewed journals in languages other than English. Moreover, caution should also be extended given that cultural contexts and health

systems not only vary significantly between the U.S. and Europe but also between (and sometimes within) European countries⁴⁵.

Fourth, a further limitation of this review is the lack of included research on trans and intersex populations extracted via the research protocol. Although additional hand searching did reveal some papers on trans and intersex people which were later included, on the whole the analysis revealed an extensive lack of dedicated and appropriate research with these populations in the peer reviewed primary literature; a situation which needs to be rectified.

Finally, in Section 4 we explored where possible, health inequalities reported in the research extracted, relating to L.G.B.T.I. people separately. However, analysis of the research papers revealed that few studies actually do this and instead, commonly collapse LGBTI people into a single group (e.g. lesbian and bisexual women; gay and bisexual men; Trans and cisgender people) despite often collecting detailed data on gender identity and trans status. Although aggregating data together in this way can be useful for research and analytical purposes, it does blur important issues which may very be specific to each group and may also merit specific attention. Therefore, in this SR it has not always been possible to tease out precisely which issues are most pertinent to which group if the research papers do not differentiate. Thus, we propose that future research with LGBTI people is designed specifically to ensure analysis can be conducted by gender identity and trans status separately thus maximising relevancy for each group.

7.3.2 Conclusions

This SR has provided a state-of-the-art analysis of primary research literature relating to the health inequalities experienced by LGBTI people. It is clear from our analysis that LGBTI people in Europe experience significant health inequalities and that these ostensibly have their origin (amongst other things) within heteronormative contexts where heterosexuality based on binary genders is upheld as the social and cultural norm, as well as minority stress associated with sexual orientation, gender identity and sex characteristics, victimisation, discrimination (individual and institutional) and stigma. Many inequalities stemming from such origins are arguably avoidable and thus maybe preventable.

Indeed, it is also clear from the research and the findings of this SR, that such inequalities can potentially be reduced via health services. Whilst this may require specific efforts by health systems including health professionals to ensure such services are specifically attuned to the needs of LGBTI people, meaning barriers to effective and efficient service delivery need to be overcome, it is also essential action and in line with European efforts to abolish discrimination on any grounds and to uphold and promote the human rights of LGBTI people.

Research identifies a myriad of barriers that health professionals face in addressing the health needs of LGBTI people, often linked to a lack of knowledge and understanding of the lives,

⁴⁵ To address this and to ensure the SSR was not limited by such bias, the Comprehensive Scoping Review (Zeeman *et al.*, 2017a) implemented a rapid-review process that engaged with 27 of the 28 Member States in order to access 'grey literature' that might not otherwise be accessible in English.

partnerships, and health concerns of LGBTI people as well as personal values, beliefs and behaviours that may knowingly or unknowingly continue to marginalise LGBTI people, and render their lives invisible. The challenge for health professionals and health systems therefore is to develop the structures for both specialist and universal health service provision that are truly inclusive and equally accessible to all regardless of gender identity, sexual orientation, or sex characteristics. We hope that the findings of this SR may go some way in facilitating and supporting this process.

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Appendix: Research studies included

Author	Institution	Title	Date	Location	Method	Journal
1. King <i>et al.</i>	University College London, UK	A systematic review of mental disorder, suicide and deliberate self-harm in LGB people.	2008	International and USA	Systematic review and meta-analysis	BMC Psychiatry
2. Bauer <i>et al.</i>	University of Western Ontario, Canada	Reported emergency department avoidance, use, and experiences of transgender persons in Ontario	2014	Canada	Respondent-driven sampling (RDS) survey with n=433 trans people	Annals of Emergency Medicine
3. Bauer <i>et al.</i>	University of Western Ontario, Canada	Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada.	2015	Canada	RDS survey with N=380 trans people who reported on suicide outcomes	BMC Public Health
4. Bailey <i>et al.</i>	University of Hull, UK	Suicide risk in the UK trans population and the role of gender transition in decreasing suicidal ideation and suicidal attempt	2014	UK	Survey with n=889 trans people	Mental Health Review Journal
5. Blondeel <i>et al.</i>	University, Ghent, Belgium	Evidence and knowledge gaps on the disease burden in sexual and gender minorities: a review of systematic reviews	2016	Belgium and international	Narrative review of 30 systematic reviews	International Journal for Equity in Health
6. Meads & Moore	Brunel University, Middlesex, UK	Breast cancer in lesbians and bisexual women: systematic review of incidence, prevalence and risk studies	2013	UK, USA and international	Systematic review	BMC Public Health
7. Meads <i>et al.</i>	Queen Mary University, UK	Lesbian, gay and bisexual people's health in the UK: a theoretical critique and systematic review.	2012	UK and international	Systematic review	Diversity and Equality in Health and Care
8. Pennant <i>et al.</i>	University of Birmingham, UK	Improving LGB healthcare. A systematic review of literature	2009	UK and international	Systematic review	Diversity in Health and Care
9. Katz-Wise & Hyde	University of Wisconsin–Madison, USA	Victimization experiences of lesbian, gay, and bisexual individuals: a meta-analysis.	2012	USA and 18 countries	Meta-Analysis	Journal of Sex Research
10. Goldbach <i>et al.</i>	The University of Southern California, USA	Minority stress and substance use in sexual minority adolescents: A meta-analysis.	2014	USA and international	Systematic review and meta-analysis	Prevention Science
11. Elliott <i>et al.</i>	University of Cambridge UK	Sexual minorities in England have poorer health and worse healthcare experiences: A national survey	2015	UK and USA	English General Practice patient survey of n=2,169,718 including 27,497 LGB	Journal of General Internal Medicine
12. Eliason <i>et al.</i>	San Francisco State University, USA	A systematic review of the literature on weight in sexual minority women	2015	USA	Systematic review	Women's Health Issues
13. Sharek <i>et al.</i>	Trinity College Dublin, Ireland	Older LGBT people's experiences concerns with healthcare professional and services in Ireland	2015	Ireland	Survey and qualitative interviews with n=144 older LGBT people	International Journal of Older People Nursing
14. Chakraborty <i>et al.</i>	University College London, UK	Mental health of the non-heterosexual population of England	2011	UK	Adult psychiatric morbidity survey n=7,403	British Journal of Psychiatry

15. Haas <i>et al.</i>	American Foundation for Suicide Prevention, USA	Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations	2010	USA and international	Narrative review	Journal of Homosexuality
16. Sanders <i>et al.</i>	University of Central Lancashire, UK	Young women with a disorder of sex development: learning to share information with health professionals, friends and intimate partners about bodily differences and infertility	2015	UK	Interpretive phenomenological analysis with n=13	Journal of Advanced Nursing
17. Lee <i>et al.</i>	Karolinska Institutet, Sweden	Review of recent outcome data of disorders of sex development (DSD): Emphasis on surgical and sexual outcomes	2012	Sweden, USA, Belgium, Netherlands	Narrative review	Journal of Paediatric Urology
18. Jones	University of New England, Australia	The needs of students with intersex variations	2016	Australia	Online survey with n=272 intersex participants	Sex Education
19. Köhler <i>et al.</i>	Humboldt University, Germany	Satisfaction with genital surgery and sexual life of adults with XY disorders of sex development: Results from the German clinical evaluation study	2012	Germany, Austria, Switzerland	Psychosexual inquiry with n=57 intersex participants	Journal of Clinical Endocrinology & Metabolism
20. Thyen <i>et al.</i>	Lubeck University, Germany	Utilization of healthcare services satisfaction with care in adults affected by disorders of sex development (DSD)	2014	Germany, Austria, Switzerland	Survey with n=110 intersex participants	Journal of General Internal Medicine
21. Utamsingh <i>et al.</i>	Duke University, USA	Heteronormativity and practitioner–patient interaction	2016	Durham, NC	LGBTQ and pansexual participants n=133, questionnaire, case study, written reflections	Health Communication
22. Marques <i>et al.</i>	University of Porto, Portugal	Lesbian medical encounters: Heteronormativity	2015	Portugal	Individual interviews with n=30 lesbians	Healthcare of Women International
23. Fish & Bewley	De Montfort University, UK	Using human rights-based approaches to conceptualise lesbian and bisexual women's health inequalities	2010	UK	Questionnaire with LB women n=6,490	Health and Social Care in the Community
24. Bourne <i>et al.</i>	London School of Hygiene & Tropical Medicine, UK	Physical Health Inequalities Among Gay and Bisexual Men in England: A Large Community-Based Cross-Sectional Survey	2016	UK	Online survey with gay and bisexual men n=5,799	Journal of Public Health
25. Blosnich <i>et al.</i>	University of Rochester, USA	A systematic review of tobacco inequalities for sexual minorities	2013	USA and international	Systematic review	Tobacco Control
26. Hickson <i>et al.</i>	London School of Hygiene & Tropical Medicine, UK	Mental health inequalities among gay and bisexual men in England, Scotland and Wales: a large community-based cross-sectional survey	2016	UK	Online survey with gay and bisexual men n=5,799	Journal of Public Health
27. Lyons A. <i>et al.</i>	La Trobe University, Australia	Rural-urban differences in mental health, resilience, stigma and social support among young Australian gay men	2015	Australia	Online survey with n=1,034 gay men	Journal of Rural Health
28. Lyons, T. <i>et al.</i>	British Columbia Centre for Excellence in HIV/AIDS, and University of British Columbia, Canada	A qualitative study of transgender individuals' experiences in residential addiction treatment settings: Stigma and inclusivity	2015	Canada	Individual interviews with (n=34) trans people	Substance Abuse Treatment, Prevention, and Policy

29. Whitehead <i>et al.</i>	Northwestern University, USA	Outness, Stigma, and Primary Healthcare Utilization among Rural LGBT Populations	2016	USA	LGBT online survey (n=1,014)	Plos One
30. Alessi <i>et al.</i>	The State University of New Jersey, USA	'The darkest times of my life': Recollections of child abuse among forced migrants persecuted because of their sexual orientation and gender identity	2016	USA & Canada	26 individual interviews with refugee and asylum seekers	Child abuse and neglect
31. Fish & Williamson	De Montfort University, UK	Exploring lesbian, gay and bisexual patients' accounts of their experiences of cancer care in the UK	2016	UK	15 individual interviews LGB people	European Journal of CA care
32. Boehmer <i>et al.</i>	Boston University School of Public Health, USA	Cancer survivorship and sexual orientation	2011a	USA	California health interview Survey (n=122,394)	Cancer
33. Boehmer <i>et al.</i>	Boston University School of Public Health, USA	An ecological analysis of colorectal cancer incidence and mortality: Differences by sexual orientation	2011b	USA	Census data (n=594,391) of same-sex partner households	BMC Cancer
34. Boehmer <i>et al.</i>	Boston University School of Public Health	Sexual minority population density and incidence of lung, colorectal and female breast cancer in California	2014	USA	California cancer registry & national health interview survey	BMJ Open
35. Hill & Holborn	Queen Margaret Edinburgh UK	Sexual minority experiences of cancer care: a systematic review	2015	Scotland & international	Systematic review	Journal of Cancer Policy
36. Cochran & Mays	University of California Los Angeles, USA	Risk of Breast Cancer Mortality Among Women Cohabiting with Same Sex Partners: Findings from the National Health Interview Survey, 1997–2003	2012	USA	National health interview survey n=136,174 male and female n=692	Journal of Women's Health
37. Rose <i>et al.</i>	University of Sydney, Australia	Let's talk about gay sex: Gay and bisexual men's sexual communication with healthcare professionals after prostate cancer	2016	Australia	Survey n=124 and 46 interviews	European Journal of CA care
38. Gonzales <i>et al.</i>	University of Minnesota, USA	Comparison of health and health risk factors between lesbian, gay, and bisexual adults and heterosexual adults in the United States: results from the national health interview survey	2016	USA	National health interview survey n=68,814	JAMA Internal Medicine
39. Gonzales & Henning-Smith	University of Minnesota, USA	Inequalities in health and disability among older adults in same-sex cohabiting relationships	2015	USA	National health interview survey n=698 men and n=630 women	Journal of Aging and Health
40. Fredriksen-Golsen & Muraco	University of Washington, USA	Aging and sexual orientation: A 25-Year Review of the Literature	2010	USA	Narrative review	Research on Aging
41. Fredriksen-Golsen <i>et al.</i>	University of Washington, USA	Health inequalities among lesbian, gay, and bisexual older adults: Results from a population-based study	2013	USA	Survey data from the Behavioural risk factor surveillance system n=96 992	American Journal of Public Health
42. Fredriksen-Golsen <i>et al.</i>	University of Washington, USA	The physical and mental health of lesbian, gay male, and bisexual (LGB) older adults: the role of key health indicators and risk and protective factors	2012a	USA	Survey with n=2,439 older adults, phone interviews	The Gerontologist

43. Fredriksen-Golsen <i>et al.</i>	University of Washington, USA	Disability among lesbian, gay, and bisexual adults: Disparities in prevalence and risk	2012b	USA	Survey data from the Behavioural risk factor surveillance system N=96 992 (n=82,531)	American Journal of Public Health
44. Fredriksen-Golsen <i>et al.</i>	University of Washington, USA	Disparities in health-related quality of life: A comparison of lesbians and bisexual women	2010	USA	Survey data from the Behavioural risk factor surveillance system n=1,496)	American Journal of Public Health
45. Wao <i>et al.</i>	University of South Florida, USA	MSM's versus healthcare providers' perceptions of barriers to uptake of interventions: Systematic review, meta-synthesis	2016	USA	Systematic review and meta-synthesis	International Journal of Sexual Health
46. Zeeman <i>et al.</i>	University of Brighton, UK	Promoting resilience and emotional well-being of transgender young people: research at the intersections of gender and sexuality	2016	UK	Participatory qualitative methods including focus group with trans youth (n=5)	Journal of Youth Studies
47. Moe & Sparkman	Old Dominion University, USA	Assessing service providers at LGBTQ-affirming community agencies on their perceptions of training needs and barriers to service	2015	USA	Survey of service providers (n=109)	Journal of Gay & Lesbian Social Services
48. Semlyen <i>et al.</i>	University College London, UK	Sex Sexual orientation and symptoms of common mental disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys	2016	UK	Meta-synthesis	BMC Psychiatry
49. Reisner <i>et al.</i>	Harvard Medical School Boston, USA	Transgender health inequalities: comparing full cohort and nested matched-pair study designs in a community health centre	2014	USA	Health surveillance survey (n=155)	LGBT Health
50. Reisner <i>et al.</i>	Harvard Medical School Boston, USA	Global health burden and needs of transgender populations: a review	2016	30 countries including EU	Review and synthesis	Lancet
51. Van Beusekom <i>et al.</i>	University of Amsterdam, The Netherlands	Gender nonconformity and mental health among lesbian, gay, and bisexual adults: Homophobic stigmatization and internalized homophobia as mediators	2016	The Netherlands	Online survey (n=748) with LGB individuals	Journal of Health Psychology
52. Maguen & Shipherd	University of California, USA	Suicide risk among transgender individuals	2010	USA	A survey with trans participants (n=153) to assess suicidal risk	Psychology & Sexuality
53. Nokoff <i>et al.</i>	University of Colorado, USA	Prospective assessment of cosmesis before and after genital surgery.	In press	USA	Prospective observational study with children <2 years of age (n=37)	Journal of Pediatric Urology
54. Sherriff <i>et al.</i>	University of Brighton, UK	"What do you say to them?" Investigating and supporting the needs of lesbian, gay, bisexual, trans, and questioning (LGBTQ) young people	2011	UK	Qualitative methods with 29 young people and practitioners	Journal of Community Psychology
55. Ellis <i>et al.</i>	Sheffield Hallam University, UK	Trans people's experiences of mental health and gender identity services: A UK study	2015	UK	Survey of trans people n=889)	Journal of Gay & Lesbian Mental Health

56. Budge <i>et al.</i>	University of Louisville, USA	Anxiety and depression in transgender individuals: The roles of transition status, loss, social support, and coping	2013	USA	Various online measures with trans participants (n=351)	Journal of Consulting and Clinical Psychology
57. Colledge <i>et al.</i>	London School of Hygiene & Tropical Medicine, UK	Poorer mental health in UK bisexual women than lesbians: evidence from the UK 2007 Stonewall Women's Health Survey	2015	UK	Survey with n=937 bisexual-identified and n=4,769 lesbian-identified women	Journal of Public Health



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HEALTH LGBTI

REDUCING HEALTH INEQUALITIES EXPERIENCED BY LGBTI PEOPLE

A review of health inequalities experienced by LGBTI people and the barriers faced by health professionals in providing healthcare for LGBTI people

Comprehensive Scoping Review

June, 2017

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Health4LGBTI

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Executive summary

AIMS

This report is a state-of-the-art review study carried out in the context of the EU funded pilot project [Health4LGBTI \(SANTE/2015/C4/035\)](#). The aim of this Comprehensive Scoping Review (CSR) was to complement the findings of the Scientific Review (SR; Zeeman *et al.*, 2017a) by exploring grey literature from European bodies and agencies as well as from across all Member States (MS) of the European Union (EU). In doing so, this CSR aimed to provide potential source material to inform components of the wider Health4LGBTI project; namely the development of dedicated training for health professionals on reducing health inequalities experienced by LGBTI people.

METHODS

An adapted version of Arksey and O'Malley's (2005) framework for conducting scoping studies was used to structure the CSR activities via two key tasks which included a review of key [European/international grey literature](#) and, [rapid-reviews of relevant grey literature](#) from European Member States. For the former, searches were pragmatic utilising a combination of non-scientific electronic databases, reference lists of included literature, and hand searching of relevant EU/International organisations. For the latter, experts were identified in each European MS to conduct 'rapid-reviews' of relevant grey literature from their own countries. The aim was to access grey literature that might not otherwise be accessible (e.g. non-English and/or not indexed in scientific databases), ensuring a good geographical coverage of the information and data collected across MS and in doing so, embracing different social and cultural contexts. Both reviews were centred around [four core questions](#) including: 1) What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings? 2) What is known about the health inequalities of LGBTI people focusing on vulnerable intersections (e.g. rural, older, younger, refugee, immigrant, disability, poverty) as it relates to healthcare? 3) What are the potential barriers faced by: i) LGBTI people when using or trying to access healthcare, and; ii) health professionals when providing care for LGBTI people? and; 4) What examples of promising practice exist to address the specific health needs of LGBTI people?

RESULTS

What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Findings of the combined European review and rapid-reviews were consistent in revealing a range of inequalities experienced by LGBTI people in health-related settings. For example, in several rapid-reviews from Member states including Belgium, Hungary, Ireland, Poland, Slovakia, Spain, and Sweden, LGBT people were reported to have increased rates of depression, suicide and self-harm with younger LGBT people being at greatest risk. Other inequalities included and/or were related to: suicide ideation, anxiety, stress, stigma, and disproportionate rates of sexually transmitted infections including HIV for gay and bisexual men and trans women. Reviews delivered minimal information on the general health profiles of LGBT people, with even less information gained on the health inequalities for intersex people.

What is known about the health inequalities of LGBTI people focusing on vulnerable intersections (e.g. rural, older, younger, refugee, immigrant, disability, poverty) as it relates to healthcare?

The rapid-reviews revealed limited grey literature in terms of intersectionality and discrimination that LGBTI people may have experienced based on more than one marker of difference such as sexuality and gender, sex, age, disability or ethnicity. Of the reviews that did explore literature on intersectionality areas covered included: LGBTI people with disabilities; older LGBTI people, and; LGBTI who were also migrants, refugees or asylum seekers. For example, one rapid-review drew attention to grey literature highlighting how LGBT people with disabilities may face two stigmatised positions due to being more dependent because of chronic illness, and thus having less privacy in exploring and developing their sexual orientation and gender identity. Due to double marginalisation, LGBTI people with disabilities may have a greater need to access health services for physical and psychological support.

What are the potential barriers faced by: 1) LGBTI people when using or trying to access healthcare, and; 2) health professionals when providing care for LGBTI people?

The findings from both reviews were consistent in revealing a number of barriers faced by LGBTI people when accessing healthcare. As examples these included: prejudicial attitudes and intolerant discriminatory behaviour of staff including inappropriate curiosity; unequal treatment; needs being ignored or not recognised (e.g. lesbian women not being invited for cervical screening due to wrongly being assumed that they are a 'low-risk' group or men who have sex with men being barred from donating blood due to fears that they may be HIV-positive); heteronormativity including gender-normativity leading to LGBTI people being 'Othered' including being subjected to humiliation and verbal harassment; denial of access to treatment (e.g. assisted reproductive technology); fear of disclosure of gender identity, sexual orientation or sex characteristics leading to healthcare avoidance. These concerns were more pronounced for trans and intersex people due to their experiences of marginalisation and discrimination whilst accessing care. In terms of the potential barriers faced by health professionals when providing care for LGBTI people, the reviews identified barriers such as: lack of knowledge and cultural competence concerning the lives and healthcare needs of LGBTI people; lack of basic awareness or consideration of the sexual orientation, gender identity and/or sex characteristics of LGBTI people who access health services; a lack of specialist mental health services and counselling services for LGBTI people; health professionals' own prejudices leading to the unequal treatment of LGBT people with regards healthcare.

What examples of promising practice exist to address the specific health needs of LGBTI people?

Despite the difficulties, inequalities, and barriers that LGBTI people still encounter in the field of health, a number of promising practices in the European literature and Member States were evident. As examples, these included: inclusive policies to ensure that LGB people can access healthcare alongside other people and that their specific needs are met; free, anonymous HIV testing and counselling including provision of centres providing assistance and support for people living with HIV (e.g. Bulgaria, Croatia, Czech Republic, Italy, Portugal, Slovenia); peer mentoring for LGBT people in crises (Czech Republic); a queer social group to interact with refugees and thereby foster mutual understanding (Luxembourg); information leaflets for health professionals to address LGBTI health (Poland); queer leadership development,

counselling and psychological support (Slovakia) and a suicide prevention strategy for LGBT people (Italy).

CONCLUSIONS

The purpose of this CSR was to access grey literature that might not otherwise be accessible via the 'usual' review methods (e.g. systematic and narrative reviews). Overall, the CSR review methodology was successful in gaining access to a wealth of rich data and information much of which has previously been 'hidden' via more mainstream extraction techniques. The results of the European review and MS rapid-reviews were consistent in demonstrating the existence of key health inequalities, barriers, and discrimination based on gender identity and gender expression, sexual orientation, and sex characteristics for LGBTI people. Although some encouraging promising practices in various health settings and contexts were evident, there is nevertheless still much to be done to ensure that the fundamental human rights of LGBTI people are both upheld and promoted. Appropriate and mandatory training for health professionals across all European Member States' health systems is an important step in this direction.

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List of abbreviations

AIDS	Acquired immune deficiency syndrome
CAIS	Complete Androgen Insensitivity Syndrome
CoE	Council of Europe
CSR	Comprehensive Scoping Review (this report)
DSD	Disorders of Sex Development
DSM-5	Diagnostic and Statistical Manual of Mental Disorders V5
EC	European Commission
EP	European Parliament
EU	European Union
FGR	Focus Group Report
FRA	Fundamental Rights Agency
HCP	Healthcare Professional
HIV	Human Immunodeficiency Virus
ICD-11	International Classification of Diseases V11 R
LGBTI	Lesbian, Gay, Bisexual, Trans, and Intersex
MS	Member State
MSM	Men who have Sex with Men
RR	Rapid-Review
SOGI	Sexual Orientation and Gender Identity
STI	Sexually Transmitted Infection
SR	Scientific Review
SSR	State of the Art Synthesis Report
TGEU	Transgender Europe
UN	United Nations
UNDP	United Nations Development Programme
UNPFA	United Nations Populations Fund
WHO	World Health Organisation
WSW	Women who have Sex with Women
PACE	Parliamentary Assembly Council of Europe

Glossary of key terms

Here we provide some of the most commonly terms used throughout this report and in the two companion reports (see Appendices). They are taken directly from ILGA-Europe's most commonly used phrases and acronyms which can be found here: www.ilga-europe.org/resources/glossary.

Cisgender	A term referring to those people whose gender identity and gender expression match the sex they were assigned at birth.
Gay	Refers to a person who is sexually and/or emotionally attracted to people of the same gender. It traditionally refers to men, but other people who are attracted to the same gender or multiple genders may also define themselves as gay.
Gender	Refers to a social construct which places cultural and social expectations on individuals based on their assigned sex.
Gender expression	Refers to people's manifestation of their gender identity to others, by for instance, dress, speech and mannerisms. People's gender expression may or may not match their gender identity/identities, or the gender they were assigned at birth.
Gender identity	Refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms. Some persons' gender identity falls outside the gender binary and related norms.
Gender reassignment surgery (GRS)	Medical term for what trans people often call gender confirmation/affirmation surgery, which is sometimes (but not always) part of a person's transition.
Homosexual	People are classified as homosexual on the basis of their gender and the gender of their sexual partner(s). When the partner's gender is the same as the individual's, then the person is categorised as homosexual. The term focuses on sexuality rather than on identity and may, in some contexts, have a negative and pathologising connotation.
Intersex	Relates to a range of physical traits or variation that lie between binary ideals of male and female. Intersex people are born with physical, hormonal or genetic features that are neither wholly female nor wholly male; or a combination of female and male; or neither female nor male. Many forms of intersex exist; it is a spectrum or umbrella term, rather than a single category.
Heteronormativity	Refers to the set of beliefs and practices that gender is an absolute and unquestionable binary, therefore describing and reinforcing heterosexuality as a norm. It implies that people's gender and sex characteristics are by nature and should always be aligned, and therefore heterosexuality is the only conceivable sexuality and the only way of being 'normal'.
Heterosexism	Heterosexism is a set of discriminatory attitudes, bias and behaviours relying on gender as a binary to favour heterosexuality and heterosexual relationships.
Queer	Previously used as a derogatory term to refer to LGBTI individuals in the English language, queer has been reclaimed by people who identify beyond traditional gender categories and heteronormative social norms. However, depending on the context, some people may still find it offensive. Also refers to queer theory, an academic field that challenges heteronormative social norms concerning gender and sexuality
Sex	The classification of a person as male or female. Sex is assigned at birth and written on a birth certificate, usually based on the appearance of their external anatomy and on a binary vision of sex which excludes intersex people. A person's sex however, is actually a combination of bodily characteristics including: chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics.

Sex characteristics	A term that refers to a person's chromosomes, anatomy, hormonal structure and reproductive organs. OII Europe and its member organisations recommend protecting intersex individuals by including sex characteristics as a protected ground in anti-discrimination legislation. This is because many of the issues that intersex people face are not covered by existing laws that only refer to sexual orientation and gender identity. This is seen as being a more inclusive term than 'intersex status' by many intersex activists, as it refers to a spectrum of possible characteristics instead of a single homogenous status or experience of being intersex.
Sexual orientation	Refers to each person's capacity for profound affection, emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender.
Trans	Is an inclusive umbrella term referring to people whose gender identity and/or gender expression differ from the sex/gender they were assigned at birth. It may include, but is not limited to: people who identify as transsexual, transgender, transvestite/cross-dressing, androgyne, polygender, genderqueer, agender, gender variant, gender non-conforming or with any other gender identity and/or expression which does not meet the societal and cultural expectations placed on gender identity.
Transsexual	An older and medicalised term used to refer to people who identify and live in a different gender. The term is still preferred by some people who intend to undergo, are undergoing or have undergone gender reassignment treatment (which may or may not involve hormone therapy or surgery).
Transition	Refers to a series of steps people may take to live in the gender they identify with. Transition can be social and/or medical. Steps may include: coming out to family, friends and colleagues; dressing and acting according to one's gender; changing one's name and/or sex/gender on legal documents; medical treatments including hormone therapies and possibly one or more types of surgery.

SECTION ONE: Background

1.1 About Task 1

Task 1 of the Health4LGBTI project was a state-of-the-art review study carried out in the context of the EU funded pilot project Health4LGBTI (SANTE/2015/C4/035). The review study focused on the health inequalities faced by LGBTI people (especially those in vulnerable situations) and the potential barriers faced by health professionals when providing care for LGBTI people. Co-led by the University of Brighton (UoB) with ILGA-Europe in collaboration with all Consortium partners, the review study comprised two key activities:

- 1) A **Scientific Review (SR)** of relevant International/European primary research literature published in academic peer reviewed journals (in English only; see Zeeman *et al.*, 2017a).
- 2) A **Comprehensive Scoping Review (CSR)** of relevant grey literature from (where possible) all 28 European Member States (MS).

Together, these two key activities informed the production of the key Deliverable for Task 1: State-of-the-art synthesis report (D1.1; see Figure 1).

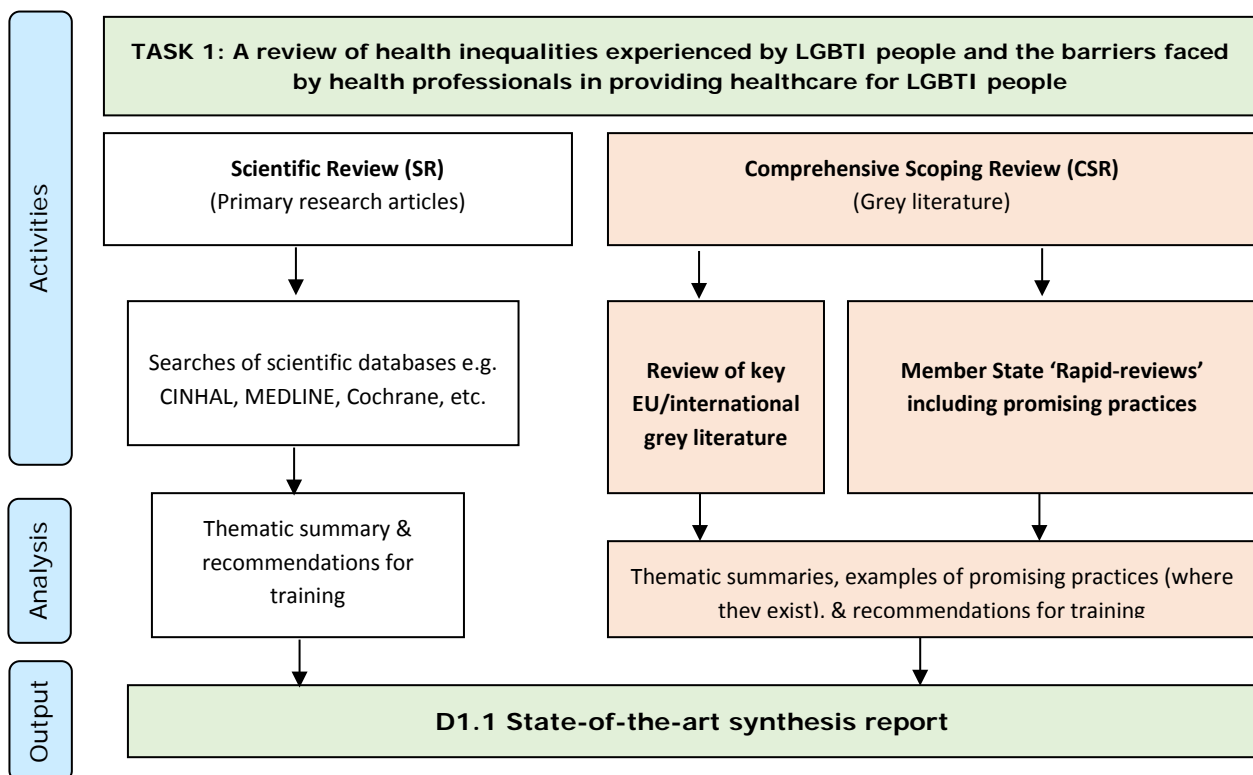


Figure 1. Overview of Task 1

1.2 Aims of the Comprehensive Scoping Review

The aim of this Comprehensive Scoping Review (CSR) was to complement the findings of the Scientific Review (SR; Zeeman *et al.*, 2017a) by focusing on the following key questions (closely mirroring the aims of the SR but with some minor differences):

- 1) What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?
- 2) What is known about the health inequalities of LGBTI people focusing on **vulnerable intersections** (e.g. rural, older, younger, refugee, immigrant, disability, poverty) as it relates to healthcare?
- 3) What are the **potential barriers** faced by: 1) LGBTI people when using or trying to access healthcare, and; 2) health professionals when providing care for LGBTI people?
- 4) What examples of **promising practice** exist to address the specific health needs of LGBTI people?

In addition to the above, as part of the rapid-review process the CSR also included an additional focus on exploring the **existence of training initiatives** for health professionals in each MS to address the health needs of LGBTI people. This additional focus was conducted to maximise the opportunity of working with MS to identify training initiatives. However, as this focus on training fell outside the scope of Task 1 and this report, data gathered was submitted to the relevant project partners for subsequent analysis and is therefore not presented in this current report.

1.3 About this report

This current report represents the **Comprehensive Scoping Review (CSR)** designed to complement the findings of the Scientific Review (SR; Zeeman *et al.*, 2017a; see also Zeeman *et al.*, 2017b) by exploring additional grey literature from European bodies and agencies as well as from across all Member States (MS) of the European Union (EU). In doing so, this CSR aimed to provide potential source material (e.g. themes, case examples, promising practices) to inform components of the wider **Health4LGBTI project**; namely the development of dedicated training module(s) for health professionals on reducing health inequalities experienced by LGBTI people.

This CSR report is divided into five main sections as follows:

Following this introduction, **Section Two** presents briefly the aims, methods and processes used to conduct the CSR. **Section Three** presents the findings of the key European/International literature structured around four main questions. **Section Four** presents thematic summaries of the findings from the rapid-reviews from MS. Finally, **Section Five** considers briefly some of the recommendations, limitations, and conclusions of the CSR.

1.4 A brief note on context and terminology

It is important to note that this CSR along with the companion Scientific Review (SR; Zeeman *et al.*, 2017a) provides the base-line information to inform the key deliverable for Task 1 (D1.1 State-of-the-art Synthesis Report). The State-of-the-art Synthesis Report (SRR; Zeeman *et al.*, 2017b) is a summary document bringing together this present CSR as well as the SR. Thus, the present CSR is only one part of Task 1 and should only be read and contextualised within the overarching SSR.

Throughout this CSR report, the terms sexual orientation, gender identity and sex characteristics are used where relevant in line with commonly accepted language reflected in

European policy directives, national guidelines, and third sector recommendations¹. Where possible we have tried to be precise with certain sections referring specifically and deliberately to LGB or LGBT people instead of LGBTI people; this is done to acknowledge the original research participants in the particular study in question. Where a particular study only included focused certain groups such as LGB, but the issues were also relevant for 'T' and 'I' people, then this was indicated by including the latter in parenthesis e.g. LGB(TI), LGBT(I) etc.

Finally, it is important to note that the rapid-review protocol asked for Member State experts to differentiate (where possible) between L.G.B.T.I. when reporting on grey literature from their countries. However, in some cases it was unclear which group(s) the literature reported (particularly where translated) was referring to. Consequently, where this is unknown or we were unable to verify, the full acronym of LGBTI is used. Thus some caution must be applied in extrapolating the issue in question to each of the groups.

¹ See www.ilga-europe.org/resources/glossary

SECTION TWO: Methods

2.1 Introduction

This Section presents the methods and process used to conduct this scoping review. In doing so, details of the conceptual framework to guide the process are provided before outlining the processes by which the European/international review and rapid-review of European Member States was conducted.

2.2 Methods

The CSR scoped published grey literature only, and did not assess the quality of any retrieved documents. An adapted version of Arksey and O'Malley's (2005) framework for conducting scoping studies was used to structure pragmatically the CSR activities via two key tasks (see Table 1 below):

- 1) A review of key [European/international grey literature](#) (e.g. including the major EU institutions and agencies as well as other relevant international organisations such as the OECD, WHO, and the United Nation's Economic, Social and Cultural Rights Committee), and;
- 2) [Rapid-reviews](#) of relevant grey literature from European Member States.

Stage	Description
1. Identifying the question	Identifying the research question provides the roadmap for subsequent stages. Research questions are broad in nature as they seek to provide breadth of coverage.
2. Identifying relevant studies	Identifying relevant studies and developing a decision plan for where to search, which terms to use, which sources are to be searched, time span, and language(s). Example sources include electronic databases, reference lists, hand searching of organisations and relevant conferences. Although breadth and practicalities of the search are important, clear parameters should be made upfront about how these will impact the search criteria (inclusion/exclusion).
3. Study selection	Study selection involves <i>post hoc</i> inclusion and exclusion criteria. These criteria are based on the specifics of the research question and on new familiarity with the subject matter through reading the studies.
4. Charting the data	A data-charting form is developed and used to extract data from each study. A 'narrative review' or 'descriptive analytical' method is used to extract contextual or process oriented information from each study.
5. Collating, summarising, and reporting results	An analytic framework or thematic construction is used to provide an overview of the breadth of the literature. A thematic analysis is then presented.
6. Consultation (optional)	Opportunities for stakeholder involvement (e.g. advisory board peer review)

Table 1. [Framework for conducting scoping studies \(adapted from Arksey and O'Malley, 2005\)](#)

Together the literature from the European/international review and Member State rapid-reviews provided the data for this CSR report (Figure 2 next page).

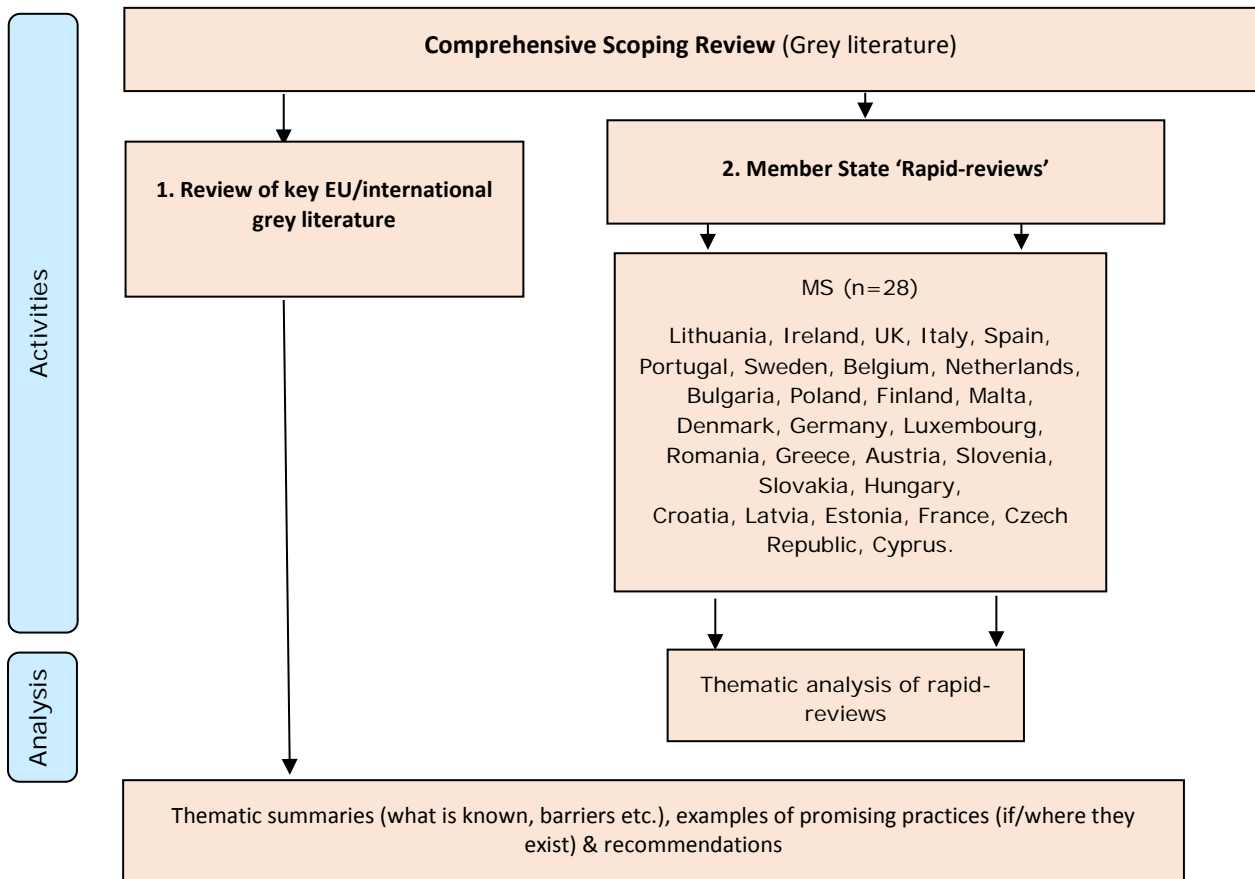


Figure 2. Overview of the CSR

2.2.1 Review of key European/international grey literature

Relevant European/international grey literature (e.g. legislation, policies, practices, programmes, projects, initiatives, surveys and reports) were collected, reviewed, and analysed thematically around the core questions for the CSR. Given the potential volume of such grey literature is large and diverse, this aspect of the review only examined the *most relevant* literature from: the major EU institutions (e.g. European Commission including relevant Directorate-Generals, relevant European Agencies such as the Fundamental Rights Agency); the Council of Europe including the Sexual Orientation and Gender Identity Unit (SOGI), and the European Social Charter Committee; the European Institute for Gender Equity (EIGE), and other relevant international organisations such as the OECD, WHO, and the United Nations (UN).

Search strategy

Based on the adapted version of Arksey and O'Malley's (2005) framework for conducting scoping studies (Table 1), searches were pragmatic utilising a combination of non-scientific electronic databases (e.g. SOGI database via the Council of Europe, DG Sante projects database etc.), reference lists of included literature, and hand searching of relevant EU/International organisations (e.g. websites) and if/where relevant conference sites/reports.

Inclusion/exclusion criteria

Inclusion of key EU/international grey literature was determined by language (English only), time (2006 onwards), and some geographical restrictions were applied (European primary focus, wider international focus where directly relevant; see Table 2 below). Precise criteria for inclusion/exclusion of grey literature were agreed with Consortium partners.

Inclusion	Exclusion
EU/international literature focusing on the CSR core questions and published by relevant institutions and international organisations	Academic/scientific literature/grey literature focusing on LGBTI lives and general concerns ²
Grey literature relating to multiple countries (primarily European MS)	Literature relating to a single European MS (Rapid-reviews cover MS specific literature)
Published between 2006-2016	Prior to 2006
Published in English	Non-English

Table 2. Inclusion/exclusion criteria for key EU/international grey literature (CSR)

2.2.2. Rapid-reviews by Member States (MS)

In a collaboration between the University of Brighton (UoB) and ILGA-Europe, this activity identified experts in each European MS to conduct 'rapid-reviews' of relevant grey literature from their own countries. The purpose of this part of the CSR was to access grey literature that might not otherwise be accessible (e.g. non-English and/or not indexed in [scientific] databases), ensuring a good geographical coverage of the information and data collected across MS and in doing so, embracing different social and cultural contexts.

Rapid-reviews focussed on:

- 1) What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?
- 2) What is known about the health inequalities of LGBTI people focusing on **vulnerable intersections** (e.g. rural, older, younger, refugee, immigrant, disability, poverty) as it relates to healthcare?
- 3) What are the **potential barriers** faced by: 1) LGBTI people when using or trying to access healthcare, and; 2) health professionals when providing care for LGBTI people?
- 4) What examples of **promising practice** exist to address the specific health needs of LGBTI people?

To address the above, the following indicative areas were explored:

- **Research and/or evaluation studies** (e.g. questionnaires and surveys, interviews, etc.) not published in academic journals, on perceived or experienced discrimination by LGBTI people regarding healthcare.
- **Relevant MS guidance, frameworks, policies and/or legislation** referring specifically to LGBTI people and healthcare (e.g. these could be local, regional, or national policies/legislation).
- **Complaints information** or data concerning perceived or experienced discrimination by LGBTI people relating to healthcare.

² Scientific literature (primary research) are addressed separately in the Scientific Review (see Zeeman *et al.*, 2017a).

- **Examples of promising practices** which engage with LGBTI people appropriately regarding access to healthcare and/or address health inequalities experienced by LGBTI people (e.g. descriptions of projects, programmes, initiatives, policies, working practices, procedures).

Information from MS was gathered via a rapid-review template (see Appendix) designed specifically for the purposes of the Health4LGBTI project. A small pilot of the rapid-review template and process was undertaken in [Ireland](#) and [Estonia](#) during April 2016 to test the efficacy of the template prior to commencing the review process with all MS. Following minor revisions, the template was sent out to the remaining MS for completion between May 2016 and August 2016. Data received from the rapid-reviews were thematically analysed.

SECTION THREE: Findings from the European/international grey literature

3.1 Introduction

This Section presents the findings of the European/international grey literature review around the core questions of the CSR. Given the volume of such grey literature is large and diverse, this aspect of the review only examined the most directly relevant literature (e.g. the EC and its agencies such as the Fundamental Rights Agency, the Council of Europe including the Sexual Orientation and Gender Identity Unit (SOGI), the WHO etc.).

3.2 Why are health inequalities related to healthcare important to address?

The average health of EU citizens has continued to improve over the last decade. However, differences in the health of people living in separate parts of the EU and between the most advantaged and most disadvantaged sections of the population remain substantial and in some instances have increased ([EC, 2009](#)). Addressing health inequalities within and between European Member States (MS) is crucial at local, national, regional, and international levels. Health inequalities do not necessarily result from individual behaviour, genetic factors, or lifestyle factors. People may be treated differently when accessing healthcare because of discrimination that occurs based on sex, 'race', religion or belief, disability, age, sexual orientation, gender identity, and sex characteristics ([FRA, 2013a, 2013b](#)).

Health inequalities for LGBTI people can deter people from accessing fundamental medical care, and lead to healthcare practices that are based on beliefs that it is legitimate to alter the human body via surgical procedures without the full and informed consent of the person who undergoes the intervention ([PACE 2013, FRA, 2015](#)). Moreover, LGBTI people in more vulnerable situations, such as minority ethnic/religious lesbian women or gay disabled men, may experience unequal or unfair treatment in relation to access and quality of healthcare because of constellated disadvantage or intersectional factors ([FRA, 2012, 2013b](#)). Addressing health inequalities related to healthcare is therefore necessary to guarantee an adequate quality of life for all people, not only to alleviate suffering, but also to ensure good health in the longer term ([FRA, 2014](#)). Moreover, addressing health inequalities experienced by vulnerable populations that are subjected to discrimination not only contributes to social justice, but it is also an economic necessity ([EC, 2009; FRA, 2015](#)).

3.3 What are LGBTI health inequalities and barriers to accessing healthcare identified in European grey literature?

International policies and research demonstrate the various inequalities and barriers that LGBTI people encounter in health-related settings. When they seek healthcare, LGBT people perceive that they experience worse treatment in the health sector compared to their peers ([Council of Europe \[CoE\], 2011](#)). Prejudicial attitudes amongst health professionals and institutionalised normativities regarding sexual orientation, gender identity and sex characteristics in health and social care services can deter people from accessing fundamental medical care ([FRA, 2014](#)). The prejudiced attitudes of medical staff towards LGBT people may be linked to knowledge based on outdated treatment approaches of homosexuality and trans identities ([CoE, 2011](#)).

The Council of Europe's (CoE) Parliamentary Assembly (PACE) resolution on discrimination on the basis of sexual orientation and gender identity ([CoE, 2010](#)) recognises that LGBT people face deeply rooted prejudice, hostility and widespread discrimination all over Europe, including in health settings. Moreover, discrimination and stigmatisation can be very damaging for the mental health of LGBT people. LGBT people have a higher incidence of poor health compared to heterosexual and cisgender people, particularly with regards to mental health. Suicide amongst LGBT people especially for the young has been identified as an urgent health priority ([CoE, 2011](#)).

Literature shows a link between disclosure and negative experiences when LGBT people use or try to access health services. People who disclose their sexual orientation to medical staff and health providers are more likely to experience barriers and discrimination compared to those who conceal their sexual orientation or gender identity ([FRA, 2014](#)). Furthermore, expectations and experiences of stigma and discrimination may result in a mistrust between LGBT patients and their health providers, which may lead to LGBT people not seeking medical care if they need it or withholding information about their sexual orientation and gender identity ([CoE, 2011](#)). This mistrust between LGBT people and their medical practitioners may be related to fears that the privacy and confidentiality of their health status, sexual orientation or gender identity and medical records is not respected.

3.3.1 Health inequalities, barriers and discrimination based on sexual orientation

Homosexuality and bisexuality are still seen as pathological problems by a large proportion of healthcare professionals in EU Member States - and, in some cases, this pathologisation is still present in medical curricula, training, and training materials ([FRA, 2016](#)). Furthermore, professionals may assume that their patients are heterosexual, and if proved otherwise, the medical staff may feel uncomfortable or unduly focus on sexuality, instead of the actual health issues reported by the patients ([CoE, 2011](#)).

FRA's [2014](#) survey of LGBT people found that a considerable proportion of LGB people who had accessed health services in the preceding 12 months felt that healthcare personnel discriminated against them for being LGB. The differences across the LGB groups were as follows: bisexual men, 8%; gay men, 9%; bisexual women, 10%; and lesbian women, 13%. However, there was considerable country-level variation. For example, one fifth of lesbian respondents in Sweden and the United Kingdom who accessed health services in the past year reported experiencing discrimination based on their sexual orientation; the same was true of only 5% of equivalent respondents in Bulgaria, Cyprus, Luxembourg, the Netherlands and Slovenia.

Moreover, the 2014 survey identified various experiences of LGBT people when using or trying to access health services ([FRA, 2014](#)). Examples included difficulty in gaining access to healthcare; having to change general practitioner or other specialists because of their negative reactions; receiving unequal treatment or experiencing intolerant medical staff; forgoing treatment for fear of discrimination; specific needs being ignored; inappropriate curiosity; and pressure or being forced to undergo medical or psychological tests. Within LGB participants, lesbian women were more likely than other groups to say that they have experienced one or more of these situations. Lesbian women commonly face specific barriers related to healthcare ([CoE, 2011](#)). For example, some studies suggest that low numbers of lesbian and bisexual women participate in screening for breast, cervical and uterine cancer

possibly because both they themselves and medical professionals (wrongly) assume that they are a 'low-risk' group. Furthermore, lesbian women's vulnerability to HIV/AIDS and other sexually transmitted infections (STIs) is largely unacknowledged and often disregarded in awareness-raising campaigns ([CoE, 2011](#)).

An additional problem encountered by LGB people related to health services is that same-sex partners are not recognised as being next-of-kin in countries where no legal recognition is awarded to same-sex partners ([CoE, 2011](#)).

Men who have sex with men (MSM) have also been identified as a key population in relation to HIV prevention, diagnosis, treatment, and care ([WHO, 2014](#)). Globally gay, bisexual, and other MSM are more likely to be living with HIV than the general population. Structural factors such as stigma, discrimination and violence based on sexual orientation and the criminalisation of same-sex sexual practices, contribute to deterring the availability, access and uptake of HIV and other STI prevention, testing and treatment services amongst these men ([UNAIDS, 2014](#); [WHO, 2015](#)).

However, it is important to note that whilst the term 'men who have sex with men' can be useful for epidemiological reasons, it can also be problematic because it refers to people with different identities, behaviours, and lifestyles. Consequently, many gay and bisexual men face situations where they are assumed to be HIV-positive when accessing health services ([CoE, 2011](#)) regardless of their actual sexual practices or behaviours. A further problematic consequence is the banning of gay and bisexual men from donating blood in many MS. Although in some MS such as the UK, promising policy changes have meant a change in focus to 'risk behaviours' rather than the sexual orientation of the donor ([CoE, 2011](#)). It is also important to note that since 2011, several countries across Europe have changed their legislation from a permanent to a 12-month deferral for blood donation by MSM.

3.3.2 Health inequalities, barriers, and discrimination based on gender identity and gender expression

The European/international grey literature shows that trans people face a range of specific obstacles when trying to access health services. Within the FRA's European LGBT survey ([FRA, 2014](#)) for example, on average 10% of LGBT respondents who accessed healthcare in the 12 months leading up to the survey reported that they had experienced discrimination from healthcare personnel. Amongst trans participants the level of discrimination was twice as high. Almost one in five (19%) trans respondents to the survey reported that they had experienced discrimination from healthcare personnel within the past 12 months. Increased disclosure to medical staff/healthcare personnel was linked to experiences of discrimination. Of those trans respondents who were not open to medical staff, 16% reported negative experiences. This rose to 30% when they were open to most or to all medical staff they encountered ([FRA, 2014](#)).

The PACE resolution on discrimination on the basis of sexual orientation and gender identity ([CoE, 2010](#)) acknowledges that trans people "face a cycle of discrimination and deprivation of their rights in many EU Member States due to discriminatory attitudes and barriers in obtaining gender reassignment treatment and legal recognition of their identified gender". One consequence of such experiences is the relatively high suicide rate amongst trans people ([CoE, 2010](#)). Moreover, the PACE resolution on discrimination against trans people ([PACE,](#)

[2015](#)) clearly states that trans people face widespread discrimination in Europe including difficulty accessing health services. Trans people are at particular risk of multiple and intersectional discrimination. For example, access to medical treatment for 'sex reassignment' of trans people who are detained or in custody is a particular concern ([FRA, 2015](#)).

The specific needs of the trans population make access to healthcare highly a relevant issue ([FRA, 2014](#)). Although MS have a duty to provide gender reassignment as 'medically necessary' treatment ([ECHR, 2016](#)), the differences between the 28 Member States are significant, ranging from States where specialist centres are available to those where some but not all essential treatment is available ([CoE, 2011](#)). Normally a person who wants to access gender reassignment treatment must meet strict and unified 'one size fits all' criteria to qualify for treatment. Additionally, trans people may face significant financial obstacles to access gender reassignment treatment ([CoE, 2011](#)).

The Issue Paper on Human Rights and gender identity ([2009](#)) commissioned and published by the former CoE Commissioner for Human Rights, identified three main issues regarding the healthcare of trans people. First, some medical classifications and practices still pathologise trans people and alternative classifications need to be explored in close consultation with trans people and their support organisations. Second, trans people face various barriers regarding access to gender reassignment treatment. For example, experiences of trans people within the healthcare system is often negative, with healthcare professionals being uninformed, biased and sometimes overtly rude with their patients (e.g. deliberately referring to the patient in their non-preferred gender). The third issue concerns access to general non-trans related healthcare where for example, some trans people reported adverse treatment by healthcare professionals *because* they were trans.

Trans youth can be particularly vulnerable when accessing healthcare. A study commissioned by the CoE on the rights of trans and intersex children ([Schneider, 2013](#)) points out various problematic medical approaches in the treatment and care of trans children including: (1) practices and diagnoses stemming from the assumption that children's non-gender typical behaviours and identities are pathological; (2) normalising of 'conversion' therapies, which derive from the premise that variations in gender expression and gender identity need to be 'treated'; and (3) deeply unethical practices such as advising minors to have sexual intercourse, psychiatric consultations in front of an audience, or non-medically justified examinations of genitalia.

Lastly, trans people have also been identified as a key population in relation to HIV prevention, diagnosis, treatment and care ([WHO, 2014](#)). However, trans-specific HIV data are limited and the majority of published literature only address trans women due to their disproportionate HIV prevalence ([WHO, 2015](#)). The WHO note that the severe stigma and discrimination trans people experience presents challenges to estimating the global size of the trans population, their levels of HIV risk and their protective behaviour ([WHO, 2015](#)).

3.3.3 Health inequalities, barriers, and discrimination based on sex characteristics

Intersex people face several challenges that relate to the law and medical intervention ([FRA, 2015](#)). The CoE Issue Paper ([CoE, 2015](#)) "Human rights and intersex people" addresses various problematic issues surrounding the medicalisation of intersex people. First, the report raises concerns regarding the current medical approach of reassigning or 'fixing the sex' of

intersex people: *"notwithstanding the significant change in attitudes since the 1950s regarding sexuality and gender diversity, it seems that the medical field often rejects the voices of intersex people harmed by surgery."* (p. 20). Despite the considerable psychological distress caused by the negative outcomes of surgery which can result in self-harming and suicidal behaviour, to-date, medical and surgical treatment of intersex infants and minors rests on the belief that such treatment is necessary and desirable. Thus, although parents of intersex children are asked to provide their proxy consent to the treatment, they are often ill-informed and are not given adequate time or options necessary to provide fully informed consent.

Second, the report clarifies on how variations in sex characteristics of intersex people are currently codified in medical classifications as pathologies or disorders, usually referred to as 'disorders of sex development'. Thus, "it is worrying that the gap between the expectations of human rights organisations of intersex people and the development of medical classification has possibly widened over the past decade. This raises serious questions with regard to the medical profession's ability to help intersex people attain *"the highest possible level of health that they have a right to."* (CoE, 2015, p.23).

The study commissioned by the CoE on the rights of trans and intersex children (Schneider, 2013) points out various issues relating to healthcare and intersex children: (1) the fundamental right to bodily and mental integrity, and trauma as a result of medical practices; (2) problems on informed consent including parents' decision-making powers should not be absolute, and that some intersex young people report that although they agreed to surgery during adolescence, they sometimes regretted it later because they were not able to give fully informed consent.

3.4 Barriers faced by health professionals when providing care for LGBTI people

FRA's recent 2016 report 'Professionally speaking: challenges to achieving equality for LGBT people' (FRA, 2016) identifies two main barriers faced by health professionals when providing care for LGBTI people: 1) many health professionals are ostensibly unaware of the specific health issues LGB people may face, most of the time as a result of a lack of specific training and access to proper data on populations and communities that may be 'invisible' and/or hidden; 2) professionals' own prejudices, which may stem from religious beliefs, social prejudice or misconception leading to the unequal treatment of LGBT people. FRA's report also specifies various other barriers and constraints which impact on health professionals when providing care for LGBT people such as: limited healthcare measures for LGBT people across member states including specific protocols, policies, and guidance; lack of application where protocols already exist; problematic legal contexts for the healthcare of trans people; and resource constrains in healthcare settings (FRA, 2016). For instance, with regards to legal contexts, as noted later in the summaries of the Member State (MS) rapid-reviews (see Section Four), in some countries inequitable practice exists whereby legal limitations such as those in the Czech Republic, require trans people have to formally end their registered partnerships/marriage prior to transitioning.

3.5 What do European and international frameworks and policies mean for LGBTI inequalities and access to healthcare?

Article 35 of the European Union Charter of Fundamental Rights ([EU, 2000](#)) states that *“everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities”*. However, despite the recognition of such rights, vulnerable populations such as LGBTI people still face significant barriers when accessing healthcare. The European Commission’s communication on health inequalities ([EC, 2009](#)) recognises that vulnerable groups commonly face various obstacles when accessing healthcare and that more research is required on health inequalities, the development of training, and the sharing of promising and good practices. Accordingly, the EU Health Programme for the period 2010-2014 sets out that Member States should *“contribute to addressing health inequalities and the promotion of equity and solidarity through actions under the different objectives and by encouraging and facilitating the exchange of good practice”* ([EC, 2014, para.10](#)).

A further European framework relevant to LGBTI inequalities and access to healthcare, is the *“European Pact for Mental Health and Well-being”* ([EU, 2008](#)). As set-out in the Scientific Review ([Zeeman et al., 2017a](#)), LGBTI people experience significant health inequalities with regards to poorer mental health, and are at increased risk of developing disorders such as depression or suicidal ideation as a result of stigma and discrimination. The EU acknowledges the importance and relevance of mental health and well-being for the European Union, its MS, stakeholders and citizens. Set out in the *“European Pact for Mental Health and Well-being”*, the EU states recognises that mental well-being is an essential constituent of health and that high levels of stigmatisation in key areas (such as at school or at work) could generate mental health issues. The Pact sets out that there is a need to improve the knowledge base on mental health and well-being by collecting data on the state of mental health in the population and by commissioning research into the epidemiology, causes, determinants and implications of mental health and ill-health, and the possibilities for interventions and best practices in and outside the health and social sectors. For vulnerable populations such as LGBTI people this is particularly important along with appropriate interventions that take into account and are sensitive to the diversity of European populations.

3.5.1 Yogyakarta Principles

The Yogyakarta Principles ([2007](#)) are a universal guide to human rights which affirm binding international legal standards with which all MS must comply regarding LGBT people, and state that: *“Everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity”* (Principle 17). Furthermore, within the same Principle 17, nine key recommendations are detailed including the following: *“Adopt the policies, and programmes of education and training, necessary to enable people working in the healthcare sector to deliver the highest attainable standard of healthcare to all people, with full respect for each person’s sexual orientation and gender identity”*. Additionally, Principle 18 requires the protection from medical abuse, stating that *“no person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity”*. As noted earlier, this is particularly relevant regarding trans and intersex populations.

3.5.2 Council of Europe (CoE)

The CoE has paid specific attention to the health of stigmatised and vulnerable populations such as LGBTI people. The recommendation of the Committee of Ministers to MS on health services in a multicultural society ([CoE, 2006](#)) states that when adapting health services to the needs of multicultural populations, MS governments should base their policies on the values propounded by the CoE. These values are: human rights and patient's rights, human dignity, social cohesion, democracy, equity, solidarity, equal gender opportunity, participation, freedom of choice balanced by the obligation to help individuals look after their own health. CoE standards on combating discrimination on the grounds of sexual orientation or gender identity ([CoE, 2011](#)) assembles the relevant legal and political texts adopted by the Committee of Ministers, the Parliamentary Assembly and the Congress of Local and Regional Authorities of the Council of Europe, including access to healthcare.

In 2010 the CoE's Committee of Ministers adopted recommendations on measures to combat discrimination on the grounds of sexual orientation and gender identity ([CoE, 2010a](#)). Regarding health, the concrete measures state that MS should adopt are: (1) appropriate legislative and other measures to ensure that the highest attainable standard of health can be effectively enjoyed without discrimination on grounds of sexual orientation or gender identity; in particular, they should take into account the specific needs of LGBT people in the development of national health plans including suicide prevention measures, health surveys, medical curricula, training courses and materials, and when monitoring and evaluating the quality of health-care services; (2) appropriate measures should be taken in order to avoid the classification of homosexuality as an illness, in accordance with the standards of the WHO; (3) to take appropriate measures ensuring that trans people have effective access to appropriate gender reassignment services, including psychological, endocrinological and surgical expertise in the field of trans healthcare, without being subject to unreasonable requirements; no person should be subjected to gender reassignment procedures without their (informed) consent; and (4) appropriate legislative and other measures to ensure that any decision limiting the costs covered by health insurance for gender reassignment procedures should be lawful, objective and proportionate.

Moreover, the explanatory memorandum to the recommendation ([CoE 2010b](#)) suggests that MS should put in place the appropriate education and training policies and programmes to enable people working in the healthcare sector to deliver the highest attainable standard of healthcare to all people, including: studies and research on the health of LGBT people to identify and meet their specific needs; taking account of LGBT people's special needs in the design of national health plans, health surveys, medical training programmes, and training courses and materials, and in the monitoring and quality assessment of healthcare services; guaranteeing that education, prevention, care and treatment programmes and services in the area of sexual and reproductive health respect diverse of sexual orientations and gender identities, and are equally available to all; encouraging health professionals and social workers to create an environment that is reassuring and open to young LGBT people, for example by conducting information campaigns.

3.5.3 United Nations

The UN Committee on economic, social and cultural rights (see General Comment 14, [UN, 2000](#)), clarifies the concept of the right to the highest attainable standard of health and recalls

that the covenant on economic, social and cultural rights that forbids any discrimination in access to healthcare on the grounds of sexual orientation or other statuses, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. In addition, the committee (General Comment No.20, [UN, 2009](#)) states that gender identity is protected against discrimination. Moreover, the General Comment No.22 ([UN, 2016](#)) on the right to sexual and reproductive health, addresses various topics which are particularly relevant for LGBTI people, including: (1) intersectional forms of discrimination faced by LGBTI people, which are a barrier to the full enjoyment of their sexual reproductive health and rights (SRHR); (2) SRHR are interdependent on other rights for example, the right to education, the right to sexual education, and/or the right to work; (3) SRHR are an integral part of the right to health, and as such comprise four key elements especially pertinent for LGBTI people including availability, accessibility, acceptability and quality; (4) laws prescribing forced sterilisation in the context of legal recognition, pathologisation and 'conversion therapies' are violations of human rights; (5) acknowledging that LGBTI people as more vulnerable to experience multiple discrimination; (6) lastly, the Committee points out that the failure to prevent violence towards LGBTI people is a violation of the obligation to protect, including the protection against "medically unnecessary, irreversible and involuntary surgery and treatment performed on intersex infants or children" (p.15).

Moreover, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, from the Human Rights Council, calls upon all Member States to repeal any law allowing intrusive and irreversible treatments to LGBTI people, including forced genital-normalising surgery, involuntary sterilization, unethical experimentation, medical display, 'reparative therapies' or 'conversion therapies', when enforced or administered without the free and informed consent of the person concerned ([UN, 2013](#)).

3.6 HIV/STIs and key populations

3.6.1 Gay, bisexual, and other MSM, and trans people

The WHO has focused policies on HIV and other STIs in key populations such as gay, bisexual and other MSM as well as trans people. For these populations, various recommendations and guidelines have been developed referring to a diversity of topics such as: promoting a human-rights framework; working with communities (including community-based HIV testing and counselling linked to care and treatment); community empowerment; adapting to local needs and contexts; and guidance on pre-exposure oral prophylaxis (see for example, [UNDP, 2016](#); [UNPFA, 2015](#); [WHO, 2014, 2015a, 2015b](#)).

Similarly, the EU has also paid close attention to HIV and other STIs in key populations. For example, the EU ([2014](#)) action plan on HIV/AIDS in the EU and neighbouring countries (2014-2016) identifies gay and bisexual men as a priority group (under the nomenclature of MSM), and proposes the following actions: intensify the promotion of safer-sex behaviour amongst MSM; information on HIV prevention integrated in sexual and reproductive health education and healthcare services; intensify implementation of voluntary counselling and testing programmes amongst MSM and other most at risk groups in health settings, and community based facilities, ensuring effective link to treatment and care; and, increase innovative testing

strategies including outreach and peer support to ensure access to voluntary counselling and testing³.

Related to the prevalence of HIV and other STIs within the population of gay and bisexual men, the Court of Justice of the European Union (2015) states that the permanent deferral from blood donation for men who have had sexual relations with another man may be justified, having regard to the situation prevailing in the Member State concerned. It also states that the principle of proportionality might not be respected by a permanent ban on MSM for giving blood. However, according to the European Parliament's (EP) intergroup on LGBT rights (EP, 2015), this ruling represents a missed opportunity in recognising that it is sexual behaviour, not sexual orientation, that is important when determining whether someone can give blood; and that being gay or bisexual does not automatically pose a threat to public health. ILGA-Europe has also alerted for the need to focus on practices rather than on sexual orientation of the candidates to blood donation (ILGA-Europe, 2015).

3.7 Frameworks and policies specific to trans and intersex health

'Sex reassignment' surgery remains unavailable or access thereto problematic, in some Member States of the EU (FRA, 2015). The Issue Paper (2009) by the former CoE Commissioner for Human Rights on gender identity states that the European Court of Human Rights (ECHR) has established that Member States are obliged to provide trans people with the possibility of undergoing surgery leading to full gender-reassignment. Moreover, the case law of the ECHR clearly requires Member States not only to provide for the possibility to undergo surgery leading to full gender-reassignment, but also that insurance plans should cover "medically necessary" treatment in general which gender reassignment surgery is part of (ECHR, 2016). Likewise, the PACE resolution on discriminations against trans people (PACE, 2015) makes the following recommendations: (i) make gender reassignment procedures (such as hormone treatment, surgery, and psychological support) accessible for trans people and ensure that they are reimbursed by public health insurance schemes; limitations to cost coverage must be lawful, objective and proportionate; (ii) include trans people explicitly in suicide prevention research, plans, and measures; explore alternative trans health-care models, based on informed consent; (iii) amend classifications of diseases used at national level and advocate for the modification of international classifications, making sure that trans people, including children, are not labelled as mentally ill, whilst ensuring stigma-free access to necessary medical treatment.

There is a growing awareness that trans people should stop being treated as if their identities are pathological (FRA, 2015). The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) released by the American Psychiatric Association replaced the term 'gender identity disorder' with 'gender dysphoria'. In the DSM-5, gender non-conformity is not in itself considered to be a mental disorder. Instead, the presence of clinically significant distress associated with the condition is the critical element of a gender dysphoria diagnosis (APA, 2013; FRA, 2015). In the 2017 beta version of the International Classification of Diseases (ICD-11) prepared by the WHO, Section 7 on mental and behavioural disorders does not include the category 'gender identity disorders'. Instead, the WHO now proposes a 'gender incongruence' category, under the new Section 6, 'Conditions related to sexual health'. The

³ Implementation of policy on HIV/AIDS is funded through the EU Health Programme. A comprehensive list of relevant projects funded since 2003 can be found here: http://ec.europa.eu/health/sti_prevention/projects/index_en.htm

ICD-11 beta draft also includes a diagnosis of 'gender incongruence in childhood', referring to pre-pubertal children – which has been reported as a step towards pathologisation of gender diversity in childhood, especially since there is no need for medical treatment before puberty (TGEU, 2014). The European Parliament in its Resolution on the EU Roadmap against homophobia and discrimination on grounds of sexual orientation and gender identity (European Parliament, 2014b), reiterated that: "The [European] Commission should continue working within the World Health Organisation to withdraw gender identity disorders from the list of mental and behavioural disorders and to ensure a non-pathologising reclassification in the negotiations on the 11th version of the International Classification of Diseases (ICD-11)".

The [ICD-11 beta draft](#) refers for the first time to 'disorders of sex development' therefore reinforcing the pathologisation of intersex people. In the EU intersex issues have gradually been recognised as relevant to fundamental rights protection – even if they are still largely treated as medical issues falling outside the scope of public scrutiny (FRA, 2015). Recently, the CoE has been raising attention to the discrimination and Human Rights violations that intersex people face in healthcare. In the Issue Paper (CoE, 2015) "Human rights and intersex people", the Commissioner for Human Rights makes the following recommendations: (i) MS should end medically unnecessary "normalising" treatment of intersex people, including irreversible genital surgery and sterilisation, when it is enforced or administered without the free and fully informed consent of the person concerned; and (ii) national and international medical classifications which pathologise variations in sex characteristics should be reviewed with a view to eliminating obstacles to the effective enjoyment, by intersex people, of human rights, including the right to the highest attainable standard of health. The EU Agency for Fundamental Rights affirms that health professionals should be better aware of the challenges that intersex people encounter, and should "ensure that the fundamental rights of intersex people are fully respected - particularly when they are children" (FRA, 2015, p.69). Moreover, the Agency acknowledges that "EU Member States should avoid imposing 'sex-normalising' medical treatments on intersex people without their free and informed consent. This would help prevent violations of the fundamental rights of intersex people, especially children, by way of practices with irreversible consequences" (FRA, 2015, p.74).

Trans and intersex children are especially vulnerable in terms of healthcare. The CoE Commissioner for Human Rights, commented (CoE, 2014) that the early "normalising" treatments do not respect intersex people's rights to self-determination and physical integrity - because intersex babies and younger children are not in a position to give their consent. Accordingly, the PACE resolution (2013) on children's right to physical integrity is clear when stating the need to "ensure that no-one is subjected to unnecessary medical or surgical treatment that is cosmetic rather than vital for health during infancy or childhood, guarantee bodily integrity, autonomy and self-determination to people concerned, and provide families with intersex children with adequate counselling and support". In Schneider's 2013 study on the rights of trans and intersex children (Schneider, 2013), the author makes various recommendations, including: (i) give complete priority to stopping so-called "normalising" surgery and hormone treatment on intersex children who are not able to give their consent; (ii) promote training for health professionals reflecting the current debates on medical support to intersex children and about the pathologisation of trans children and the psychosocial risks that they face; (iii) include trans children in suicide prevention programmes as a high-risk group.

An interagency statement on eliminating forced, coercive and otherwise involuntary sterilisation, various UN bodies – including the World Health Organisation (WHO), the Office of the High Commissioner for Human Rights (OHCHR), UN Women, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the UN Development Programme (UNDP), the UN Population Fund (UNFPA) and the UN's Children's Fund (UNICEF) – noted that: "Intersex people in particular, have been subjected to cosmetic and other non-medically necessary surgery in infancy, leading to sterility, without informed consent of either the person in question or their parents or guardians. Such practices have also been recognised as human rights violations by international human rights bodies and national Courts" ([WHO, 2014](#), p.2).

3.8 Gaps in EU policies/protection – what is missing and what needs to be in place?

Although there are a number of texts adopted by the EU that can be applied to LGBTI people (e.g., [EC, 2009](#); [EU, 2014](#)), so far the EC has never explicitly taken policy measures to address the health needs of LGBTI people. Within the EU anti-discrimination legal framework, there is no formal protection against discrimination in the area of health; and it is not clear whether health can be interpreted as included under goods and services. This area is protected only on the grounds of race/ethnic origin ([Directive 2000/43/EC](#)) and sex ([Directive 2004/113/EC](#)). EU gender equality legislation is interpreted as including gender reassignment for trans people, but it is unclear whether it also protects on the grounds of gender identity. Nevertheless, in the area of goods and services, the grounds of sexual orientation will only be protected when the directive on the principle of equal treatment between people irrespective of religion or belief, disability, age or sexual orientation (proposed by the [EC, 2008](#)) is adopted. For intersex people, the grounds of sex characteristics are not covered. However, EU gender equality legislation could be interpreted as covering this ground.

3.9 Promising practice identified in European grey literature

Despite the difficulties, inequalities, and barriers that LGBTI people still encounter in the field of health, there are a number of promising practices that signal a change in course. Healthcare professionals are reporting promising practices in terms of policies to ensure that LGB people can access healthcare alongside other people and that their specific needs are met ([FRA, 2016](#)). Additionally, there is evidence of positive experiences and developments concerning the cooperation between trans healthcare professional networks and civil society organisations supporting trans people ([FRA, 2016](#))⁴.

Moreover, as part of the EU diplomatic efforts to abolish any kind of discrimination against individuals and to uphold the human rights of LGBTI people, diplomatic efforts in this area are focused on: (1) eliminating discriminatory laws and policies, decriminalisation, and ending the death penalty for same-sex relations; (2) promoting equality and non-discrimination at work, in healthcare and in education; (3) combating violence by the state or by individuals against LGBTI people; and (4) supporting and protecting human rights defenders. Guidelines to promote and protect the enjoyment of all Human Rights for LGBTI people ([Council of the European Union, 2013](#)) acknowledge the right to health as a Human Rights issue.

⁴ See also Section 4.6 of this report for examples of promising practices reported by Member States as part of the rapid-review process.

Examples of promising events in the field of LGBTI health:

- In October 2013 within European Health Forum Gastein Conference, the EU supported a workshop on "[EU Session on Improving Access and Combating Discrimination in Healthcare with a focus on vulnerable groups](#)", in which ILGA-Europe was invited to speak.
- In November 2013, the European Parliament LGBT intergroup co-hosted a [high-level hearing](#) on the challenges and obstacles LGBTI people face in the field of health and healthcare, with a particular focus on HIV/AIDS. Various high-level stakeholders took the floor including Tonio Borg (former Commissioner for Health and Consumer Policy), as well as UNAIDS and ILGA-Europe representatives.
- In 2013, ILGA-Europe and Transgender Europe sent shadow reports to the Social Rights Committee of the CoE [European Social Charter](#), on the implementation of the Article 11 on the right to health in relation to the requirement of sterilisation and the lack of access to gender reassignment treatment in 20 countries – as well as a collective complaint on the requirement of sterilisation in Czech Republic.
- In January 2014, the UNAIDS organised an [expert consultation](#) on "Changing the Game - How can Europe move towards zero new HIV infections, zero discrimination and zero AIDS-related deaths? UNAIDS expert consultation", with the participation of ILGA-Europe.
- In March 2014, the EC organised a conference entitled "[Health in Europe, making it fairer](#)", which addressed the issue of improving fairness and equity in health in Europe, improving access to health and combatting discrimination in health. ILGA-Europe was invited to speak on Human Rights and HIV.
- In July 2014, UNAIDS together with ILGA-Europe and IGLYO, organised the [consultation](#) "Nothing for us without us - Unleashing youth leadership to address the challenge of HIV and LGBTQI rights in Europe".
- In 2014 and 2015, ILGA-Europe organised two events on LGBTI health in which the EC took the floor: a [roundtable on LGBTI health in Paris \(2014\)](#) and a [roundtable on mental health in Dublin \(2015\)](#).

SECTION FOUR: Thematic analysis of rapid-reviews by Member States

4.1 Introduction

As a reminder, ILGA-Europe in partnership with the University of Brighton (UoB), identified experts in each European MS in order to conduct 'rapid-reviews' of relevant grey literature from their own countries. The purpose of this task was to access grey literature that might not otherwise be accessible (e.g. non-English and/or not indexed in [scientific] databases), ensuring a good geographical coverage of the information and data collected across MS and in doing so, embracing different social and cultural contexts.

Following receipt of the completed reviews from MS during August 2016, each rapid-review was read, edited for consistency (e.g. language, structure), and then developed into a stand-alone document to act as a useful future resource for MS⁵. Each rapid-review was also summarised to provide a succinct one-page summary. This process facilitated the emergence of key overarching themes from across 27 out of 28 MS who completed the review⁶.

The sections that follow therefore present the overarching themes that were developed by considering all 27 MS reviews in addition to drawing, where relevant, on aspects of country-specific issues. The rapid-review summaries are cross-referenced to their comprehensive full and stand-alone versions.

4.2 What is known about health inequalities faced by LGBTI people as it relates to healthcare settings?

Theme 1: Inequalities

According to a number of rapid-reviews from Member states, LGBT people have increased rates of depression, suicide and self-harm⁷ [x7 MS: Belgium, Hungary, Ireland, Poland Slovakia, Spain, Sweden] with those who are younger at greatest risk [x4 MS: Ireland, Poland, Spain and Slovakia]. Estimates in the grey literature suggest that 30% of young LGBT people in Poland attempted suicide, whilst young LGBTI people in Ireland had 2 times the level of self-harm, 3 times the level of attempted suicide, 4 times the level of severe/extremely severe stress, anxiety and depression compared to youth in general. An example from the Spanish rapid-review particularly highlights mental distress in the form of feelings of 'rage' and 'guilt' can manifest physically in terms of pain and discomfort:

5 It is important to note that the data presented in the rapid-reviews are the work of key contributors from the respective Member State and are acknowledged as such in the introductory section of this report (where explicitly consented). Moreover, the information provided in quotations are specific and reflect the experience of individuals as reflected in the grey literature reviewed. This means that any meaning derived from quotations cannot be generalised and is limited to the particular time, context, and place in which it was originally reported.

6 Numerous attempts were made by ILGA-Europe to engage with the Cypriot partner to complete the rapid-review during May-August 2016. The deadline for Cyprus was extended to the end of November 2016. However no review was received despite further follow-ups and consequently the formal review period was closed in early December 2016.

7 Although other health inequalities pertaining to general health might exist, this section only presents what was reported in the rapid-reviews submitted by Member State experts.

"I arrived home... crying and I locked myself in my room to cry... I had insomnia and thought about how unfair that was ... going back to school. I swayed between rage and guilt. I remember having bellyaches... every time I felt bad I had aches... bellyaches. When I started to feel bad, really bad, to the point of not being able to stand it anymore, everything went to my stomach, so that many times I felt doubly ridiculous because (...) when I felt that guilty my belly ached a lot and I really needed to use the toilet". (LGB Young person, Spain)

(Source: Report - Generelo et al., 2012 Homophobic bullying and suicide risk amongst young and teenage LGBT people. FELGTB)

Theme 1.1: Suicidal ideation, depression and self-harm

For trans people increased rates of depression and suicide attempts were widely reported across Member States in their rapid-reviews [x8 MS: Belgium, Hungary, Ireland, Lithuania, Poland, Poland, Spain, Sweden]. In addition for lesbian and bisexual women, those who were younger and older were reported in the grey literature reviewed to experience a higher incidence of depression, suicide, and self-harm [x7 MS: Belgium, Hungary, Ireland, Poland, Slovakia, Spain and Sweden]. A survey in Belgium for example, showed lesbian and bisexual women aged 18-23 were particularly prone to suicidal thoughts and actions with 56.6% of girls who participated (n=400) thought at least once of ending their lives, whilst 14.4% attempted suicide at least once as this quote indicates.

"Hmm, oh well ... purely out of feeling bad and if I now look back I think it was very stupid of me, but back then, I felt so badly and wanted the feelings to go away and so I did something stupid and needed help. That was really ... at that time it was really because I was not happy with myself and the fact that I was different, so that was really it purely out of being lesbian." (Young lesbian, Belgium)

(Source: Report - Schoonacker et al., 2009 A study of mental and social well-being of lesbian and bisexual girls in Flanders. University of Brussels)

Causes of suicidal ideation were reported in the rapid-reviews to include external stressors such as experiences of verbal abuse and being bullied, mainly at school. Most lesbian and bisexual girls were reported to be aware that heteronormativity often results in internalised homonegativity and awareness of stigma related to LGBT identities. The Belgian survey in particular, showed a clear link between external and internal stressors and mental wellbeing.

Theme 1.2: Stigma as a cause of health inequalities

As a consequence of being stigmatised, LGBT people appear to be at higher risk of violence from others such as strangers, school friends, and health professionals [x8 MS: Greece, Hungary, Lithuania, Poland, Romania, Slovakia, Slovenia, Spain]. For instance, in the Slovenian rapid-review a survey is reported with 1145 gay and lesbian participants which found almost half of respondents had experienced some type of violence, mostly from strangers and school friends, but with 1.7% also experiencing violence from doctors. Indeed, other rapid-reviews also reported how LGBTI people reported experiencing verbal or physical abuse by health professionals whilst accessing healthcare [x4 MS Spain, Romania, Slovakia, Poland].

"I was abused by a gynaecologist. I was so shocked and hurt that I didn't report him. But it was clear that the nasty man conducted a brutal exploration when he learnt that I was a lesbian woman. When I told some lesbian friends they called me a fool for telling him about me being lesbian." (Lesbian woman, Spain)

(Source: Report - López et al., 2013 Sexual orientation and/or gender identity-based discrimination in Spain. FELGBT)

4.3 Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

In their rapid-reviews MS contacts reported a range of legislation, regulations, and policies that were specific to each MS. For example, the protected status of gender and sexuality under equalities legislation or the absence thereof; funding for treatment and health insurance that included instances where surgery for trans and intersex people remained unfunded due to being considered cosmetic; access to assisted reproductive technology with parameters for inclusion and exclusion; legislation for gender transitioning of trans people and access to medical treatment, hormone treatment and surgery; legislation on surgical intervention for intersex people; policies for access to health information of same-sex partners; regulations specifying the conditions for donating blood and who are included/excluded. Since the legal acts, legislation, regulations and policies are wide-ranging and diverse, they are not summarised here. For more detailed information refer to the individual rapid-review of each MS.

4.4 What are potential barriers faced by LGBTI people when using or trying to access healthcare?

Theme 2: Normativity

Heteronormativity including gender-normativity were visible in all rapid-reviews submitted by Member States [x27 MS]. This occurs where gendered norms of masculinities/femininities are upheld and heterosexuality is sustained as the status quo. The lives and bodies of trans and intersex people seemingly disrupt such dominant norms of gender and LGB identities therefore question heterosexuality as the norm. LGBTI people were reported as being treated as 'other' leading to marginalisation. As an example, the Hungarian rapid-review reported on a survey from the grey literature which showed 28% of LGBT people experienced discrimination in the healthcare system including denial of treatment or examination, impacting particularly people living with HIV. Other forms of discrimination found in the Hungarian survey included humiliation, verbal harassment, inappropriate curiosity and/or negative attitudes towards LGBT individuals. The following quotation from the survey reflects how normativity can lead to inappropriate behaviour and marginalisation ending ultimately in feelings of humiliation:

"I was consulting in [name] at the Gynaecology Clinic about genital reconstruction surgery and asked to take off my clothes because they did not [sic] see a woman with a penis before. Then they called in some 4-5 medical students and they surveyed my naked body." (Trans person, Hungary)

(Source: Report - Hidasi, B. 2014 Transcare documentation of discrimination in the field of health of trans people in Hungary. Transvanilla Transgender Association)*

Theme 2.1: Sex and gender binaries

Rapid-reviews from Austria, the Netherlands, Slovenia, and Slovakia highlighted documents that show how some intersex and trans people have found the norms that perpetuate the male/female divide or maintain rigid masculine/feminine gender binaries unhelpful [x4 MS: Austria; Netherlands, Slovenia, Slovakia]. Reviews highlight literature that show how trans and intersex people may experience discrimination as they do not fit established gendered or sexed norms. For example, the Slovakian review highlighted a guidebook which refers to trans persons in general and on trans people who wish to gain legal gender recognition. From this report, the review draws attention to a pertinent quote:

“My doctor told me a couple of times that I do not fulfil the requirements of the looks. She wanted me to change my looks and the way I behave. She told me that my hair is wrong, my clothes are not good, despite the fact that I wear rather neutral clothing. She told me that the transition is not about my happiness, but about how I fit into society.” (Trans person, 24 year-old, Slovakia)

(Source: Guidebook - Transfúzia 2015 The standards of trans-inclusive environment in the healthcare system. Transfúzia)

From the Slovakian rapid-review it became apparent that health professionals may attempt to help trans people to change their gender expression to conform to gendered norms related to clothing, behaviour and hairstyle that conform to traditional representations of masculinities/femininities. Some trans people do not fit these normative categories as their gender expression disrupts commonly accepted ideals. An Austrian paper for psychotherapists suggests that health professionals should remain open to plurality in gender expression to include those who differ from the norm.

“...some of her colleagues are not willing to get in touch with the life of other (i.e. trans) people, for example when those psychotherapists talk about their clients like ‘he really looks like a woman’ or ‘she thinks she is a man’. Psychotherapists who cling to normative categories should not provide psychotherapy”. (Austria)

(Source: Magazine Article – Kunert, C. 2014 What's the point of that masquerade? WLP News, Zeitschrift des Wiener Landesverbandes für Psychotherapie)

From the rapid-reviews of Austria, Netherlands, Slovenia, and Slovakia it became apparent that where health practitioners show limited awareness of the impact of upholding traditional gendered norms, training and greater awareness of diversity and plurality would aid inclusion of trans people.

Theme 2.2: Denied access to assisted reproductive technology

In the rapid-reviews from several MS, assisted reproductive technology was reported to be available to heterosexual couples who experienced difficulties conceiving. However, the reviews also highlighted how in some cases, lesbian couples or those in same-sex partnerships (or single individuals) are denied access or struggle to gain access to reproductive medical interventions [x7 MS: Czech Republic, Hungary, Malta, Slovakia, Slovenia, Spain, UK]. As an example, Spain's rapid-review reported the following:

"We are a lesbian couple. [Name of a mutuality for public servants] denied us the access to assisted reproduction when we were, in fact, included in the legal event of being a sterile couple. We tried all administrative ways, just to receive a number of administrative resolutions, each one more insulting than the previous ones". (Lesbian woman, Spain)

(Source: Report - López et al., 2013 Sexual orientation and/or gender identity-based discrimination in Spain. FELGBT)

For two MS (Spain, UK), the reviews highlighted that even when LGB people were legally entitled to assisted reproductive technology, they were sometimes prevented from accessing treatment by gatekeepers like health professionals, doctors or public/civil servants who found reasons not to refer them on to specialist services.

In the Czech Republic rapid-review an example was reported whereby assisted reproduction was only offered as treatment for infertility of men or women, who together form the *infertile* couple. For lesbian couples therefore, the consequences of exclusion meant having to try to find sperm donor elsewhere or by presenting with a 'fake' male partner:

"They often do not check the donor; they do not ask him about his medical condition... We met with just one possible donor like that and in our opinion, judging only from a visual point of view, he had jaundice - or go to a clinic with a fake partner which is – in many cases – a humiliating process for them". (Lesbian woman, Czech Republic)

(Source: Report - Kutálková, P. 2016 Rainbow families in the shadow of the state, the situation of gay families with young children. Prague Pride)

From the rapid-reviews of MS [x7 MS: Czech Republic, Hungary, Malta, Slovakia, Slovenia, Spain, UK] it became apparent that access to the specialist services that assisted LGB people to conceive and procreate were sparse, resulting in people undertaking potentially high risk informal arrangements without appropriate preceding screening and monitoring.

Theme 3: Discrimination and homo-/bi-/trans-/inter-phobia

Across almost all MS the rapid-reviews reported that LGBTI people commonly experience individual or institutional transphobia/biphobia/homophobia/interphobia [x20] when accessing treatment and care. 'Fear' of LGBTI people became visible where they were subjected to discrimination for example in Slovakia, some trans people faced degrading language and treatment from health professionals when accessing care:

"I felt that my doctor needed to constantly inform me that I am a sick person – she called me a toy of nature, a deviation. She told me that people like me used to be shown in circus freak shows. It was a constant part of the visit that she reminded me where I belong, in relation to her and society" (Trans person, aged 30, Slovakia)

(Source: Guidebook - Transfúzia 2015 The standards of trans-inclusive environment in the healthcare system. Transfúzia)

Theme 3.1: 'Conversion therapy'

Data from the rapid-reviews suggest that the widely condemned practice of so-called 'conversion therapy' persist in some European Member States [x11 MS: Bulgaria, France, Greece, Malta, Poland, Portugal, Romania, Slovakia, Slovenia, Spain]. 'Conversion therapy' is

based on assumptions that homosexuality, bisexuality and/or trans identities are a mental disorder and should be treated. In some MS, rapid-reviews reported experiences of health professionals subjecting LGBT people to conversion therapy as seen in these quotes:

"The psychologist that I visited the last time is religious – she is a Christian. I am too, but not so much... When I opened up to her regarding my sexual orientation, she agreed to counsel me but only if I agreed to change my life and my orientation. She tried to send me to [name of a pilgrimage site], told me that they will cure me there of this compulsion... But I don't want to give this up, I was very sad". (Quote from survey with LGBT people, Slovakia)

(Source: Guidebook - Smitková & Kuruc, 2012 Recommendations and incentives for psychologists working with lesbian, gay, bisexual and trans (LGBT) clients. Iniciatíva Inakosť)

Similarly, in this example from Poland:

"The doctor offered me an appointment with an exorcist, as a good way to dealing with being transgendered". (Trans person, Poland)

(Source: Report - Dunarski & Jaderek, 2015 The standards of trans-inclusive environment in the healthcare system. Fundacja Trans-fuzja)

Even though 'conversion therapy' as a practice still appears to exist in some MS, a welcome diversion to this practice is evident in Malta where a legal ban on conversion practice is proposed to protect LGBT people and vulnerable minors. Maltese law is currently under review to prohibit any form of pathologisation of sexual orientation, gender identity or gender expression (Frye, 2016; TGEU, 2016).

Theme 4: Fear

In many countries, rapid-reviews of grey literature suggested that LGBT people commonly feared disclosing their sexual orientation and gender identity due to fear of rejection, fear of judgement, fear of discrimination, or negative consequences that might affect their treatment and care in the health system [x16 MS: Bulgaria, Croatia, Czech Republic, Finland, France, Germany, Greece, Hungary, Italy, Lithuania, Poland, Portugal, Romania, Slovakia, Slovenia, Spain]. Fear of discrimination was extensive:

"They made [asked] me various intimate questions, including on my biology and sexuality. I was so uncomfortable that I left as soon as possible. I was afraid for my well-being." (Trans man, 21 years old, Portugal)

(Source: Report/brochure - Pinto, et al., 2015 Equality on health. Associação ILGA Portugal)

In the French rapid-review, it was reported that some trans people fear that they will be refused treatment, fear being exposed as trans in the doctor's waiting room, or fear humiliation or feeling uncomfortable due to uncommon body/scars. Some feared being addressed with the wrong gender and being asked too many questions:

"[name] must explain her situation every time she asks for an appointment because she is mis-gendered due to her deep voice." (Trans woman, France)

(Source: Leaflet - Chrysalide 2012 L'accueil médical des personnes transidentitaires. Chrysalide)

In the Polish rapid-review, the experiences of a 21-year-old gay man were reported as he had been subjected to unprofessional behaviour by a doctor who made derogatory comments regarding pain relief:

"...[The Doctor] as a joke described the medical procedure as painless, unless the patient is homosexual, because such people are not anaesthetised." (Gay man, 21 year-old, Poland)

(Source: Report - Trociuk et al., 2014 The principle of equal treatment - law and practice 14. Equal treatment of LGB patients in healthcare. Analysis and recommendations. Ombudsman Office)

What was clear from the rapid-reviews was that based on sexual orientation and gender identity, LGBT people are commonly treated differently in the health system of different MS with some fearing negative consequences such as being withheld pain relief during medical procedures. Moreover, it also seems that many health professionals have a limited awareness of equal rights and the protected nature of sexual orientation and gender identity in many European Union MS.

Theme 4.1: Confidentiality of health information

A number of rapid-reviews [x11 MS: Croatia, Czech Republic, France, Hungary, Lithuania, Malta, Poland, Portugal, Slovakia, Slovenia, Spain] identified concern over confidentiality in terms of health information. For example, the Spanish rapid-review reported on qualitative research available as grey literature showing how some health professionals are not aware that LGBT people may resist disclosing their status (e.g. sexual orientation or gender identity) or discuss their health issues due to concerns that it would not be kept confidential. One health professional in the quote below showed awareness of the concern over confidentiality and how his behaviour might put young LGBT patients at ease:

"Sometimes I wonder whether I should say to the patient 'I can assure you that this is confidential although I know your parents, this is between you and me', it looks like you have to say it so that the person believes it and I think that patients should be aware by now that coming to consultation is absolutely private and confidential..." (Doctor, GP, Spain)

(Source: Report - Martin-Pérez et al., 2010 Discourses and attitudes of primary healthcare professionals about LGBT people and their sexual health in Madrid. Asociación Española de Transexuales)

Theme 4.2: Fear of coming-out

Several MS rapid-reviews reported on grey literature that showed how some young LGBT people feared 'coming out' to their peers, health professionals and in school settings due to potential negative consequences [x6 MS: Greece, Hungary, Italy, Poland, Slovakia, Spain]. Fear of disclosure was not limited to young people only. Data from a Lithuanian informational brochure highlighted the experience of a lesbian woman:

"After experiencing the first symptoms of an illness, I feel huge emotional stress, because I know that after turning to a healthcare facility either I will have to 'come-out' as lesbian and to shock my doctor or I will have to conceal this fact and to face many misguided questions. As long as I have the choice, I will stay at home and will try to treat myself

independently. The healthcare sector is alien, unsafe and not understanding my needs.” (Lesbian woman, Lithuania)

(Source: Brochure – LGL 2010 Ten things about LBT women’s health. The National LGBT Rights Association)*

Across the rapid-reviews, data suggested that many LGBTI people anticipated negative consequences when disclosing their sexual orientation, gender identity or sex characteristics to health professionals and for some, what they anticipated materialised.

“I went to my doctor with a stress-related illness and mentioned that ‘coming out’ to my family had been a recent source of stress. He responded by telling me that his sister had recently ‘come out’, told me that he was still revolted by it, and said that his family were operating a ‘don’t ask don’t tell’ policy. He didn’t seem to have any awareness that this might have an impact on my reaction to him!” (Bisexual woman, UK)

(Source: Report – TLGF 2014 Beyond babies & breast cancer: Expanding our understanding of women’s health needs. The Lesbian and Gay Foundation)

“I changed general practitioner after she gave me the results of a routine blood test, when she stated that ‘one never knows what your kind might be spreading.’ (Gay man, Spain)

(Source: Report - López et al., 2013 SO and/or GI based discrimination in Spain. FELGBT)

“I once went for a stomach check-up and the GP asked me whether I had done an HIV test. He told me I should go to do it without even asking me whether I was promiscuous or not – I could have been a virgin.” (Gay man, 51 – 60 year-old, Malta)

(Source: Report – Xuereb, M. 2008 A survey on sexual orientation and gender identity discrimination against lesbian, gay, bisexual and transgender persons in Malta. MGRM)

From the rapid-reviews it became apparent that due to negative consequences such as being attributed responsibility for spreading infectious diseases following disclosure of sexual orientation, some may avoid seeking help from health professionals and the services they represent, leading to increased risk of poor health. The rapid-review from the UK presented a study which included an interview with a lesbian woman who drew attention to how the creation of LGBTI friendly environments may help reduce fear of accessing health services.

“If health workers made it obvious, for example, through posters or direct contact with me, that patient’s sexuality was not an issue for them and that lesbians were welcome, I might feel easier about visiting the GP for things like smears”. (Lesbian woman, UK)

(Source: Guidelines – Ashworth, A. 2012 Sexual orientation: A guide for the NHS. Stonewall UK)

Thus it is clear that professionals can influence barriers which prevent LGBTI people’s access to health care. When LGBTI people are met with openness, inclusion and without judgement, LGBTI people are more able to ‘come out’ and speak freely about their lives, behaviour and health concerns.

Theme 5: Intersectionality

Across all the rapid-reviews of grey literature, there was limited reference to intersectionality regarding discrimination that LGBTI people may have experienced based on more than one marker of difference such as sexuality and gender, age, disability or ethnicity. However, of

the rapid-reviews that did address intersectionality, references to the grey literature related to LGBTI people with disabilities, older LGBTI people or LGBTI who were also migrants, refugees or asylum seekers [x7 MS: Lithuania, Malta, Netherlands, Poland, Portugal, Romania, Slovakia]. These are explored briefly below.

Theme 5.1: Asylum seeker and refugees

Rapid-reviews from Belgium, Finland, Luxembourg, and the UK drew attention to grey literature that highlighted how some LGBTI asylum seekers and refugees experience disproportionate transphobia, biphobia, interphobia⁸ and homophobia combined with overt racism [x4 MS: Belgium, Finland, Luxembourg, UK]. Moreover, additional reviews also highlighted how LGBT people are fearful of 'coming-out' or acknowledging their sexual orientation or gender identity [x3 MS: Croatia, Finland, France]. Fear of 'coming-out' placed individuals in difficult positions because of expectations to provide supporting evidence of their LGBT identity in order to qualify for asylum in Europe. In many instances, this evidence is non-existent and the cycle of marginalisation is perpetuated in the countries where they seek refuge. People end up in refugee centres. The Belgian rapid-review provided data highlighting a correlation between the size of refugee centres and homophobic or transphobic incidents that occurred.

"We need to invest in more and smaller centres for asylum seekers. Incidents concerning homo- and transphobia mostly occur in bigger refugee centres (+ 500 inhabitants). Only in smaller centres safety and wellbeing of LGBT refugees is more guaranteed (and other vulnerable groups)." (Belgium)

(Source: Report – Mills, K. 2016 Safe havens for LGBTI refugees. Fedasil)

Smaller centres were reported as protecting against transphobia and homophobia to a degree. However the Finnish rapid-review indicated that asylum seekers and refugees needed specific healthcare due to the trauma of being displaced combined with marginalisation linked to sexual orientation and gender identity.

"...medical check-ups and basic healthcare was much needed". (Finland)

(Source: News Article – Red Cross 2016 Mobile healthcare team dismantles in reception centres. Finnish Red Cross)

Theme 5.2: LGBTI people with disabilities

Data from four rapid-reviews suggest that some LGBT people with disabilities are particularly marginalised at the intersections of disability, their gender identity and/or sexual orientation [x4 MS: Austria, Belgium, Germany, Poland]. The Belgian rapid-review in particular, drew attention to grey literature highlighting how LGBT people with disabilities may face two minority positions. For example, the review stated that LGBT people with disabilities may be more dependent on others regarding care due to chronic illness, and also have less privacy in exploring and developing their sexual orientation and gender identity. Due to double marginalisation, LGBT people with disabilities may have a greater need to access health

⁸ Interphobia encompasses negative attitudes and feelings towards people who are born with, or develop in puberty, sex traits that are not typically male or female, known as intersex Traits whether they are actually born with them or simply exhibit non-binary gender identity or expression, which is commonly associated with having congenital Intersex Traits. See <http://oii-usa.org/2417/what-is-interphobia>

services for physical and psychological support due to experiences of discrimination (Germany) and to help them gain an understanding of their gender and/or sexual identities (Austria). A review from Austria highlighted how formal or voluntary psychological support services for people with disabilities often did not emphasise inclusion of LGBTI people

"NGOs focus on disability OR homosexuality and when we wanted to launch a support group for disabled LGBT people and asked [name] for support they answered "we don't need that". (Austria)

(Source: Report – Qwien 2011 Final report "Disability is queer culture". Zentrum für schwul/lesbische Kultur und Geschichte)

The Austrian rapid-review indicated that professionals appear unaware of the need for inclusion of LGBTI people with disabilities, which reduces the prevalence of much needed treatment and therapy. However, the German review suggests:

"Cultural sensitivity and a better understanding of gender, sexuality and disability [by health professionals] could help to reduce barriers in this area." (Germany)

(Source: White Paper – Peters, C. 2011 LSBT mit behinderung in der gesundheitsversorgung. Queerhandicap e.V.)

According to the German rapid-review greater knowledge and understanding of the health needs of LGBTI people with disabilities can aid health professionals to provide services that accommodate their needs whilst acknowledging that gender and sexuality is relevant to open and inclusive service delivery.

Theme 5.3: Older LGBT people⁹

Grey literature from the rapid-reviews suggest that health services appear to be limited or inadequate for older LGBT people [x8 MS: Czech Republic, Finland, France, Germany, Lithuania, Netherlands, Spain, UK]. For example, in the Czech Republic review, attention is drawn to literature that suggests that the managers of some health and social care institutions are not always aware that LGBT older people are in their facilities and therefore, their needs are not necessarily considered in the context of care for older people.

"Actually, so far I haven't thought there could be a LGBT senior. I thought that only the young ones are ..." (Manager of a health and social care institution, Czech Republic)

(Source: Report - Špatenková & Olecká 2016 LGBT elderly people. PROUD)

Moreover, the Czech Republic review also highlighted how although some medical professionals were aware of diversity in sexual and gendered identities, they did not always see the relevance of sexual orientation or gender identity for treatment and care needs.

"Is he sick? He is. And that he is LGBT? So what? We provide healthcare based on his health not on the basis of his sexual orientation. We're a hospital not a brothel. We are interested in his illness not his sexual orientation ..." (Health professional, Czech Republic)

(Source: Report - Špatenková & Olecká 2016 LGBT elderly people. PROUD)

⁹ Although information provided by MS did not include reference to intersex people, this lack of availability of services may also extend to older intersex people. See Bauer & Truffer (2017).

Theme 6: Medicalisation and social control

The Romanian rapid-review reported on grey literature which starkly highlighted that even though homosexuality is no longer regarded as a mental disorder by medical classification systems (including the DSM-5 and ICD-11), some LGB people continue to be subjected to medicalisation where their identities are associated with mental disorder and illness:

“I think homosexuals have a mental problem, like a chronic illness that distorts the normal perception on perpetuation of the species. They use perverted sexual relations, hideous ways of generating pleasure that ultimately, as we all know, lead to ailments installed in the prefrontal cortex, temporal lobes... throughout the limbic system, leading to addiction, depression, suicide”. (Student health professional, Romania)

(Source: Report – Marin, C. 2015 Documentation of discrimination in the field of LGBT health in Romania. ACCEPT Association)

Additional evidence of the pathologisation of the lives and bodies of trans people was reflected in reviews of grey literature from several MS whereby trans people were regarded as ill or mentally disordered. In some countries, reviews highlighted that for some trans people, in order to transition legally, socially, and undergo gender reassignment surgery, a medical diagnosis is required such as ‘gender dysphoria’ [x13 MS: Bulgaria, Croatia, Czech Republic, Finland, France, Germany, Greece, Hungary, Poland, Portugal, Slovakia, Slovenia, UK].

“Gender dysphoria or transsexualism are mental disorders that require specific therapeutic measures.” (Physician, Czech Republic)

(Source: Report – Otáhalová & Plešmid 2015 The main problems of the current legislation in the area of legal recognition of gender identity and possible solutions. PROUD)

“In my personal case (as a transvestite), I want to live in harmony with my surroundings and more especially with my wife... In the academic environment, transvestites, transsexual people etc. are still too often regarded as mentally ill. To see that, you only need to look on the Internet. A number of small groups are fighting to have these terms removed from the official list of mental illnesses.” (Trans person, Belgium)

(Source: Report – Motmans, J. 2010 Being transgender in Belgium. Mapping the social and legal situation of transgender people. Institute for the equality of women and men)

From the Belgian rapid-review it became apparent that the drive to have gender dysphoria removed as mental disorder in the systems of diagnosis and classification (DSM-V) or transsexualism (ICD-10), as these terms are contested by some as trans people who need a diagnosis to access medical treatment. Health practitioners and medical doctors act as gatekeepers guarding access to care. In the Netherlands trans people face a two-year waiting period for surgery impacting on their psychological wellbeing. As a result, 50% of all trans people have experienced some social consequences such as loss of employment, delay in education, loss of friends or family disharmony. Some trans people therefore self-medicate because of the challenges related to long waiting times. Knowingly or unknowingly, the behaviour of health professionals compounded by systemic barriers act as a form of social control that limits access to much needed treatment.

"A trans woman went to the pharmacy with a valid receipt. The pharmacist did not fill the prescription and said: 'You won't get female hormones; I can see that you are a man'."
(Trans woman, Austria)

(Source: Magazine Article – Kunert, C. 2014 *What's the point of that masquerade? WLP News, Zeitschrift des Wiener Landesverbandes für Psychotherapie*)

Theme 6.1: Sterilisation of trans people

In some MS, rapid-reviews [x4 MS: Czech Republic, Finland, Hungary, Slovakia] reported on literature showing that either a legal limitation existed in policy or law; or a social norm was evident which results in trans people being sterilised during transition in order to gain legal gender recognition. For example, the Slovakian review reported on grey literature suggesting that for trans people to undergo sex reassignment surgery, for some surgery implied being sterilised which of course means losing the ability to procreate and have children:

"My doctor told me in a very insensitive way that hysterectomy is a necessity defined within the law. When I asked her what law, she talked it down. Then she asked me if I can imagine a man having a child. She said it is not normal and people 'like that' should not be able to procreate." (Slovakia)

(Source: Guidebook - Transfúzia 2014 *The standards of trans-inclusive environment in the healthcare system. Transfúzia*)

Similar reports were evident from the Czech Republic and Hungarian rapid-reviews:

"Gender dysphoria or transsexualism ... require specific therapeutic measures. We - as physicians who for decades try to help these people - do not consider discriminatory or inhuman, if a legal sex change requires castration/sterilisation." (Doctor, Czech Republic)

(Source: Report – Otáhalová & Plešmíd 2015 *The main problems of the current legislation in the area of legal recognition of gender identity and possible solutions. PROUD*)

"I visited [name] doctor to ask for hormone therapy. [The doctor was] not willing to start my therapy without [sterilisation]. I told her I want to give birth in the future so I don't want that surgery. She was totally disgusted and refused to treat me." (Trans man, Hungary)

(Source: Report - Hidasi, B. 2014 *Transcare documentation of discrimination in the field of health of trans* people in Hungary. Transvanilla Transgender Association*)

Theme 6.2: Funding for treatment

Rapid-reviews highlighted that in some MS, health insurance does not cover some or all transition treatment for trans people. These forms of treatment were described as being 'cosmetic' by some practitioners and the institutions they represented. Thus, private provision in such cases is sometimes sought at great personal cost instead of state funded National Health Services [x6 MS: Greece, Hungary, Latvia, Lithuania, Malta, Slovakia]. Moreover, state funded specialist services to support gender transitioning were reported as being difficult to access or not provided by a range of MS [x9 MS: Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Portugal, Romania, Slovakia].

"My doctor told me that he cannot really help me, since this procedure is not available in Slovakia. He tried to explain the situation to me, but it was very confusing. He told me to come back in half a year to see what can be done." (Trans person, 28 year-old, Slovakia)

"I have contacted 16 doctors from [name] and local towns. Most of them wrote back to me explaining that they do not work with people like me and they have no information [about the options of transitioning in Slovakia]. They know nothing, they are not trained or they simply wrote to me that they are not interested in meeting me." (Anonymous, 20 year-old, Slovakia)

(Source: Guidebook - Transfúzia 2015 The standards of trans-inclusive environment in the healthcare system. Transfúzia)

Inaccessible treatment or long periods of waiting for sex reassignment surgery can have a significant impact on mental health and wellbeing. Even though mental health services were considered vital to the wellbeing of trans people, these services were not always available pre-transition, whilst transitioning or post-transition [x8 MS: Croatia, Czech Republic, France, Greece, Hungary, Lithuania, Romania, Slovakia].

Theme 6.3: Invisibility of intersex people

References to grey literature regarding intersex people were rarely mentioned in many of the rapid-reviews [x18 MS: Croatia, Czech Republic, Denmark, Finland, Germany, Greece, Hungary, Italy, Latvia, Lithuania, Luxembourg, Poland Portugal, Slovakia, Slovenia, Spain, Sweden, UK]. This is indicative of the need for more research on the needs of intersex people related to accessing healthcare and greater visibility of intersex people.

Theme 6.4: Medicalisation of intersex bodies

Nevertheless eight rapid-reviews did mention intersex people and concerns over unnecessary pathologisation and medicalisation where intersex variations are regarded as 'disorders of sex development' or 'DSD'¹⁰ within biomedicine and their related systems of diagnosis and classification [x8 MS: Belgium, Bulgaria, Croatia, Denmark, Germany, Netherlands, Slovakia, UK].

*"The medical healthcare still has the monopoly on knowledge on inter*conditions. 'DSD' is taboo and gets too little attention in healthcare settings. Medical teams need to work more multidisciplinary and need to be aware of the nonsense of binary thinking (male/female). Professionals within healthcare don't have the right education to deal with inter*. Research about the needs of inter*people is focused on medical issues rather than sociological." (Doctor, Belgium)*

(Source: Presentation – Cools, M. 2013 Inter, an introduction: Body and gender: past simplicity. UZ Ghent)*

¹⁰ We use the term 'Disorders of Sex Development' or 'DSD' in quotes where it is used to highlight that it is a contested term mainly used in biomedical settings.

“Counter-discourses challenge the current Danish medical practice. Cultural gendered recognition, is prioritised and seen as more important than the physical and mental risks associated with the medical practice. Based on the expectation of cultural gendered recognition, as an idealised concept of ‘man’ and ‘woman’ bodies and identities, the healthcare professionals perform genital corrective surgery on infants. The medical practice reflects an expectation of a specific gender behaviour, a particular form of sexual behaviour... It is concluded that the healthcare professionals are unaware of how their perceptions of cultural norms of gender, sex and body... are used to legitimise their practices.” (Denmark)

(Source: Masters Thesis – Soffiusion, B. 2015 The normative healthcare system. Roskilde University)

Theme 6.5: Surgical intervention aiming at normalising intersex bodies

Some rapid-reviews report on literature which suggests that intersex people are commonly subjected to normalising surgery at a young age without informed consent [x3 MS: Austria, Croatia, Denmark, Germany].

“While intersex children may face several problems, in the ‘developed world’ the most pressing is the ongoing Intersex Genital Mutilation, which present a distinct and unique issue constituting significant human rights violations.” (Austria)

(Source: NGO Report – VIMO 2015 Intersex genital mutilation. Human rights violations of persons with variations of sex anatomy. Verein Intersexueller Menschen Österreich (VIMÖ) & Zwischengeschlecht.org)

Interestingly, the rapid-review from Germany highlighted literature stating that surgery on intersex minors with ambiguous sex characteristics to align their body with male/female sex markers can be regarded as interference with the right to physical integrity that may limit the ability for some intersex people to procreate. Decisions that impact on physical integrity or sexual and gender identity of intersex people should be based on their right to self-determine and any intervention should occur in the context of informed consent. Similarly, the Maltese rapid-review reported that it is unlawful in this MS for medical practitioners or other professionals to conduct any sex assignment treatment and/or surgical intervention on the sex characteristics of a minor where treatment and/or intervention can be deferred until the person to be treated can provide informed consent. For Germany in case of intersex minors whom may not be able to provide informed consent, such measures should only be adopted after thorough consideration of the advantages, disadvantages and long-term consequences for the child. Interventions should only be undertaken based on thorough assessment of the medical, psychological and psychosocial advantages or disadvantages of early intervention where the guiding principle is the welfare of the child. In the event of doubt, such operations should be postponed until the person concerned has gained competence to consent to an intervention.

Proposed changes state that medical diagnosis and treatment¹¹ of intersex people should be provided by specialised interdisciplinary centres and conducted by teams comprising of medical practitioners and experts in all the relevant fields. Ongoing medical care should then be provided at independent specialised centres and accompanied by simultaneous advice

¹¹ The term treatment is used here as some intersex people may access hormone treatment or due to the lack of certain hormones medication to prevent for example osteoporosis.

given by other affected individuals and support services provided in settings within 50 km from where they live. Findings indicated a need for decentralised approach and better education of health professionals in general. All treatment measures should be comprehensively documented and remain accessible to those concerned for at least 40 years.

Theme 6.6: Prohibition of blood donation

A number of rapid-reviews drew attention to literature demonstrating examples of where some health professionals were prevented from accepting blood donated by those who engaged in same-sex sexual behaviour or men who have sex with men due to the perceived risk of sexually transmitted infections [x11 MS: Croatia, Czech Republic, Germany, Greece, Hungary, Italy, Lithuania, Malta, Poland Portugal, Slovakia].

“Gay and bisexual men are often excluded (from) blood donation, although this exclusion is not required nor allowed by law. The law only requires the permanent exclusion of people ‘whose behaviour exposes them to high risk of acquisition of STIs’, or the temporary exclusion (4 months) of all those people ‘who have occasional sex’. The law (and the proposed questionnaire for evaluation) never mentions homosexuals or men who have sex with men. However, LGBTI organisations are often informed about cases of permanent exclusion after direct questions about sexual orientation.” (Italy)

(Source: Law – Italian Ministry of Health 2005 Decreto del ministro della salute 3 marzo 2005 “Protocolli per l'accertamento della idoneità del donatore di sangue e di emocomponenti”)

Even where the exclusion of MSM or homosexual men did not exist as a legal requirement, people may have been prevented from donating blood by the health professionals who gatekeep access to these services.

4.5 What are the potential barriers faced by health professionals when providing care for LGBTI people?

Theme 7: Lack of knowledge

Several rapid-reviews specifically drew attention to literature highlighting the seemingly limited education and training opportunities available for health professionals to address the specific health needs of LGBTI people in Member States. The rapid-review from Finland reported on a survey conducted by the American Psychiatric Association, where only 30% of psychologists and psychology students were familiar with issues concerning gender variance and trans people meaning that 70% did not have the relevant knowledge. Several rapid-reviews from MS provided examples of quotes from the grey literature showing the need to increase knowledge to tackle ignorance around LGBTI issues both in the negative (e.g. abhorrent statements and viewpoints) and the more positive (e.g. self-reflection and recognition by health professionals that they need specific training):

“Homosexuality in my opinion is an intellectual cancer, gay people have a very limited level of consciousness, always installed in a pattern of behaviour driven by selfishness, not being capable of responsibility to family, society. I am against homosexuality and consider it to be a severe neuro-immuno-psychological pathology. This disease weakens the immune system making them prone to serious infections and even cancer. I would

feel uncomfortable to consult a homosexual for the above mentioned reasons, but I would be happy to help him if he wants to return to normal.” (Health professional, Romania)

(Source: Report – Marin, C. 2015 Documentation of discrimination in the field of LGBT health in Romania. ACCEPT Association)

“I think we all want the same, information at schools and information at healthcare services. My GP said we were not in a hurry; if she had waited for 17 years she could wait for longer. I had to come here [the LGBT service] to get a letter to be admitted to the Gender Unit. The doctor had no information or interest”. (Mother of a 17 years old girl, Spain)

(Source: Guide – Programa LGTB de la Comunidad de Madrid 2015 Guidelines for supporting gender diverse minors. Social Services Department Madrid)

Some reviews highlighted specifically literature showing that some health professionals have limited knowledge of how to support LGB youth who might be struggling with their sexual orientation:

“I think you have to be very precise and I personally think that I do not have sufficient knowledge, information, ideas on how to deal with it. How to guide a young person who is in an identity crisis? What am I? Am I gay, lesbian, bisexual? What does that mean? How do I bring it out or how do I do that? How do I find it?” (Health professional, Netherlands)

(Source: Report – Emmen et al., 2014 Jong & Anders. Nederlands Jeugdinstituut en Movisie)

“Early on in my smear history I told a nurse that I had a female partner and she was completely taken back and said ‘I don’t know what to do about that’... she was really confused as to what to do next clinically... she said ‘well you are here and we can do it anyway’ but she hadn’t been trained for that situation” (Lesbian woman, UK)

(Source: Report – Bottomley et al., 2014 Are you ready for your screen test? The Lesbian and Gay Foundation & University of Salford)

7.1: Health professionals not aware of LGBTI status

Rapid-reviews suggest that health professionals are often not aware of the sexual orientation and/or gendered identities or sex characteristics of LGBTI people who access their health services due to heterosexist bias [x9 MS: Hungary, Ireland, Italy, Lithuania, Poland, Slovakia, Slovenia, Spain, Sweden, UK]. For example, the Portuguese rapid-review mentions a survey which showed 70% of the health professionals studied assumed that their patient(s) were heterosexual. When formulating questions related to sexual orientation, only 17% of the health professionals in the study included the possibility of patients being LGB. The responsibility to contest that invisibility tends to fall exclusively on the patient, despite their hesitation to ‘come out’ due to fear of discrimination and stigmatisation. The Portuguese survey reported 66% of participants anticipated some form of discrimination or a reduction in the quality of their care when they did ‘come out’.

7.2: Lack of mental health services

Due to multiple layers of marginalisation many LGBTI people are subjected to discrimination and stigmatisation. Consequently, the incidence of mental health problems can be much

higher for this population group compared to the general population. However, much grey literature reported by MS highlighted how specialist mental health services and counselling services for LGBTI people are generally lacking [x14 MS: Belgium, Croatia, France, Germany, Greece, Hungary, Italy, Lithuania, Poland, Portugal, Romania, Slovakia, Spain, Sweden].

4.6 What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Theme 8: Promising practice

The rapid-review also included a section on examples of promising practice (if they existed) regarding addressing the specific health needs of LGBTI people in their country. Examples provided spanned a broad range of settings for example: HIV testing and support centres where free, anonymous and voluntary HIV testing and consulting centres were provided [x5 MS: Croatia, Czech Republic, Italy, Portugal, Slovenia]; centres providing assistance and support for people living with HIV [x6 MS: Bulgaria, Czech Republic, Denmark, Finland, Greece, Portugal]; peer mentoring for LGBT people in crises (Czech Republic); a queer social group to interact with refugees and thereby foster mutual understanding (Luxembourg); information leaflets for health professionals to address LGBTI health (Poland); queer leadership development, counselling and psychological support (Slovakia) and a suicide prevention strategy for LGBT people (Italy).

Specific examples of promising practice reported were:

Country: Austria

Target Group: Trans* and inter* people

Promising Practice: Tabera founded in 2015, is an advice centre for trans* and inter* people providing psychotherapy, support groups or support during the coming out process. In addition, Tabera provides public lectures, workshops, and seminars.

Country: The Netherlands

Target Group: Lesbian and gay seniors over 65

Promising Practice: "Als u begrijpt wat ik bedoel..." (in English, 'if you understand what I mean') is a project for 'Pink Seniors over 65' that provides a story telling space to keep older lesbian and gay people engaged, optimistic and less isolated.

Country: Italy

Target Group: Men who have Sex with Men

Promising Practice: Deliberazione P.G.84587/2014 – CONVENZIONE TRA IL COMUNE DI BOLOGNA, L'AZIENDA U.S.L. DI BOLOGNA E L'ASSOCIAZIONE is an agreement between municipal and local health authorities with the LGBTI association PLUS to provide access to HIV prevention and testing for MSM.

Country: Latvia

Target Group: LBT women

Promising Practice: 10 dalykų apie LBT moterų sveikatą (in English '10 Things About LBT Women's Health') is a brochure to address LBT women's health covering topics such as "Coming Out in Healthcare Setting", "Sexual Health", "Risk Factors for Cancer", "Risk Factors for Heart Disease", "Mental Health", "Addictions" "Eating Disorders", "Violence", "Motherhood", "Health of Trans Women" and further recommendations for health professionals.

Country: Romania

Target Group: LGBTI people

Promising Practice: The Romanian Association for Mental Health had a program for personal development of LGBTI people, designed to cater for their specific needs, especially when faced with a largely heteronormative society.

Country: Slovakia

Target Group: Queer people (LGBT)

Promising Practice: Q-Centrum is a community centre established by the non-governmental organisation Queer Leaders Forum in Bratislava. The aim of the centre is to provide social, legal and psychological counselling to LGBT clients.

Country: Luxembourg

Target Group: LGBTI refugees / Queer people

Promising Practice: CIGALE Centre LGBTI refugee support group meets every week providing social support to reduce social isolation and offers pedagogic counselling when needed. Additionally, the centre offers a Queer get-together as an inclusive socialising event for queer people to get in touch with LGBT refugees in order to increase wellbeing and provide a wider sense of understanding and acceptance by locals.

For further examples refer to the individual rapid-review summaries from each MS in the following Section 4.7.¹²

4.7 Summaries of MS rapid-reviews

As noted in Section 4.1, following receipt of the completed rapid-reviews from MS, each rapid-review was read, lightly edited for consistency (e.g. language, structure), and then developed into a stand-alone document to act as a useful future resource (these are available directly from the authors and include full details of any references/documents cited). Each rapid-review was then summarised to provide a succinct one-page summary. As noted previously, the data presented here are the work of key contributors from the respective Member State reporting on the grey literature. We therefore cannot attest to the accuracy or completeness of this information. However, we are very grateful for their contributions and willingness to engage in the Health4LGBTI project.

The following pages present the one-page summaries of the rapid-reviews for each of the 27 responding Member States.

¹² A number of rapid-reviews did not identify any promising practices. However, it is difficult to know whether this means there is an absence of promising practices in specific MS, or a lack of awareness of such practices.

Austria

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities:	http://www.health-inequalities.eu/about-hi/at-national-level/austria/
LGBTI Rights	ILGA-Europe Rainbow Map for Austria	http://ilga-europe.org/sites/default/files/2016/austria.pdf
EU data	Austria in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/austria_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

None mentioned

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Bundesgesetz über die Gleichbehandlung Equal Treatment Act 2004	Protects against discrimination in employment and in the access to and supply of necessary goods and services. In employment people are entitled to equal treatment regardless of their gender, ethnicity, religion, belief, age and sexual orientation. Discrimination based on sexuality is not protected.
Gesetz zur Bekämpfung von Diskriminierung (Wiener Antidiskriminierungs-gesetz) Act to combat discrimination, Vienna's anti-discrimination law 2004	The Act applies to Vienna and protects social, health, education, access to and supply of necessary public goods and services, access to and extension of self-employment. It protects against direct and indirect discrimination and harassment. People are entitled to equal treatment regardless of their ethnicity, religion, belief, disability, age, sexual orientation, gender identity and gender, especially on the basis of pregnancy and having a child. Here LGBTI people are protected against discrimination
Fortpflanzungsmedizingesetz Reproductive Medicines Act 2015	The Reproductive Medicine Act regulates assisted reproductive technologies. People are allowed to use assisted reproductive technology (ART) if living in a marriage or cohabitation or as a woman living in a same-sex union.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Intersex people may be subjected to 'genital mutilation' in non-consensual, medically unnecessary, irreversible, cosmetic genital surgery, and/or other harmful medical treatment to ensure intersex bodies conform to the biomedical norm for sex development to either masculinise or feminise intersex bodies.	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Lack of training as many healthcare employees have little specialised knowledge and may have discriminating attitudes. Gay, lesbian and trans people face derogatory comments and meet disapproval when accessing healthcare.	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>20 Jahre Schwerpunktpraxis An openly gay general practitioner, opened his office 20 years ago specialising in treatment and care of gay patients, but patients who are not gay are also welcome. He was cofounder of HOMED (homosexuals in healthcare).</p> <p>Tabera was founded 2015 and is an advice centre for trans* and inter* people providing psychotherapy, support groups or support during the coming out process. Tabera provides public lectures, workshops and seminars.</p>	

Belgium

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities:	http://www.health-inequalities.eu/about-hi/at-national-level/belgium/
LGBTI Rights	ILGA-Europe Rainbow Map for Belgium	https://rainbow-europe.org/#8624/0/0
EU data	Belgium in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/belgium_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

<p>Trans people suffer from depression more often and have higher suicide attempts. Trans people reported the lowest levels of support from family and friends. Trans people run high risk of mental health problems than.</p> <p>Lesbian and bisexual women (18-23) are particularly prone to suicidal thoughts and actions with 56.6% of lesbian and bisexual girls thought at least once of making an end to their lives and 14.4% had at least one suicide attempt. Factors leading to depression, suicidal thoughts and self-harm were external stressors such as experiences of verbal abuse and being bullied mainly at school.</p> <p>LGBTI asylum seekers and refugees experience disproportionate homophobia, transphobia and biphobia.</p> <p>Gay men show HIV rates of 1 in 20 men are positive.</p>
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2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
The LGBT Strategy Paper 2011	Belgium has one of the highest rates on deaths by suicide in the LGBT population. The Flemish Minister of Health produced an action plan to reduce suicide rates with 20% by 2020.
National Strategic Plan on HIV prevention 2014 – 2019	HIV prevention; testing and treatment; and care and support. The strategy is written in a context where more than a 1,000 new HIV infections are being reported each year. The plan prioritizes most affected populations including men who have sex with men and migrant workers.
Inter-federal plan against homophobia and transphobia 2013	The plan creates an overall framework in consultation and formulates a strategic plan to address the main problems that LGBT people face within healthcare

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>LGBT people with disabilities face two minority positions. They are more dependent on others and on care and have less privacy exploring and developing sexual and gender identity.</p> <p>LGB people with a background of migration (including asylum seekers and refugees) are a double minority facing racism as well as homophobia.</p>	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Health professionals are socialised into a health system that supports binary thinking (male/female), (homosexual/heterosexual) and use terms that pathologise intersex lives such as disorders of sex development.</p>	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>“Keep an eye on sexual identity” is a manual for health professionals that sets out what health professionals have to consider when trying to improve the health and general wellbeing of LGBTI people, and what to think of when providing care.</p> <p>Holebifoon is a helpline that provides information and lends an ear to all with questions or concerns.</p>	

Bulgaria

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities:	http://www.health-inequalities.eu/about-hi/at-national-level/bulgaria/
LGBTI Rights	ILGA-Europe Rainbow Map for Bulgaria	https://rainbow-europe.org/#8626/0/0
EU data	Bulgaria in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/bulgaria_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

LGBT women experience higher rates of psychological violence. Trans women who are sex workers experience increased rates of violence, often exercised by police.

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Law on Protection against Discrimination 2003 Amended 2015	Anti-discrimination law to prevent discrimination on grounds of race, gender, religion, disability, age and sexual orientation. The original law includes “sexual orientation”, referring to L.G.B.; the amendment of April 2015 included “change of sex (gender)” amongst the protected characteristics, which expands the protection to trans people.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	Access to psychological support services for LGBT women who have experienced psychological violence is limited. Trans people have difficulty accessing specialist services like endocrinology, or practitioners who are supportive of their desire to transition. Intersex variations are poorly understood and often medicalised and pathologised by practitioners in health settings. <i>“It is very important who would be the first to talk with the family. If this conversation is postponed, if there are unsaid things, and unclear statements, or if inappropriate language is being used, such as ‘your child is a hermaphrodite’ – the whole life of the child could be ruined. Parents should be informed by a psychologist, genetics specialist or endocrinologist who is well prepared to talk about sexual development disorders.”</i>

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	Law on protection against domestic violence (03.2005) does not provide protection to people living in same-sex families resulting in the institutions dealing with domestic violence ignoring cases of domestic violence in same sex couples or do not provide services the state provides to heterosexual families.

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	Positive about HIV/AIDS is a newsletter containing examples of positive practice for the prevention of HIV/AIDS, and provided support to different vulnerable groups, and of people living with HIV/AIDS.

Croatia

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities:	http://www.health-inequalities.eu/about-hi/at-national-level/croatia/
LGBTI Rights	ILGA-Europe Rainbow Map for Croatia Republic	https://rainbow-europe.org/#8627/0/0
EU data	Croatia in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/croatia_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

No - No information provided.

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Same-sex Life Partnership Act 2014	Regulates life partnership of same sex people, the principles, conclusion and termination of life partnerships, the procedures, register and legal effects of life partnerships.
Regulation on Blood and Blood Components 1998 Art 16	Collection of blood and blood components where those who engage in homosexual behaviour are permanently excluded from donating blood.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>5.7% LGBTIQ (Q = queer) people in Croatia have experienced discrimination based on their sexual orientation, gender identity or gender expression in health settings. Of LGBTIQ people, 83% were not out to their general practitioner and 72% thought the quality of their healthcare would be negatively influenced by coming out; and 60% thought they were more likely to experience discrimination due to their sexual orientation, gender identity or gender expression or sex characteristics. LGBTIQ people did not come out as they feared their information will not be treated as confidential (32.4%), as well as being aware of prejudice against LGBTIQ people (19.4%), being afraid of discrimination (18.8%); and due to health professionals' assumptions that everyone is heterosexual (11.1%).</p> <p>The rights and status of LGBTI people remain unprotected in Croatia. As a result, LGBTI people struggle to gain access to health services for specialist care. Institutional homophobia/biphobia/transphobia exists in health services where sex reassignment surgeries are allowed, but only after the person has been diagnosed with gender identity disorder (gender dysphoria). Intersex people and their lives remain invisible in Croatia. There are no legal acts or policies that refer to intersex people and intersex issues are not present in public discourse. Children remain unprotected from unnecessary invasive surgery in early childhood.</p>	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>There is a lack of education or training available to health professionals in understanding the health needs of LGBTI people. On consulting a doctor for gender transitioning, a trans person found the doctor did not know what trans was, which discouraged her from asking any further help.</p> <p>Legal limitations where health professionals are prevented from accepting blood from those who engage in homosexual behaviour.</p>	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>HIV testing and consultation centres for free and anonymous HIV testing and consulting (CTS) are open in Zagreb, Rijeka, Split, Pula, Dubrovnik, Korčula, Osijek and Slavonski Brod with Iskorak Zagreb providing rapid HIV testing in a LGBT centre where the sample is taken from the fingertip and the result can be known in a few minutes.</p>	

Czech Republic

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: The Czech Republic	http://www.health-inequalities.eu/about-hi/at-national-level/czech-republic/
LGBTI Rights	ILGA-Europe Rainbow Map for the Czech Republic	https://rainbow-europe.org/#8629/0/0
EU data	The Czech Republic in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/czechrepublic_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

No - No information provided.

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Ministry of Health - Decree on Human Blood 143/2008.	Czech hospitals and blood centres exclude people who have engaged in homosexual practices in the last 12 months from donating blood
The Civil Code	Deals with sex change (personal status)
Act on Specific Health Services	Addresses medical issues (treatment of the patient and specific conditions for surgery)

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	Trans people and their identities are colonised by biomedicine and psychiatry without respecting and understanding each trans person as an individual. Much scope remains in health settings for inclusion of non-binary gender where trans people identify outside the dominant medical model as trans, genderqueer, non-binary etc.

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	Services are not available for older LGBTI people who are often invisible or closeted with limited awareness of their specific health needs. Health professionals are interested in illness without seeing the person and their sexual orientation, gender identity/gender expression or sex characteristics more holistically. For example, a national report quoted a doctor: "Is he sick? He is. And that he is LGBT? So what. We provide healthcare based on his health, not on the basis of his sexual orientation. We're a hospital, not a brothel. We are interested in his illness, not his sexual orientation ..."

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	<p>LGBT - Peer Mentoring Portal for LGBT in Crises - founded by Prague Pride, tens of voluntary mentors/counsellors (LGBT people, parents of LGBT people, their friends etc.) offering online psychological help</p> <p>Czech AIDS Help Society - On-line counselling, 24/7 free anonymous helpline, legal assistance in cases of discrimination against HIV-positive people, seminars on HIV / AIDS.</p> <p>House of light - Socio-refugee centre providing assistance and support for HIV positive people who find themselves in a difficult personal or social situation and are in need of temporary safe place where they can overcome this difficult period, free and anonymous HIV testing.</p>

Denmark

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Denmark	http://www.health-inequalities.eu/about-hi/at-national-level/denmark/
LGBTI Rights	ILGA-Europe Rainbow Map for Denmark	https://rainbow-europe.org/#8630/0/0
EU data	Denmark in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/denmark_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

No - No information provided.

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Health Act 2014	Section on castration § 115 determines that the decision to use castration as part of gender reassignment surgery cannot be decided by the patient and clinician alone, but has to be approved in addition by an administrative body.
Ministry of Health Regulation	Deals with trans people who seek medical treatment (waiting times)
Danish Health Authority Function plan 2016	Addresses a function plan for psychiatry, gynaecology, obstetrics and plastic surgery.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	Trans people have limited access to specialist health services and as a result sought gender reassignment treatment abroad. In Denmark 37% of trans people felt health services did not address their needs. Of ethnic minority LGBT people, 30% have been subject by family members to attempts at 'healing' them with some having been taken to the doctor or psychologist for that purpose.

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	Institutional practices have become accepted over time for example where intersex people are subjected to 'normalising' surgery to fit the binary sex norm of either masculinity or femininity. Diversity and plurality is not acknowledged. LGBTI health professionals are subjected to prejudice from colleagues and patients.

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	The Castle with the Rainbow is a nursing home for older people that targets LGBT people for inclusion. Checkpoint offers free, anonymous and rapid HIV and syphilis testing and counselling. Increased efforts in cancer (Styrket indsats på kræftområdet) recommends a pilot test of HPV vaccine for MSM.

Estonia *

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Denmark	http://www.health-inequalities.eu/about-hi/at-national-level/ESTONIA/
LGBTI Rights	ILGA-Europe Rainbow Map for Denmark	https://europa.eu/european-union/about-eu/countries/member-countries/estonia_en
EU data	Estonia in the EU	https://rainbow-europe.org/#8631/0/0

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Qualitative research with LGBTQ people felt that compared to heterosexual cisgender people, LGBTQ individuals experience more psychological problems, including depression and suicidal thoughts. Most interviewees admitted that they had needed psychological or psychiatric help at some periods of life and/or the need to take antidepressants.</p> <p>Gay men are prevented from blood donation. Research participants indicated that through the enforcement of this rule, they feel stigmatised and rendered as second-class citizens.</p> <p>Trans people problematised the state-sanctioned gender reassignment process as lengthy, cumbersome and overly bureaucratised, resulting in various negative experiences for their everyday lives. Some transgender people said how they completely avoid going to any doctor for fear of being stigmatised or discriminated against, health they lack professional medical assistance.</p>	

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Equal Treatment Act 2009	The purpose of the act is to ensure the protection of persons against discrimination on grounds of nationality (ethnic origin), race, colour, religion or other beliefs, age, disability or sexual orientation. However, the act does not provide protection from discrimination in access to services of social welfare, social security and healthcare, including social benefits. Therefore LGB people are excluded from this protection .

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

No - No information provided.

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>A document from the Estonian Medical Students' Association, reports on an informal and possibly one-time training for medical students on how to help trans people. The aim was to give tips on how to respect and support the trans community. Key barriers identified were lack of knowledge and information about how to treat trans people</p>	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response:	Explanation (if available)
Example(s):	
<p>Regular ongoing national study targeting Men who have Sex with Men especially on safer sex and HIV. However, this study does not seem to be used extensively in actually improving the practice of healthcare settings and workers. Therefore there is a lot of potential as regular data comes in with this study but it is unclear how much this actually influences the reality of MSM.</p> <p>Health of Lesbian and Bisexual Women –Leaflet by Estonian LGBT Association (2012) on the specific healthcare needs that lesbian and bisexual women might have. Useful to both L&B women but also healthcare professionals. One hospital refused to display the leaflets in their premises (especially a women's clinic), referring that men who come there with their female partners might be offended.</p>	

* This review summary is based only on the data received during the piloting of the rapid-review template prior to being sent out for completion to all Member States. No further data was available from the MS expert.

Finland

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Finland	http://www.health-inequalities.eu/about-hi/at-national-level/finland/
LGBTI Rights	ILGA-Europe Rainbow Map for Finland	https://rainbow-europe.org/#8632/0/0
EU data	Finland in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/finland_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

No - No information provided.

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Ministry of Social Affairs and Health - Act 785/1992 Status and Rights of Patients	Rights of patients when accessing healthcare and medical services (informed consent, dignity and respect)
Ministry of Justice – Act 1325/2014 Non-discrimination Act	Promotes equality and prevent discrimination (includes LGB, not trans or intersex)
Ministry of Social Affairs and Health – Decree 1053/2002 Gender reassignment	Guidelines for gender reassignment and medical clearance for legal gender recognition (trans and intersex people)

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Trans people are sterilised in order to legally change their gender. The Ombudsman for equality found the sterilisation requirement a violation of human rights, self-determination and physical integrity. In addition, the ICD-10 definition of transgender as a mental disorder affects the opinions and attitudes of healthcare professionals leading to unnecessary pathologisation and prejudice.	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Heteronormative assumptions held by health professionals made LGBT people reluctant to access healthcare leading to secrecy, invisibility, incorrect information and mistrust between the patient and professionals. LGBTI specific training for health professionals is lacking. "Education for healthcare professionals should include topics on appropriate treatment of LGBTI people, their right to self-determination and special needs within the healthcare system".	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Improving the situation of gender and sexual minorities (LGBTI) in healthcare maps training needs, develop training initiatives.</p> <p>Sex and trans is a trans support network, HIV centre and support service for LGBTI people, their partners and healthcare professionals.</p> <p>Closets in the 21st century – how to get away from heteronormativity? University of Tampere student union and Finnish Student Health Service (YTHS) together with Seta – LGBT Rights in Finland arranged a panel discussion to determine: "Is tolerance and equality reality in practice as well as in official statements and objectives? Who are left in closets, and who holds the key?"</p>	

France

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: France	http://www.health-inequalities.eu/about-hi/at-national-level/france/
LGBTI Rights	ILGA-Europe Rainbow Map for France	https://rainbow-europe.org/#8633/0/0
EU data	France in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/france_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Increased rates of sexually transmitted diseases for lesbians and women who have sex with women due to lower rates of screening

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Code de la santé publique 2016. National code	Equal access to healthcare, health as a fundamental right (article L. 1110-1) prohibition of discrimination (articles L. 1110-3, 4127) on grounds of sexual orientation or gender identity.
Programme d'actions gouvernemental contre les violences et les discriminations commises à raison de l'orientation sexuelle ou de l'identité de genre 2012 Policy: Action Plan	List of actions to be taken against homophobia and transphobia by reducing aggression, helping young people, ending everyday discrimination.
Plan national de lutte contre le VIH et les IST 2010-2014 Policy: Health Ministry	List of actions to be taken against homophobia and transphobia by helping young people, ending everyday discrimination etc.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
LGB people may find it difficult to find the right doctor and disclose their sexual orientation due to fear of rejection by some physicians. Health beliefs can be a barrier. He did not think he would be getting old. "Initially, it was thirty years ago, I was given a life expectancy of eight days. And then, it was one year, then two, then three ... I am facing aging and I was not expecting it, I should not be there. So this is new to me. I haven't got any sex in the last fifteen years and I miss it. I especially need tenderness and cuddles, more than the sex act itself".	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Knowledge of LGBTI lives and health is limited resulting in ignorance of sexual practices, specific prevention and needs. Difficulty of knowing what the expectations of these patients are with limited knowledge of specific risks and questions to ask. No prevention campaign for STDs for lesbians and women who have sex with women.	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
L'accueil médical des personnes transidentitaires is a leaflet for health professionals on the health needs of trans people.	

Germany

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Germany	http://www.health-inequalities.eu/about-hi/at-national-level/germany/
LGBTI Rights	ILGA-Europe Rainbow Map for Germany	https://rainbow-europe.org/#8635/0/0
EU data	Germany in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/germany_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Outpatient facilities serve twice as many LGBTI older people compared to inpatient services with 50% of institutions acknowledging there is a significant need to address LGBT older persons' health. 57.1% of trans people experienced discriminatory encounters with medical staff.	

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Allgemeines Gleichbehandlungsgesetz (AGG) [General Act on Equal Treatment] 2006	Preventing discrimination on grounds of race, ethnicity, gender, religion, belief, disability, age or sexual orientation (labour and civil law)
The Civil Code	Deals with sex change (personal status)
Act on Specific Health Services	Addresses medical issues (treatment of the patient and specific conditions for surgery)
Beratungsergebnis der gemeinsamen Arbeitsgruppe aus Vertretern des „Arbeitskreises Blut nach §24TFG“ und des Ständigen Arbeitskreises „Richtlinien Hämotherapie nach §§12a und 18 [Guideline of German Medical Association] 2012	Men who have sex with men (MSM) are permanently excluded from blood donation due to risk related to sexual behaviour in the context of STDs.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
LGBTI people experience discrimination when accessing healthcare. For example the lives and bodies of trans people are medicalised when attempting to gain access to treatment due to long periods of assessment, diagnosis and surgery. LGBTI people have difficulty accessing adequate counselling and psychological support services. Disabled LGBTI people are double marginalised at the intersections of their sexual orientation, gender identity, sex characteristics and disability.	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Lack of LGBTI issues in professional training and university education leading to discrimination.	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
German Ethics Council Expert Opinion on the situation of intersex people suggest that surgery of intersex minors to align their body with male/female sex characteristics should only occur in exceptional circumstances where the health or life of the intersex minor is at risk. . All treatment should be comprehensively documented and remain accessible for 40 years. The time-bar provisions applicable to criminal acts against children should be extended to criminal acts resulting in irreversible impairment of fertility and/or sexual sensitivity.	

Greece

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Greece	http://www.health-inequalities.eu/about-hi/at-national-level/greece/
LGBTI Rights	ILGA-Europe Rainbow Map for Greece	https://rainbow-europe.org/#8636/0/0
EU data	Greece in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/greece_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Response: Yes – see full review	Explanation (if available)
Example(s):	
A survey on homophobic and transphobic violence found 60% of gay men have experienced violence based on their sexual orientation.	

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Law 4285/2014 "Modification of Law. 927/1979 (A 139)	Protects against discrimination based on sexuality and gender.
Insurance coverage for healthcare benefits of those in civil partnerships Act 2016.	Since legalisation of civil partnerships in 2015, same sex partners are entitled to health insurance.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Of LGBT people, 11% said that they have experienced discrimination from health professionals because of their sexual orientation and gender identity. Some psychologists and psychiatrists undertake treatment to cure homosexuality where LGBTI people are encouraged to become heterosexual.	
Of gay and trans victims of violence who sought medical care, only 14.7% thought they were treated appropriately supporting widespread mistrust of health professionals, treatment and care.	
Trans people are placed in hospital room according to their legal gender on official documents which does not necessarily match their gender.	
Trans people are recorded as intersex in health settings to ensure insurance covers surgical costs of transitioning.	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Health professionals can't accept donated blood from men who have sex with men.	
Health professionals are limited in treatment options for trans people due to limitations of health insurance.	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Checkpoint is a non-clinical, community based HIV, HBV, HCV and Syphilis prevention and testing promotion facility that offers counselling, testing and signposting to other services.	
Program for Combating Discrimination Based on Sexual Orientation and Gender Identity offers a helpline and psychological support for LGBTQI+ youth, their parents and educators.	
www.gaysexualhealth.gr is a website for gay men that provides information on STDs, HIV/Aids and sexual health.	

Hungary

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Hungary	http://www.health-inequalities.eu/about-hi/at-national-level/hungary/
LGBTI Rights	ILGA-Europe Rainbow Map for Hungary	https://rainbow-europe.org/#8637/0/0
EU data	Hungary in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/hungary_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

No - No information provided.

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Act CXXV on equal treatment and the promotion of equal opportunities 2003	Protection against discrimination (including gender and sexuality).
Act no. CLIV of 1997 on healthcare [2005 amendment]	Human reproduction technology (excludes lesbian couples)
Act no. XXIX of 2009 on registered partnership	Deals with registered partnerships for same-sex couples (provides cohabiting LGBTI people next-of-kin status)

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>A Hungarian survey showed 28% of LGBT people experienced discrimination in healthcare system including denial of treatment or examination affecting people living with HIV more often, or humiliation, verbal harassment, inappropriate curiosity or negative attitudes towards LGB individuals.</p> <p>“I was consulting in Budapest at the Gynaecology Clinic about genital reconstruction surgery and asked to take off my clothes because they did not see a woman with penis before. Then they called in some 4-5 medical students and they surveyed my naked body.” (humiliation)</p> <p>LGB people feared that their confidentiality would be compromised by health professionals sharing their sexuality or HIV status with lay people (non-health professionals).</p>	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Health professionals are often not aware of their patients' LGBTI status or sexuality.</p> <p>Training and education is required to generate understanding and prevent health professionals' discriminate against LGBTI people.</p> <p>Health professionals can't accept blood donated by men who had sex with men (MSM) in the last 12 months.</p>	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

No - No information provided.

Ireland

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Republic of Ireland	http://www.health-inequalities.eu/about-hi/at-national-level/republic-of-ireland/
LGBTI Rights	ILGA-Europe Rainbow Map for the Republic of Ireland	https://rainbow-europe.org/#8639/0/0
EU data	The Republic of Ireland in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/ireland_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Response: Yes – see full review	Explanation (if available)
Example(s):	
LGBTI young people had: 2 times the level of self-harm, 3 times the level of attempted suicide, 4 times the level of severe/extremely severe stress, anxiety and depression. Of LGBTI people, 70% had seriously thought of ending their life at some stage and recreational drug use was 2 times higher amongst LGBTI people compared to the general population.	

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Equal Status Act 2000 to 2012 (as amended)	Promotes equality and bans discrimination (including gender and sexuality)
A guide to the Equal Status Act 2015 Irish Human Rights and Equality Commission	Sets out the aims, grounds for protection and how the Act protects against discrimination.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Of LGBT people, only 40% felt respected by healthcare providers when accessing treatment and care with 45% actively sought out LGBT-friendly healthcare professionals because of bad experiences that they had with providers in the past.	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Recent research found 76.9% of LGBT participants felt healthcare providers need to have more knowledge of and sensitivity of LGBT issues. Healthcare providers were only aware of respondents' LGBT identity (sexual orientation, gender identity or sex characteristics) in 44% of cases, thus 56% of LGBT people were not out to healthcare providers.	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Connecting for Life is Ireland's National Strategy to Reduce Suicide (2015-2020) allowing for a partnership approach between statutory agencies and LGBT NGOs to jointly tackle the issue of LGBT mental health inequalities and LGBT suicidality, and to collaborate on a shared goal of reducing these inequalities and reducing mental health and suicide risk.	

Italy

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Italy	http://www.health-inequalities.eu/about-hi/at-national-level/italy/
LGBTI Rights	ILGA-Europe Rainbow Map for Italy	https://rainbow-europe.org/#8640/0/0
EU data	Italy in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/italy_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

No - No information provided.

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
(Decreto del Ministro della Salute 3 marzo 2005 "Protocolli per l'accertamento della idoneità del donatore di sangue e di emocomponenti")	Gay and bisexual men are often excluded from blood donating, although this exclusion is not required nor allowed by law. Law specifies permanent exclusion of people "whose behaviour exposes them to high risk of acquisition of STIs", or the temporary exclusion (4 months) of all those people "who have occasional sex". The law (and the proposed questionnaire for evaluation) never mentions gay men or MSM. However, LGBTI organisations are often informed of cases of permanent exclusion after direct questions about sexual orientation.
L. 165/91 "Obbligatorietà della vaccinazione contro l'Epatite virale B" and "Vaccinazione per epatite B : precisazioni al DM 20/11/2000. Ministry of Health	Deals with access to Hepatitis B vaccination. Those at higher risk of Hepatitis B (such as 'homosexual men') can gain free vaccination.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	Fear of being treated unfairly by health professionals because of sexual orientation (heterosexist judgement); and fear to disclose sexual orientation to medical doctors, gynaecologists or psychologists due to concerns over privacy. A survey found for LGB people 80% of women didn't come out to their GP with 68.5% did not disclose their sexual orientation to their GP whilst 34.5% of women and 31.6% of men feared unfair treatment once they came out. Of gay and bisexual men, 10.9% could not access free or affordable HIV testing and 58.3% were dissatisfied with counselling (or didn't receive any counselling).

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	Not knowing when people are LGB as patients often did not disclose their sexual orientation.

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	SAT-PINK Opuscolo informativo provides information about the gender transitioning process and services available to trans people. Gender transitioning and related medical intervention is free of charge. Deliberazione P.G.84587/2014 - CONVENZIONE TRA IL COMUNE DI BOLOGNA, L'AZIENDA U.S.L. DI BOLOGNA E L'ASSOCIAZIONE is an agreement between municipal and local health authorities with the LGBTI association PLUS to provide access to HIV prevention and testing for MSM.

Latvia

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Latvia	http://www.health-inequalities.eu/about-hi/at-national-level/latvia/
LGBTI Rights	ILGA-Europe Rainbow Map for Latvia	https://rainbow-europe.org/#8642/0/0
EU data	Latvia in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/latvia_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

No - No information provided.

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Latvian Act changes are required to align with Council of Europe Recommendation CM/Rec 5 (2010)	A Latvian legal framework is lacking for 1) legal gender recognition; 2) protection of the rights of LGBT people in criminal law; 3) protection against discrimination on the grounds of sexual orientation and gender identity in the fields of employment, education and access to goods and services.
Article 91 of the Constitution of the Republic of Latvia	Deals with general prohibition of discrimination without specifying any grounds however human rights must be observed and protected.
Amendments are required to: <ol style="list-style-type: none"> Civil Status Acts Law (Civilstāvokļa aktu likums); Name, Surname and Ethnicity Record Change Law (Vārda, uzvārda un tautības ieraksta maiņas likums); Regulation No.916 of the Cabinet of Ministers "Procedure on Elaboration and Drawing Documents" (MK Noteikumi Nr.916 "Dokumentu izstrādāšanas un noformēšanas kārtība). Regulation No.1046 of the Cabinet of Ministers of Latvia "The Procedure on Organisation and Financing of Healthcare" 	Regarding healthcare of trans people amendments are required to regulate gender recognition and medical treatment for gender reassignment. Regulation No. 1046 sets out financing arrangements for healthcare. Requires amendment to ensure trans people can access gender reassignment treatment.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Gender reassignment surgery and treatment of trans people is explicitly excluded from the state paid medical services.	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

No - No information provided.

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

No - No information provided.

Lithuania

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: The Republic of Lithuania	http://www.health-inequalities.eu/about-hi/at-national-level/lithuania/
LGBTI Rights	ILGA-Europe Rainbow Map for the Republic of Lithuania	https://rainbow-europe.org/#8644/0/0
EU data	The Republic of Lithuania in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/lithuania_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

No - No information provided.

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Law on Equal Treatment in the Republic of Lithuania 2003 (amended 2013)	Deals with prohibition of discrimination on grounds of sexuality (LGB identities) but omits gender identity and gender expression (excludes Trans identities). Fails to address intersectionality and discrimination based on more than one aspect.
Law on Patients' Rights and Compensation for Damage to Health 1996 (amended 2014) Lithuanian Parliament	Prohibits infringement of patient' rights (on ground of sexual orientation but not gender identity or gender expression)

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Fear due to LGBTI experiencing high levels of hostility they are hesitant to come out and remain closeted. Trans people are not protected from discrimination in health settings. Trans specific health services do not meet standards for quick, accessible and transparent treatment; services for gender reassignment should be developed as they are currently lacking and trans people fund their own treatment as a result.</p> <p>LGBTI people are not perceived as having any specific health needs that warrants attention. Sexual and reproductive health for LGBTI people are overlooked as priority focus areas.</p> <p>Blood donation is not allowed for MSM or those who engage in 'risky sexual practices'.</p> <p>"After experiencing the first symptoms of an illness, I feel huge emotional stress, because I know that after turning to a healthcare facility either I will have to come out as lesbian and to shock my doctor or I will have to conceal this fact and to face many misguided questions. As long as I have the choice, I will stay at home and will try to treat myself independently. The healthcare sector is alien, unsafe and not understanding about my needs."</p>	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

No - No information provided.

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>10 dalykų apie LBT moterų sveikatą (in English '10 Things About LBT Women's Health') is a brochure to address LBT women's health covering topics such as "Coming Out in Healthcare Setting", "Sexual Health", "Risk Factors for Cancer", "Risk Factors for Heart Disease", "Mental Health", "Addictions", "Eating Disorders", "Violence", "Motherhood", "Health of Trans Women" and further recommendations for health professionals.</p> <p>Checkpoint: ŽIV prevencijos centras (in English 'Checkpoint: Centre for HIV Prevention') provides inclusive HIV and STD testing services for men who have sex with men (MSM)</p>	

Luxembourg

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Luxembourg	http://www.health-inequalities.eu/about-hi/at-national-level/luxembourg/
LGBTI Rights	ILGA-Europe Rainbow Map for Luxembourg	https://rainbow-europe.org/#8645/0/0
EU data	Luxembourg in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/luxembourg_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

No - No information provided.

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Plan national de prévention du suicide pour le Luxembourg 2015-2019. Ministère de la Santé - Direction de la Santé. National Report.	Deals with suicide rates (rates in Luxembourg have been stable for over 10 years whilst decreasing in other EU countries). Includes a suicide prevention strategy (no mention of LGBTI populations).

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

No - No information provided.

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

No - No information provided.

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>CIGALE Centre LGBTI refugee support group meets every week providing social support to reduce social isolation and offers pedagogic counselling when needed.</p> <p>CHIGALE Centre Queer get-together is an inclusive socialising event for queer people to get in touch with LGBT refugees in order to increase wellbeing and provide a wider sense of understanding and acceptance by locals.</p> <p>CHIGALE Centre IDAHOT workshop on sexual health and wellbeing of queer women to address the health needs of lesbian and bisexual women.</p> <p>CIGALE Centre is currently working on a leaflet referring to sexual health of lesbian women, more specifically on sexually transmitted diseases (STDs).</p>	

Malta

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Malta	http://www.health-inequalities.eu/about-hi/at-national-level/malta/
LGBTI Rights	ILGA-Europe Rainbow Map for Malta	https://rainbow-europe.org/#8647/0/0
EU data	Malta in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/malta_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Response: Yes – see full review	Explanation (if available)
Example(s):	
HIV infection rates for MSM have risen by 57% in Malta between 2004-2015.	

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Gender Identity, Gender Expression and Sex Characteristics Act, 2015 National Legislation	Prohibition of discrimination on the grounds of gender identity and sex characteristics, provisions on legal gender recognition and prohibition of unnecessary medical treatment of intersex children.
Embryo Protection Act, 2012 National Legislation	Regulates medically assisted procreation and access to human embryos (excludes LGBTI people from accessing assisted reproductive technology).
The Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act, 2015 [Proposed legislation currently undergoing parliamentary process]	Ban on conversion practice is proposed and prohibits the pathologisation of any sexual orientation, gender identity and, or gender expression.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
A survey with LGBT people in Malta showed 29.4% (almost 1 in 3) of respondents who sought health services and did not conceal their sexual orientation and/or gender identity felt that they were treated less favourably than other patients. The most commonly reported discrimination was linked to blood donation, where participants were refused as blood donors because of their sexual orientation. Others relate to medical practitioners' lack of knowledge of healthcare for trans patients and the association of gay men with HIV infection. <i>Gay man, 26 – 40:</i> "I went for an HIV test. The doctor was very friendly and helpful but the receptionist was very uptight... I went with a friend of mine who is rather effeminate, but that does not give anyone the right to make snide remarks, especially at a place like that."	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Health professionals are not able to accept blood from MSM and a lifetime ban is imposed on such men. Knowledge of how to address LGBTI health needs, specially for trans people is limited. <i>Trans female, 41 – 50:</i> "Most healthcare practitioners have no idea how to deal with transgender people. They think we are some kind of monsters."	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Rainbow Support Service provides an affirmative, safe and welcoming environment for LGBTIQ individuals requiring support whilst providing training and consultancy to a range of professionals including psychologists, counsellors, social workers, health workers, etc.	

Netherlands

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: The Netherlands	http://www.health-inequalities.eu/about-hi/at-national-level/the-netherlands/
LGBTI Rights	ILGA-Europe Rainbow Map for The Netherlands	https://rainbow-europe.org/#8651/0/0
EU data	The Netherlands in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/netherlands_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>15% of MSM had had unprotected sex with casual partners within the past year.</p> <p>The prevalence of sexual violence is high for LGBT groups, though amongst bisexual women and female-to-male spectrum trans people in particular.</p> <p>Care networks for older LGB people over 55 are more often made up of friends compared to heterosexual people who rely more often on children or partners in later life.</p>	

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Sekseregistratie door de overheid en de juridische positie van transgenders 2014. National Policy Paper	Deals with legal gender recognition of trans people. To what extent and under what conditions it is possible, in the light of international obligations, to have sex in some cases indefinite? What are the legal and practical problems thereby created or solved?

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Norms upheld by health professionals of binary male/female sex characteristics are not helpful for intersex people.</p> <p>Trans people face a two-year waiting period for surgery impacting on their psychological wellbeing resulting in 50% of all trans people have had social trouble (loss of job, delay of education, friends and family disharmony) and self-medication because of long waiting times.</p> <p>Young LGBTI people are overlooked in sex education at school. More attention to sexual development for LGBTI people is needed in schools with less focus on heterosexual norms or more focus on non-binary gender and sex to include trans and intersex youth.</p> <p>Older LGBT people face exclusion and discrimination in the care centres or apartment buildings where they live.</p>	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Health professionals have limited knowledge of how to support LGBTI youth who might be struggling with their gender identity or sexual orientation: "I think you have to be very precise and I personally think that I do not have sufficient knowledge, information, ideas on how to deal with it. How to guide a young person who is in an identity crisis: What am I? Am I gay, lesbian, bisexual? What does that mean? How do I bring it out or how do I do that? How do I find it? "</p>	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Projectverslag "Als u begrijpt wat ik bedoel..." Project for Pink Seniors over 65 provided a story telling space to keep older LG people engaged, optimistic and less alone.</p>	

Poland

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Poland	http://www.health-inequalities.eu/about-hi/at-national-level/poland/
LGBTI Rights	ILGA-Europe Rainbow Map for Poland	https://rainbow-europe.org/#8653/0/0
EU data	Poland in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/poland_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Response: Yes – see full review	Explanation (if available)
Example(s):	
The LGBT population has higher rates of mental disorder (e.g. depression), but also increased use of psychoactive substances and suicide attempts. Estimates suggest that 30% of young LGBT people attempt suicide.	

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: No information available	Explanation (if available)
Example(s):	
No Acts, legislation, regulations, frameworks, policies regarding LGBTI health exist in Poland. LGBTI issues are not mentioned in any document.	

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Homophobia, transphobia and biphobia with related discrimination occurs frequently. LGB patients experience discrimination from health professionals including verbal abuse, limited contact with the doctor, refusing to provide medical information on the health status of a partner etc.	
1. "During a visit to the emergency unit, when I had a renal colic attack, the paramedics openly mocked me, with a doctor in our room, with me and my partner present. One of the paramedics... commented out loud that we are faggots. Another one.. taunting and mocking us. The other paramedics laughed in response. The doctor behaved in an unpleasant manner, I sensed mockery in his voice."	
2. A 21 year-old gay man was met with unprofessional behaviour of a doctor who made derogatory comments for example, doctor "as a joke" described the medical procedure as painless, unless the patient is homosexual, because such people are not anaesthetised.	
3. "The doctor offered me an appointment with an exorcist, as a good way to dealing with being transgender"	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Knowledge and experience of LGBTI health is lacking where health professionals did not see the need to gain a better understanding of LGBTI health needs – they perceive no need to treat heterosexual and LGBTI people any different. Health professionals uphold stereotypes for example that LGB people are more likely to change partners and suffer from infectious diseases, especially AIDS.	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Zdrowie LGBT. Przewodnik dla kadry medycznej is a translated guide based on the UK NHS guidelines for health staff in Poland to inform delivery of appropriate services for LGBT people by providing awareness of LGBT health needs.	

Portugal

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Portugal	http://www.health-inequalities.eu/about-hi/at-national-level/portugal/
LGBTI Rights	ILGA-Europe Rainbow Map for Portugal	https://rainbow-europe.org/#8654/0/0
EU data	Portugal Republic in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/portugal_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

No - No information provided.

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Law n°. 7/2011 National Law	Concerns legal gender recognition of trans people and the administrative process accompanied by medical practice for sex change.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>LGBTI people are hesitant to come out to health professionals due to anticipated discrimination and stigma. Homophobia, transphobia and biphobia is prevalent and LGBT people fear coming out to health professionals as a result. Men who have sex with men face barriers in donating blood on grounds of their sexuality and perceived risk. LGB people have been in mental health services where health professionals suggested homosexuality can be cured. "In a medical appointment, the doctor (a gynaecologist) told me that homosexuality is a disease for which there is treatment." (Lesbian woman, 26 years old)</p> <p>Trans people experience non-compliance with international guidelines and care standards (WPATH). Access to treatment (including genital surgery) is governed by the Portuguese Medical Association's approval prior to treatment.</p> <p>Trans people may be met with criticism from health professionals in relation to gender, gender expressions and gender identity "I had long hair and my doctor asked me: <i>You want to be a man but you have long hair?</i> And I was studying for primary school teacher, that confused him. He used to say: <i>You are a man but you choose a woman job.</i>" (Trans man)</p>	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Health professionals are challenged by their own heteronormativity where 70% assumed people were heterosexual. Lack of knowledge and training in LGBTI health and practice/resources available via the Portuguese National Health System. "We need more training for health professionals. Or you have a personal interest and you search and update yourself, or it is not easy to have access to this type of information." (Gynaecologist)</p> <p>"LGB people don't like to talk about their lives, unless the context is favourable to that. If a patient goes to a doctor with whom (s)he knows that can talk about everything, the coming-out is easier." (Doctor working in a ER)</p>	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Associação ILGA Portugal and the Portuguese Directorate-General of Health 2015 developed a protocol to share knowledge, and form partnerships to inform policy and training of health professionals on LGBTI health.</p> <p>CheckpointLX is a community-based centre for men who have sex with men (MSM), for anonymous, confidential and free screening of human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs), sexual counselling and referral to healthcare.</p>	

Romania

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Romania	http://www.health-inequalities.eu/about-hi/at-national-level/romania/
LGBTI Rights	ILGA-Europe Rainbow Map for Romania	https://rainbow-europe.org/#8655/0/0
EU data	Romania in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/romania_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

No - No information provided.

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Government Ordinance 137/2000 on the prevention and sanctioning of all forms of discrimination and Law no. 48/2002	Deals with prevention of discrimination (includes sexual orientation but does not include gender identity)
Law no. 95/2006 on healthcare reform	Deals with healthcare reform and prevents refusal of medical services based on sexual orientation but not gender identity.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
LGBTI people experience discrimination, marginalisation and heteronormativity in health settings as seen in these quotations: 'I think homosexuals have a mental problem, like a chronic illness that distorts the normal perception on perpetuation of the species. They use perverted sexual relations, hideous ways of generating pleasure that ultimately, as we all know, lead to ailments installed in the prefrontal cortex, temporal lobes... throughout the limbic system, leading to addiction, depression, suicide' 'Homosexuality in my opinion is an intellectual cancer, gay people have a very limited level of consciousness, always installed in a pattern of behaviour driven by selfishness, not being capable of responsibility to family, society. I am against homosexuality and consider it to be a severe neuro-immuno-psychological pathology. This disease weakens the immune system making them prone to serious infections and even cancer. I would feel uncomfortable to consult a homosexual for the above mentioned reasons, but I would be happy to help him if he wants to return to normal'.	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Lack of knowledge and training regarding LGBTI health needs whilst academic curricula do include the state of health or psychology of LGBTI people. Dominant narratives sustains homosexuality as a sexual deviation and an illness in medical courses and academic sources. In addition gender dysphoria is approached as a disorder or pathology. Health professionals hold restrictive beliefs such as homosexuality is a disease that can be cured thereby helping LGBT people become heterosexual.	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
The Romanian Association for Mental Health had a program for personal development of LGBTI people, designed to cater for their particular needs, especially when faced with a largely heteronormative society.	

Slovakia

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Slovakia	http://www.health-inequalities.eu/about-hi/at-national-level/slovakia/
LGBTI Rights	ILGA-Europe Rainbow Map for Slovakia	https://rainbow-europe.org/#8659/0/0
EU data	Slovakia in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/slovakia_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Of LGBT people 28% experienced stress with 22% having experienced depression or anxiety related to their sexual orientation or and gender identity. Moreover 7% of LGBT people reported having had an eating disorder.	

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Act On Equal Treatment and Protection Against Discrimination – Amending And Supplementing Certain Other Laws (Antidiscrimination Act No. 153/2004).	Deals with protection against direct and indirect discrimination, harassment and sexual harassment (includes sex, gender and sexual orientation; however §8 (1) positives action to “encourage members of disadvantaged groups in employment, education, culture, healthcare or services” (excludes sexuality).
Code of Ethics For Healthcare Professionals Appendix To Act (No.578/2004 Z.z.)	Provides guidance to health professionals on ethical conduct and values to uphold in patient care.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Non-married individuals are legally excluded from accessing assisted reproductive technology.</p> <p>Many trans people face degrading and dehumanising language and treatment when in contact with health professionals: “I felt that my doctor needed to constantly inform me that I am a sick person – she called me a toy of the nature, a deviation. She told me that people like me used to be shown in circus freak shows. It was a constant part of the visit that she reminded me where I belong, in relation to her and the society” (Anonymous, 30).</p> <p>Some trans people are sterilised as part of transitioning “My doctor told me in a very insensitive way that hysterectomy is a necessity defined within the law. When I asked her what law, she talked it down. Then she asked me if I can imagine a man having a child. She said it is not normal and people ‘like that’ should not be able to procreate.” (Anonymous, 24)</p> <p>Partners of LGBT patients do not have the legal right to access the necessary information about their partner’s health.</p>	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Health professionals hold restrictive beliefs for example: homosexuality is seen as a disease that can be cured. As a result health professionals subject LGB people to forms of conversion therapy.</p> <p>“The psychologist that I visited the last time is religious – she is a Christian. I am too, but not so much... When I opened up to her regarding my sexual orientation, she agreed to counsel me, but only if I agreed to change my life and my orientation. She tried to send me to [name of pilgrimage site], told me that they will cure me there of this compulsion... But I don’t want to give this up, I was very sad”</p>	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Q-Centrum is a community centre established by the non-governmental organisation Queer Leaders Forum in Bratislava. The aim of the centre is to provide social, legal and psychological counselling to LGBT clients.</p> <p>Ethical Framework for health professions working with LGBT clients produced by Q-Centrum, a NGO.</p>	

Slovenia

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Slovenia	http://www.health-inequalities.eu/about-hi/at-national-level/slovenia/
LGBTI Rights	ILGA-Europe Rainbow Map for Slovenia	https://rainbow-europe.org/#8660/0/0
EU data	Slovenia in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/slovenia_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Response: Yes – see full review	Explanation (if available)
Example(s):	
LGBT people are more likely to experience violence, mostly from strangers and schoolmates, but 1,7% from doctors.	

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Infertility treatment and bio medically-assisted procreation Act. 2000 Slovenia	Regulates access to infertility treatment. Single women and lesbian women are excluded from assisted reproductive technology.
Healthcare and Health Insurance Act. 2015 Slovenia	Regulates compulsory health insurance (includes cover of heterosexual partners but exclude same-sex partners)
Rules on compulsory health insurance. 2014 ZZS [Health Insurance Institute of Slovenia]	Access to health services required referral by a GP (no direct access to STD doctors/specialists, except for partners of people, who have STD; needs a referral from their GP).

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Stigma and fear - research showed 22% of LGB people did not disclose their sexuality to a GP due to fear of consequences and 27% are afraid to have an HIV test due to fear of disclosure. Bad past experiences with disclosure made coming out in medical settings less likely, even if it would aid treatment. For trans people 69% experienced discrimination with 6% whilst visiting a doctor.	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: No	Explanation (if available)
No information provided	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>AIDS Committee is a multidisciplinary body that includes relevant ministries, experts in prevention and control of HIV, NOGs, affected groups and the public to provide a common platform for better coordination and cooperation.</p> <p>LGBT friendly training - The City of Ljubljana grants a "LGBT friendly" certificate to organizations whose employees participate in training lasting 4 hours.</p> <p>DIC Legebitra, Institute of Microbiology and Immunology provides an anonymous and free STD testing outreach for MSM.</p>	

Spain

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Spain	http://www.health-inequalities.eu/about-hi/at-national-level/spain/
LGBTI Rights	ILGA-Europe Rainbow Map for Spain	https://rainbow-europe.org/#8661/0/0
EU data	Spain in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/spain_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>LGBTI people who were unemployed and over 50 perceived their health as poor.</p> <p>Unemployment and retirement was associated with higher access of health services in the previous year.</p> <p>Bisexual people (86%) experienced higher rates of sadness and depressive feelings.</p> <p>Trans people reported higher rates of discrimination (23%) while using health services in the previous year.</p>	

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Ministry of Health, Social Services and Equality (MSSSI) 2011 Strategy Paper	Sexual and reproductive healthcare (including LGBTI people)
Law 8/2016 - Balearic Island Parliament (and similar for other regions)	Protect the rights (health related) of LGBTI people and to eradicate LGBTI phobia.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>"I was abused by a gynaecologist. I was so shocked and hurt that I didn't report him. But it was clear that the nasty man conducted a brutal exploration when he learnt that I was a lesbian woman. When I told some lesbian friends they called me a fool for telling him about me being lesbian".</p>	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Health professionals are not always aware of LGBTI status as people conceal their sexual orientation, gender identity or sex characteristics or see their identity as fluid. "I think there is a diversity... there are not just heterosexuals and homosexuals. I think there are many things in between... maybe some have no name and being pigeonholed, sometimes, can be traumatic because, maybe you don't fit anywhere... She doesn't feel at home with what she is physically and with the representation of that, but she doesn't know what she wants to be ... In the future, she can be lesbian, she can be nothing... she can be a woman who wants to go on being a woman but does not identify as such... she can like men, she can like women, she can like everything... I don't know". (Mother of an 8-year-old girl).</p>	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
<p>Health Promotion Madrid – provides training to health and social care professionals involved in HIV testing to identify and refer intimate partner violence.</p>	

Sweden

Country Profile

Health Inequalities	European Portal for Action on Health Inequalities: Sweden	http://www.health-inequalities.eu/about-hi/at-national-level/sweden/
LGBTI Rights	ILGA-Europe Rainbow Map for Sweden	https://rainbow-europe.org/#8662/0/0
EU data	Sweden in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/sweden_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Homosexual and bisexual people report a higher incidence of health problems compared to heterosexual people. This was most common amongst bisexual women and homosexual men. Young homosexual and bisexual women have least trust in other people, showing most ill health with the highest incidence of suicidal thoughts and attempted suicide. In addition, trans people reported higher rates of mental health problems with higher rates of suicidal thoughts and suicide attempts.	

2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Stockholm County Council LGBT Policy 2012-2016	People, regardless of sex, gender, gender expression and sexual orientation should be made visible and be treated with respect and professionalism
Swedish Discrimination Act (2008: 567)	Combats discrimination but also to promotes equal rights and opportunities in healthcare, social services and social insurance
Healthcare Act (SFS 1982: 763)	The goal of health- and medical care is good health for everyone and equal access to care for the entire population
Assisted Reproduction 2005	Assisted reproduction for lesbian couples since 2005 (and trans men since 2013)
Hate Crime Act (Article 29: Swedish Penal Code)	Targeting a victim based on sexuality is a hate crime (doesn't cover gender identity or gender expression)

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Exclusion, heteronormativity and invisibility of LGBTI people experienced in health settings acted as barriers. Health professionals had limited knowledge and training related to LGBTI specific health needs leading to people not revealing their sexuality or expecting negative reactions because of previous experience. Trans people experienced a lack of respect and were subjected to normative expectations of a binary gender identity, however many did not fit the male/female or masculinity/femininity binary.	

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
Health professional display ignorance and prejudice that becomes visible in homophobia/transphobia/biphobia. Health professionals do not always understand or know how to decrease discrimination LGBTI people experience. Lack of knowledge and training related to LGBTI health needs and treatment.	

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: No - No information provided.	Explanation (if available)
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United Kingdom Country Profile

Health Inequalities	European Portal for Action on Health Inequalities:	http://www.health-inequalities.eu/about-hi/at-national-level/england/ http://www.health-inequalities.eu/about-hi/at-national-level/wales/ http://www.health-inequalities.eu/about-hi/at-national-level/scotland/
LGBTI Rights	ILGA-Europe Rainbow Map for the UK	http://ilga-europe.org/sites/default/files/2016/united_kingdom.pdf
EU data	The UK in the EU	https://europa.eu/european-union/about-eu/countries/member-countries/unitedkingdom_en

1. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

Lesbian women are at a slightly increased risk of breast cancer.
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2. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
The UK Equality Act 2010	The act protects against direct and indirect discrimination, victimisation and harassment in employment as well as private and public services within wider society. People are entitled to equal treatment regardless of their age, disability, marriage, civil partnership, being pregnant or having a child, race, religion, belief or lack of religion or belief, being or becoming a transsexual person, sex and sexual orientation. These are protected characteristics and employers have to make reasonable adjustments to work environments to overcome barriers experienced by people with protected characteristics. Positive action can be taken against discrimination.
Gender Reassignment Protocol for Scotland	The protocol deals with standards of care for trans people and the procedures provided by the National Health Service.
Care Act 2014	The Act reforms care to emphasise individual choice, providing information and advice, and enshrining a right to appeal supported by independent advocacy etc.

3. What are the potential barriers faced by LGBTI people when using or trying to access healthcare?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	Half of lesbian and bisexual women say they have had a negative experience of healthcare in the last year based on their sexual orientation. "I went to my doctor with a stress-related illness and mentioned that coming out to my family had been a recent source of stress. He responded by telling me that his sister had recently come out, told me that he was still revolted by it, and said that his family were operating a 'don't ask don't tell' policy. He didn't seem to have any awareness that this might have an impact on my reaction to him!"

4. What are the potential barriers faced by health professionals when providing care for LGBTI people?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	Practice guidelines do not acknowledge same-sex partners. "Many healthcare professionals will only discuss a patient's issues with a 'next of kin'. This is often unofficially presumed to mean a blood relative or heterosexual spouse. For day-to-day care of clients without a registered partner or spouse, the patient's or clients wishes in their choice of nominated person should be respected."

5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?

Response: Yes – see full review	Explanation (if available)
Example(s):	
	Pride in Practice is a support package that enables GPs to effectively meet the needs of LGB patients. It offers on-going, regular support for LGBTI people. The practice display a certificate as symbol of their commitment and dedication to ensuring a fully inclusive patient-centred service. The Lancashire LGBT Quality Mark assists services (Child and Adolescent Mental Health Services and Social Work services) to create a positive and productive environment for employees and reduce barriers for LGB&T service users. The service works on two levels and tackles: Inclusive services for LGBT patients; Higher quality of services.

SECTION FIVE: Recommendations, limitations, and conclusions

5.1 Introduction

The previous Sections of this CSR report have presented the findings of two scoping reviews of grey literature to explore: 1) What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings? 2) What is known about the health inequalities of LGBTI people focusing on vulnerable intersections as it relates to healthcare? 3) What are the potential barriers faced by: i) LGBTI people when using or trying to access healthcare, and; ii) health professionals when providing care for LGBTI people? and; 4) What examples of promising practice exist to address the specific health needs of LGBTI people?

Based on these findings, this brief Section elicits short recommendations or issues arising before highlighting some limitations of this CSR and conclusions.

5.2 Brief recommendations

Analysis of data from the rapid-reviews revealed a number of apparent and quite specific gaps in the grey literature. However, it is difficult to know whether there is an actual absence of literature in certain areas or whether the Member State contacts were either unaware of such literature and thus did not include it, or were aware but chose instead to focus on including other literature in their rapid-review. Consequently, the recommendations that follow are necessarily brief and tentative.

5.2.1 Research and policy

- 1) Limited grey literature appears to be available in terms of intersectionality and discrimination that LGBTI people may have experienced based on more than one marker of difference such as sexuality and gender, age, disability or ethnicity. Further research should be conducted with LGBTI people whom may experience multiple marginalisations, to investigate better their needs, impacts on health outcomes, and to understand how to improve and/or ensure appropriate access to health services.
- 2) Similarly, much of the literature from the rapid-reviews focused mainly on LGBT people. In some MS trans people had difficulty accessing specialist treatment to undergo gender transitioning. Relatively few reports were submitted by MS contacts on healthcare issues for intersex people. A greater and dedicated research and policy focus is required to increase understanding of the specific health inequalities that these people may face as well as how to improve and/or ensure appropriate access to health services including appropriate training for health professionals.
- 3) It is clear from the European review and rapid-reviews that many LGBTI people across European countries, 'fear' accessing healthcare settings and disclosing their sexual orientation, gender identity or sex characteristics (e.g. due to concerns of discrimination, lack of privacy and confidentiality and so on). Direct policy action is needed to ensure that health professionals and the health systems underpinning them,

are re-oriented to address the structural and individual inequalities that contribute to the generation of such fears.

5.2.2 Training

- 4) Practitioners in all settings need to develop LGBTI awareness and cultural competence to help ensure all LGBTI people have equal access to healthcare services and that their specific needs are recognised and addressed. Specific resources including training across Member States is therefore required for health professionals to ensure that they are aware of the specific health needs of LGBTI people and to develop or re-design services to then address these needs. As noted above, given the ostensibly significant gaps in grey literatures regarding trans and intersex people's healthcare needs, particular attention should be paid to these populations.
- 5) The design of training initiatives for health professionals should include opportunities to understand the need for equal rights of LGBTI people including the protected nature of sexual orientation, gender identity, and sex characteristics in many EU MS.
- 6) European literature and rapid-reviews were consistent in revealing instances of commonly unnecessary medicalisation and pathologisation of the lives and bodies trans and intersex people. This is often (but not only) conveyed through diagnoses, medical pathways and the related terminology used and embraced by many health professionals. Training should include a focus on acknowledging the diversity and plurality of language needed to describe and understanding better the lives, bodies, and experiences of LGBTI people in terms of gender identity, sexual orientation, and sex characteristics. As examples this may mean developing opportunities to interrogate heteronormativity (in language and practice) including explorations of diversity of gender expression, and non-binary issues including the spectrum of sex characteristics spanning beyond reductionist male/female binaries.
- 7) As noted in point 1 above, for some LGBTI people their gender and/or sexuality intersect with other markers of difference leading to multiple marginalisations, for example LGBTI people who are younger, older, disabled, an ethnic minority, asylum seeker, refugee etc. Training for health professionals should include an attention to such potential multiple marginalisations including opportunities to consider how services can be inclusive of particular needs which may require specific adaptations and specialist support.

5.3 Limitations and conclusions

5.3.1 Limitations

This CSR aimed to complement the findings of the Scientific Review (SR; Zeeman et al., 2017a) by exploring grey literature from European and international bodies and agencies as well as from across European MS. It achieved this through completion of two related yet distinct scoping reviews: 1) a review of European/international grey literature, and; 2) a rapid-reviews of grey literature from MS. In doing so, this CSR aimed to provide source material to inform components of the wider Health4LGBTI project; namely the development

of dedicated training for health professionals on reducing health inequalities experienced by LGBTI people. However, it is important to acknowledge some limitations of this CSR:

First, as noted in Section 3, the data presented from the rapid-reviews were the work of key contributors from the respective Member States which meant some reviews included translated summaries of texts only available in national languages. Whilst this is of course a key strength of this CSR in being able to access literature that might otherwise be quite 'hidden', it also means what we are unable to verify the accuracy of such translations and reporting.

Second, the original scope of the CSR (see Figure 2), was to reach all 28 Member States during the rapid-review process. However, despite numerous attempts by ILGA-Europe to engage with their Cypriot partner and agreement to complete the rapid-review during May-August 2016 no review was received. Consequently, the deadline for Cyprus was extended until the end of November 2016. However, no review was received despite further follow-ups and consequently the formal rapid-review period was closed in early December 2016. Of the 28 Member States, 27 completed their rapid-reviews.

Third, as noted in Section 1.3, the rapid-review protocol asked for Member State experts to differentiate (where possible) between L.G.B.T.I. when reporting on literature from their countries. However, in some cases it is unclear which group(s) the literature reported (particularly where translated) was referring to. Consequently, where this is unknown or we were unable to verify, the full acronym of LGBTI is used. Thus some caution must be applied in extrapolating the issue in question to each of the groups.

Finally, none of the review processes used in this CSR were designed or intended to evaluate the quality of grey literature reviewed. Consequently, some caution must be applied in the interpretation of study findings as well as the recommendations elicited.

5.3.2 Conclusions

Within the broader context of Task 1 of the [Health4LGBTI pilot project](#), the purpose of this CSR was to access grey literature that might not otherwise be accessible via the 'usual' review methodologies (e.g. systematic and narrative reviews). Overall, the CSR review methodology was successful in gaining access to a wealth of rich data and information much of which has previously been 'hidden' due to the more common use of mainstream literature extraction techniques.

The results of the European review and MS rapid-reviews were consistent in demonstrating the existence of key health inequalities, barriers, and discrimination based on gender identity and gender expression, sexual orientation, and sex characteristics for LGBTI people. Although some encouraging promising practices in various health settings and contexts were evident, there is nevertheless still much to be done to ensure that the fundamental human rights of LGBTI people are both upheld and promoted. Appropriate and mandatory training for health professionals across all European Member States' health systems is an important step in this direction.

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APPENDIX – Rapid-review template

1.0 Background to the project

Research has shown that discrimination, social exclusion, and stigmatisation faced by **lesbian, gay, bisexual, trans and intersex (LGBTI)** people has a negative impact on health and wellbeing. As a result, LGBTI people are likely to have higher rates of sexually transmitted infections (STIs) including HIV, mental health problems such as depression, anxiety and suicidal thoughts, self-harm, substance misuse and certain cancers compared to people who do not identify as LGBTI. There is also evidence to suggest that direct and indirect discrimination against LGBTI people, along with a lack of knowledge of specific health needs occurs in the health sector. These factors contribute to and reinforce health inequalities.

Consequently the EC has contracted our Consortium to carry out a number of research and training activities including this **rapid-review of relevant grey literature**. Our Consortium comprises the following five organisations:

- EuroHealthNet [a public health network, Belgium]
- Verona University Hospital [Italy]
- University of Brighton [UK]
- National Institute of Public Health-National Institute of Hygiene [Poland]
- European region of the International Lesbian, Gay, Bisexual, Trans and Intersex Association [ILGA-Europe, Belgium].

1.1 What will the rapid-review do?

By reviewing relevant grey literature from your own Member State, the rapid-review will help us to understand more about the following areas:

- a) What is **known about the health inequalities** faced by LGBTI people as it relates to healthcare settings?
- b) What are the **potential barriers** faced by: i) LGBTI people when using or trying to access healthcare, and; ii) health professionals when providing care for LGBTI people?
- c) What **examples of promising practice** exist to address the specific health needs of LGBTI people?

We will then utilise the findings along with other information (data from focus groups, a review of scientific literature as well as a targeted review of relevant European grey literature etc.) to inform the development of a dedicated training programme for health professionals on reducing health inequalities experienced by LGBTI people.

1.2 What is grey literature?

By grey literature we mean *any* document that is not a scientific article published in formal peer reviewed journals or other forms of academic publishing and distribution channels. Therefore, grey literature might include (but is not limited to) some of the following indicative examples:

Reports on LGBTI issues, evaluations of LGBTI projects, policies relating to LGBTI people, relevant legislation, government reports on LGBTI issues, surveys of LGBTI discrimination, leaflets, flyers, training materials produced by an NGO on LGBTI issues, healthcare complaints data related to LGBTI people and healthcare, any document measuring inequalities in health (e.g. experienced discrimination) by LGBTI people, examples of good/bad practices in working with LGBTI people etc., relevant information on a local/regional/national website relating to LGBTI people, inequalities and healthcare.

Box 1. Examples of grey literature

As you can see from the above, grey literature can be wide ranging and include almost any kind of data or source related to the topic under focus. It is therefore important that *only the most relevant documents, materials, reports etc. are included in the rapid-reviews.*

1.3 What will be involved in completing the rapid-review?

You will be asked to complete this template in English and email it back to Nuno Pinto, consultant@ilga-europe.org from ILGA-Europe. Completion of the rapid-review will probably take a maximum of *3-5 days*. Although there is no word limit and the availability of *relevant* grey literature will vary from country to country, we anticipate that approximately 3-5 brief summaries of grey literature will be provided for each section (translated into English where necessary). However, this will vary from country to country depending on the grey literature available. Additional details are provided in the next section.

1.4 Will I receive a fee for completing the rapid-review?

Yes! A fee will be provided by ILGA-Europe to compensate you for the time taken to complete the review. Precise details are available from Nuno Pinto (consultant@ilga-europe.org) or Sophie Aujean (sophie@ilga-europe.org). Do please make sure you complete the appropriate bank details at the end of this template.

1.5 What happens to the information I provide in the rapid-review?

Once you have submitted your rapid-review, ILGA-Europe will collate the information into a coherent package comprising the reviews received from all 28 MS contacts. Nuno Pinto will then send the collated package to the University of Brighton for analysis.

The rapid-reviews (along with findings from other activities including scoping of relevant European/international literature and a scientific review of academic journal articles) will be used to provide potential source material (e.g. themes, case examples, promising practices) feeding into the development of a dedicated training package for healthcare professionals on LGBTI issues, inequalities and access to healthcare.

Together ILGA-Europe and the University of Brighton along with Consortium partners will create a *state-of-the-art synthesis report* bringing together the different activities (including the rapid-reviews) to be submitted to the European Commission. Additional use of materials/information gathered during the rapid-reviews and other activities (e.g. scientific review) may include where appropriate, academic articles and presentations.

If you would like a copy of the final state-of-the-art synthesis report once it has been approved by the European Commission, please let your ILGA-Europe contact know.

1.6 Contact details for assistance

If you have any questions about the rapid-review, please liaise with your ILGA-Europe contact [Nuno Pinto, consultant@ilga-europe.org] or Sophie Aujean, sophie@ilga-europe.org also from ILGA-Europe.

Alternatively, if you would like to know more about how the information/data from the rapid-reviews might be used in final reporting, please contact the University of Brighton directly (Nigel Sherriff [n.s.sherriff@brighton.ac.uk] or Laetitia Zeeman [L.Zeeman@brighton.ac.uk]).

2.0 General guidance

- ✓ Please complete the rapid-review template in ***English only***
- ✓ Only include grey literature (see Box 1 for examples) that is from your own country
- ✓ Only include grey literature that is **directly relevant** to the following questions:
 - 1) **What is known** about the health inequalities faced by LGBTI people as it relates to healthcare settings?
 - 2) What are the **potential barriers** faced by: i) LGBTI people when using or trying to access healthcare, and; ii) health professionals when providing care for LGBTI people?
 - 3) What **examples of promising practice** exist to address the specific health needs of LGBTI people?
- ✓ Only include grey literature ***dated from 2010-2016***. The reason for this is to ensure any grey literature is as up to date as possible. If no relevant information can be found for this time period, feel free to look further back as needed (e.g. 2006-2016).
- ✓ The information you provide should be **inclusive of barriers and experiences faced by LGBTI people**. If you feel that you may lack information about one of those sub-groups, please either contact another local organisation or inform your ILGA-Europe's contact person.
- ✓ Completion of the rapid-review will probably take a maximum of ***3-5 days***. Although there is no word limit and the availability of ***relevant*** grey literature will vary from country to country, we anticipate that approximately 3-5 items of grey literature will be provided/reviewed for each section.
- ✓ For an example of how you could complete the template, see Appendix 1.
- ✓ **The deadline for completing the reviews is 31st July 2016**. Please ensure that your rapid-review is completed and returned to your ILGA-Europe contact Nuno Pinto, consultant@ilga-europe.org on time and preferably before the deadline if possible.

3.0 Rapid-review template

3.1 Member State details

Please complete the following table as fully as possible and then complete each of the subsequent sections.

Member State Details	
Member State (MS):	
MS Contact [Name]:	
MS Contact [Organisation]:	
MS Contact [Email]:	
Date rapid-review commenced:	16 th May 2016
Deadline to submit rapid-review:	31 st July 2016
Date rapid-review submitted:	
ILGA-Europe (lead)	
Name and email of contact:	Nuno Pinto: consultant@ilga-europe.org
	Sophie Aujean: sophie@ilga-europe.org
University of Brighton	
Name and email of contact:	Nigel Sherriff: n.s.sherriff@brighton.ac.uk
	Laetitia Zeeman: L.Zeeman@brighton.ac.uk

3.2 What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings?

To address this part of the rapid-review, grey literature on the above question might include any or some of the following. But these are *only examples* and other sources and foci of grey literature may exist and still be highly relevant.

- Reports, studies, research (e.g. by Non-Governmental Organisations, government bodies etc.) on what is known about health inequalities faced by LGBTI people as it relates to health(care) settings;
- Reports, studies, research that focuses on particularly vulnerable LGBTI sub-populations (such as the very young, elderly, refugees, immigrants, disabled, poverty etc.) as it relates to health(care) settings;
- Evaluations or descriptions of projects that address health inequalities faced by LGBTI people as it relates to healthcare settings;
- Surveys or questionnaires that provide insight into LGBTI discrimination and/or inequalities as it relates to healthcare;
- Leaflets, flyers, promotional material concerning health inequalities faced by LGBTI people as it relates to healthcare settings;
- Examples of training materials, needs analyses etc. that address known health inequalities faced by LGBTI people as it relates to healthcare settings;
- Data or reports on healthcare complaints related to LGBTI people that highlights/draws out what is known about health inequalities faced by LGBTI people as it relates to healthcare settings;
- Policy documents (local/national/regional) which may highlight what is known about health inequalities faced by LGBTI people as it relates to healthcare settings.

For *each* document/grey literature identified that is directly relevant to the above question, please complete the following table telling us a bit more about it. You may not need to (or be able to) complete all parts of the table for every document/grey literature identified. Please just complete the parts that are relevant.

If the grey literature identified is in a national language (non-English), please translate a brief summary. If the grey literature is in English, please complete the table as requested but also send a copy of the document to your ILGA-Europe contact when you submit your rapid-review.

Please copy and paste blank table (next page) as many times as you need.

3.2. What is known about the health inequalities faced by LGBTI people as it relates to healthcare settings? (e.g. mental health, sexual health, general health)	
About the document/grey literature identified	Description/explanation
Title of document:	
Authors:	
Publisher/produced by:	
Date published/produced:	
Type of document (e.g. report, leaflet, flyer, evaluation, complaints data, training module, policy documents, guidance etc.)	
What level is the document referring to? (local/regional/national)	
Target group(s) – L.G.B.T.I – please be precise	
Target group(s) – If relevant, which vulnerable LGBTI sub-populations are referred to? (e.g. young, elderly, refugees, immigrants, disabled, socially isolated, those in poverty etc.)	
Document available in a national language or English?	
Website link to the document (if in English)	
Content of the document/grey literature	
Please provide a short summary of the document in English (e.g. max 300 words). If a study, please try and include the main aim of the study, methods used (e.g. interviews, survey), sample size, LGBTI profile, which health issue, main findings, and conclusions.	
What are the key health inequalities identified by the document?	
What type of data (if any) is presented (e.g. from a questionnaire, survey, interviews, complaints data etc.)?	
What kind of healthcare setting is referred to? (e.g. GP, hospital, private clinic, mental health etc.)	
What kind of healthcare worker is referred to (e.g. nurses, clinicians, psychologists, surgeons etc.)?	
Are there any key quotes, statements, or examples provided in the document that might be useful as 'stimulus' or discussion material in a training module for healthcare professionals on LGBTI issues, inequalities and access to healthcare health professionals on LGBTI access to healthcare?	
Anything else to add?	
Any other comment?	

3.3 Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?

To address this part of the rapid-review, grey literature on the above question might include any or some of the following. But these are *only examples* and other sources and foci of grey literature may exist and still be highly relevant.

- Acts, legislation, regulations, frameworks, policies etc. specifically referring to supporting the *inclusion* of LGBTI people and healthcare – these could be at local, regional, or national level;
- Acts, legislation, regulations, policies etc. referring to supporting the *exclusion* of LGBTI people and healthcare – these could be at local, regional, or national level.

For example: UK Equality Act (2010) - An inclusive policy impacting positively on LGBTI people

The UK Equality Act 2010 brings together a range of Acts and Regulations serving as foundation to anti-discrimination law in the UK. The Act protects against direct and indirect discrimination, victimisation and harassment in employment as well as private and public services within wider society. People are entitled to equal treatment regardless of their age, disability, marriage, civil partnership, being pregnant or having a child, race (including colour, nationality, ethnic or national origin), religion, belief or lack of religion or belief, being or becoming a transsexual person, sex and sexual orientation. These factors are regarded as protected characteristics. Employers have a duty to make reasonable adjustments to work environments to overcome barriers experienced by people with protected characteristics. Positive action can be taken against discrimination.

Reference

UK [Government Equalities Office](http://www.gov.uk/guidance/equality-act-2010-guidance) (2010) 2010 The Equality Act. Gov.UK [Available online] www.gov.uk/guidance/equality-act-2010-guidance

For *each* document/grey literature identified that is directly relevant to the above question, please complete the following table telling us a bit more about it. You may not need to (or be able to) complete all parts of the table for every document/grey literature identified. Please just complete the parts that are relevant.

If the grey literature identified is in a national language (non-English), please translate a brief summary. If the grey literature is in English, please complete the table as requested but also send a copy of the document to your ILGA-Europe contact when you submit your rapid-review.

Please copy and paste blank table (next page) as many times as you need.

3.3. Are there any specific legal acts, legislation, regulations or policies in place that will or might impact on LGBTI health or healthcare in your country?	
About the document/grey literature identified	Description/explanation
Title of document:	
Authors:	
Publisher/produced by:	
Date published/produced:	
Type of document (e.g. act, policy or strategy paper, regulation, legislation, leaflet, flyer, etc.)	
What level is the document referring to? (local/regional/national)	
Target group(s) – L.G.B.T.I – please be precise	
Target group(s) – If relevant, which vulnerable LGBTI sub-populations are referred to? (e.g. young, elderly, refugees, immigrants, disabled, socially isolated, those in poverty etc.)	
Document available in a national language or English?	
Website link to the document (if in English)	
Content of the document/grey literature	
Please provide a short summary of the document in English (e.g. max 300 words). Please try to include main aim(s) of the act/legislation/policy etc. including who it applies to.	
What are the key issues identified by the document which either do/will/might impact on LGBTI health and healthcare?	
What kind of healthcare setting is referred to? (e.g. GP, hospital, private clinic, mental health etc.)	
What kind of healthcare worker is referred to (e.g. nurses, clinicians, psychologists, surgeons etc.)?	
Are there any key quotes, statements, or examples provided in the document that might be useful as 'stimulus' or discussion material in a training module for healthcare professionals on LGBTI issues, inequalities and access to healthcare health professionals on LGBTI access to healthcare?	
Anything else to add?	
Any other comment?	

3.4 What are the potential barriers faced by: i) LGBTI people when using or trying to access healthcare, and; ii) health professionals when providing care for LGBTI people?

To address this part of the rapid-review, grey literature on the above question(s) might include any or some of the following. But these are *only examples* and other sources and foci of grey literature may exist and still be highly relevant.

- Reports, studies, evaluations on barriers faced by LGBTI people when using or trying to access healthcare;
- Reports, studies, evaluations on barriers faced by health professionals when providing care for LGBTI people;
- Reports, guidance, instructions, government documents written for health professionals to provide better care for LGBTI people (by implication, highlighting barriers);
- Documents, reports, on the training needs of health professionals when providing care for LGBTI people which may imply the existence of barriers faced by health professionals;
- Examples of training modules, programmes, specialist courses etc. that might address potential barriers faced by health professionals when providing care for LGBTI people.

For example: Barriers to healthcare faced by LGBTI people (UK)

'Beyond Babies and Breast Cancer: expanding our understanding of women's health needs' brings together relevant information about the health needs and experiences of lesbian and bisexual women. Amongst other issues, the report draws on research that highlights how some GPs ask automatically assume heterosexuality excluding the possibility of a woman having a same-sex partner(s). Moreover, blatant discrimination by some GPs is reported as being not uncommon with some making inappropriate comments:

"I went to my doctor with a stress-related illness and mentioned that coming out to my family had been a recent source of stress. He responded by telling me that his sister had recently come out, told me that he was still revolted by it, and said that his family were operating a 'don't ask don't tell' policy. He didn't seem to have any awareness that this might have an impact on my reaction to him!"

Reference: The Lesbian and Gay Foundation (2013). *Beyond Babies and Breast Cancer: expanding our understanding of women's health needs*. Manchester: LGF.

For example: Barriers faced by nurses (UK)

The UK Leaflet for nurses on LGBT next of kin issues suggest the barriers faced by health professionals are: Difficulties around language that may be insensitive or exclude LGBTI people. Challenges around terms that exclude LGBTI people and their partners such as 'next of kin' suggesting that patients should be asked who they want notified in case of emergency. Difficulties around visibility where practitioners are not aware of specific health needs as LGBTI people are not open about their gender and sexuality.

Reference: Royal College of Nursing (2012). *LGBT patients: guidance for nursing staff on next of kin issues*. London: Royal College of Nursing.

For *each* document/grey literature identified that is directly relevant to the above question, please complete the following table telling us a bit more about it. You may not need to (or be

able to) complete all parts of the table for every document/grey literature identified. Please just complete the parts that are relevant.

If the grey literature identified is in a national language (non-English), please translate a brief summary. If the grey literature is in English, please complete the table as requested but also send a copy of the document to your ILGA-Europe contact when you submit your rapid-review.

Please copy and paste blank table (next page) as many times as you need.

3.4a. What are the potential barriers faced by LGBTI people when using, or trying to access, healthcare?	
About the document/grey literature identified	Description/explanation
Title of document:	
Authors:	
Publisher/produced by:	
Date published/produced:	
Type of document (e.g. report, leaflet, flyer, evaluation, complaints data, training module, policy documents, guidance etc.)	
What level is the document referring to? (local/regional/national)	
Target group(s) – L.G.B.T.I – please be precise	
Target group(s) – If relevant, which vulnerable LGBTI sub-populations are referred to? (e.g. young, elderly, refugees, immigrants, disabled, socially isolated, those in poverty etc.)	
Document available in a national language or English?	
Website link to the document (if in English)	
Content of the document/grey literature	
Please provide a short summary of the document in English (e.g. max 300 words). If a study, please try and include the main aim of the study, methods used (e.g. interviews, survey), sample size, LGBTI profile, which health issue, main findings, and conclusions.	
What are the key barriers identified that LGBTI people face when using, or trying to access healthcare?	
What kind of healthcare setting is referred to? (e.g. GP, hospital, private clinic, mental health etc.)	
What kind of healthcare worker is referred to (e.g. nurses, clinicians, psychologists, surgeons etc.)?	
Are there any key quotes, statements, or examples provided in the document that might be useful as 'stimulus' or discussion material in a training module for healthcare professionals on LGBTI issues, inequalities and access to healthcare health professionals on LGBTI access to healthcare?	
Anything else to add?	
Any other comment?	

3.4b. What are the potential barriers faced by health professionals when providing care for LGBTI people?	
About the document/grey literature identified	Description/explanation
Title of document:	
Authors:	
Publisher/produced by:	
Date published/produced:	
Type of document (e.g. report, leaflet, flyer, evaluation, complaints data, training module, policy documents, guidance etc.)	
What level is the document referring to? (local/regional/national)	
Target group(s) – L.G.B.T.I – please be precise	
Target group(s) – If relevant, which vulnerable LGBTI sub-populations are referred to? (e.g. young, elderly, refugees, immigrants, disabled, socially isolated, those in poverty etc.)	
Document available in a national language or English?	
Website link to the document (if in English)	
Content of the document/grey literature	
Please provide a short summary of the document in English (e.g. max 300 words). If a study, please try and include the main aim of the study, methods used (e.g. interviews, survey), sample size, LGBTI profile, which health issue, main findings, and conclusions	
What are the key barriers identified that health professionals face when providing care for LGBTI people?	
What kind of healthcare setting is referred to? (e.g. GP, hospital, private clinic, mental health etc.)	
What kind of healthcare worker is referred to (e.g. nurses, clinicians, psychologists, surgeons etc.)?	
Are there any key quotes, statements, or examples provided in the document that might be useful as ‘stimulus’ or discussion material in a training module for healthcare professionals on LGBTI issues, inequalities and access to healthcare health professionals on LGBTI access to healthcare?	
Anything else to add?	
Any other comment?	

3.5 What examples of promising practice exist to address the specific health needs of LGBTI people in your country?¹³

To address this part of the rapid-review, grey literature on the above question might include any or some of the following. But these are *only examples* and other sources and foci of grey literature may exist and still be highly relevant.

- Reports, flyer, leaflet, website etc. providing examples of good/promising practices for health professionals when providing care for LGBTI people;
- Reports, flyer, leaflet, website etc. providing examples of good/promising addressing health inequalities experienced by LGBTI people as it relates to healthcare;
- Reports, guidance, instructions, government documents written for health professionals that give specific examples of how to provide better care for LGBTI people (see example below);
- Report, websites, guidance, examples etc., that highlight good/promising practices regarding vulnerable LGBTI sub-populations (such as the very young, elderly, refugees, immigrants, disabled, poverty etc.) as it relates to health(care) settings;
- Examples of training modules, programmes, specialist courses etc. that might have good/promising examples, quotes, statements etc. relevant to LGBTI people, inequalities and healthcare.

For example: Promising practice from the UK

The centre for HIV and Sexual Health in Sheffield (UK) set up a support group called 'Indigo'. The group provides a space where black and ethnic minority LGB people can meet to support each other to reduce social isolation. The group offers counselling services, confidence building programmes and an opportunity to meet new friends. The hospital recognises that this forum can lessen social isolation.

Reference:

UK Department of Health (2010). Sexual orientation: A practical guide for the NHS. London. Department of Health. [Available online] www.dh.gov.uk/publications

Note:

In some cases, examples of promising (or poor) practice may not actually be documented in a report or flyer or other grey literature. Instead, you may be aware of promising practices that are happening 'on the ground' but that are not written down anywhere. If so, in the table under 'Anything else to add?', please describe the promising practice or initiative in as much detail as possible paying particular attention to what might make it promising (e.g. an example of an LGBTI NGO working in partnership with a local healthcare service or provider; local health practitioners who use appropriate language and challenge colleagues where needed in supporting the fundamental rights of LGBTI people).

¹³ By 'promising practice' we mean that evaluation has not been conducted to formally validate the practice. Therefore we use the term 'promising' practice (rather than 'good' or 'best' practice) to reflect what appears to be working. The example could be written as a case study or description of a programme, project, or initiative that appears to be working well regarding engaging with LGBTI people to promote health and/or reduce health inequalities experienced by LGBTI people.

However, not every country will be able to find examples of promising or good practices. If this is the case you may, as an *alternative*, elect to provide *examples of poor/bad practices*. Such practices can provide useful stimulus/discussion material in training scenarios for health professionals.

For *each* document/grey literature identified that is directly relevant to the above question, please complete the following table telling us a bit more about it. You may not need to (or be able to) complete all parts of the table for every document/grey literature identified. Please just complete the parts that are relevant.

If the grey literature identified is in a national language (non-English), please translate a brief summary. If the grey literature is in English, please complete the table as requested but also send a copy of the document to your ILGA-Europe contact when you submit your rapid-review.

Please copy and paste blank table (next page) as many times as you need.

3.5. What examples of promising practice exist to address the specific health needs of LGBTI people in your country?	
About the document/grey literature identified	Description/explanation
Title of document:	
Authors:	
Publisher/produced by:	
Date published/produced:	
Type of document (e.g. report, leaflet, flyer, evaluation, complaints data, training module, policy documents, guidance etc.)	
What level is the document referring to? (local/regional/national)	
Target group(s) – L.G.B.T.I – please be precise	
Target group(s) – If relevant, which vulnerable LGBTI sub-populations are referred to? (e.g. young, elderly, refugees, immigrants, disabled, socially isolated, those in poverty etc.)	
Document available in a national language or English?	
Website link to the document (if in English)	
Content of the document/grey literature	
Please provide a short summary of the promising practice (or poor/bad practice if applicable) in English (e.g. max 300 words).	
What are the key inequalities/practices/issues/barriers that the example of promising practice addresses?	
What kind of healthcare setting is referred to? (e.g. GP, hospital, private clinic, mental health etc.)	
What kind of healthcare worker is referred to (e.g. nurses, clinicians, psychologists, surgeons etc.)?	
Are there any key quotes, statements, or examples provided in the document that might be useful as 'stimulus' or discussion material in a training module for healthcare professionals on LGBTI issues, inequalities and access to healthcare health professionals on LGBTI access to healthcare?	
Anything else to add?	
Any other comment? Any other comment? (e.g. example of a promising practice that is NOT available in a document)	

3.6 Please list or summarise any training initiatives that you may be aware of specifically for health professionals to address the health needs of LGBTI people

To address this part of the rapid-review, grey literature on the above question might include any or some of the following. But these are *only examples* and other sources and foci of grey literature may exist and still be highly relevant.

- Documents, reports, on the training needs of health professionals when providing care for LGBTI people;
- Description of a relevant training initiative;
- Examples of training modules, programmes, specialist courses etc. that support health professionals in providing care for LGBTI people;
- Websites offering training modules, programmes, specialist courses etc. that support health professionals in providing care for LGBTI people.

For example: Training module on LGB issues in Primary Care (UK)

"This one hour course provides an introduction to the issues relating to lesbian, gay and bisexual (LGB) patients. The first module covers definitions, attitudes, epidemiology, and current inequalities. It also provides an introduction to the specific health issues relating to this group of patients and will discuss the ways that a practice can become more accessible to LGB patients. The second module looks at different sub-groups within this population and cover more detail on HIV and other STIs, drug use and fertility".

Reference/Source: Royal College of GPs and Public Health England
<http://elearning.rcgp.org.uk/lgb>

For *each* document/grey literature/initiative identified that is directly relevant to the above question, please complete the following table telling us a bit more about it. You may not need to (or be able to) complete all parts of the table for every document/grey literature/initiative identified. Please just complete the parts that are relevant.

If the grey literature identified is in a national language (non-English), please translate a brief summary. If the grey literature is in English, please complete the table as requested but also send a copy of the document to your ILGA-Europe contact when you submit your rapid-review.

Note:

In some cases, *examples of training initiatives that you may be aware of specifically for health professionals to address the health needs of LGBTI people, may not actually be documented* in a report or flyer or other grey literature. Instead, you may be aware of training initiatives that are happening 'on the ground' but that are not written down anywhere. If so, please describe the training initiative in as much detail as possible paying particular attention to areas which you think may make it useful/effective (e.g. an LGBTI NGO working routinely in partnership with a local healthcare service/provider to deliver training on LGBTI issues to health professionals; a training initiative that is supported by evidence-based LGBTI guidelines on health(care) in particular settings such as GPs or hospital settings etc.).

Please copy and paste blank table (next page) as many times as you need.

3.6. Please list or summarise any training initiatives that you may be aware of specifically for health professionals to address the health needs of LGBTI people	
About the training initiative	Description/explanation
Title of the training:	
Training provider (organisation):	
In partnership with:	
Is the training approved/accredited by a regulatory Body with responsibility for approval and accreditation of professional education programmes?	
Frequency of training (e.g. monthly, yearly, occasional, as and when requested etc.):	
Duration of training (in hours and/or days):	
Cost of the training for participants and/or for the training provider to deliver?	
Which L.G.B.T.I group(s) does the training address? – please be precise	
If relevant, please state which vulnerable LGBTI sub-populations the training addresses? (e.g. young, elderly, refugees, immigrants, disabled, socially isolated, those in poverty etc.)	
Who are the intended trainees? (e.g. GPs, nurses, psychologists etc.)	
Is the training voluntary or compulsory for trainees?	
What format (if any) is the training available in? (e.g. document, video, online/electronic module etc.)	
Training available in a national language or English?	
Website link to the training (if in English)	
Content of the training initiative	
Please provide a short summary of the training initiative/module/programme for health professionals which addresses LGBTI issues in healthcare (e.g. max 300 words)	
What is the main content of the training? Please tick which content applies and add in additional details where relevant/appropriate	<input type="checkbox"/> Sexual orientation, gender identity and LGBTI terminology <input type="checkbox"/> Research findings on LGBTI mental health and wellbeing <input type="checkbox"/> Specific risks for lesbian, gay, bisexual, transgender and intersex people <input type="checkbox"/> Specific needs of transgender and intersex people <input type="checkbox"/> LGBTI-inclusive practice guidelines <input type="checkbox"/> Importance of ensuring sexual orientation and gender identity are included as part of routine assessment Add other/further details here.....
What kind of training methods or techniques are used (e.g. interactive, online, group activities, participatory, didactic, lecture, workshop etc.)?	
What kind of healthcare setting is referred to? (e.g. GP, hospital, private clinic, mental health etc.)	
What kind of healthcare worker is referred to (e.g. nurses, clinicians, psychologists, surgeons etc.)?	
Are there any key quotes, statements, or examples provided in the document that might be useful as ‘stimulus’ or discussion material in a training module for healthcare professionals on LGBTI issues, inequalities and access to healthcare health professionals on LGBTI access to healthcare?	

Anything else to add?	
Any other comment?	

Thank you for completing this rapid-review!

4.0 What to do now

- ✓ If you have any questions on the rapid-review, please ask! You can contact ILGA-Europe (Nuno Pinto consultant@ilga-europe.org) or the University of Brighton (Nigel Sherriff, n.s.sherriff@brighton.ac.uk or Laetitia Zeeman, L.Zeeman@brighton.ac.uk)
- ✓ When you have completed your rapid-review, please email it with any supporting documents (only if in English) to your ILGA-Europe contact Nuno Pinto, consultant@ilga-europe.org.
- ✓ Do ensure that you send your review to ILGA-Europe *before the 31st of July!*

✓ **If you would like a copy of the final report once it has been approved by the European Commission, please let your ILGA-Europe contact know.**

4.1 Contributions and 'thank-you'

We would very much like to acknowledge the valuable time and effort you and your colleagues have made to these rapid-reviews. Consequently, in our final report we would like to [name the people who have contributed to the completion of this review](#). If you would like to be named in our final report as a contributor to the rapid-reviews, please provide details below:

Name of contributor:		Organisation:	
Name of contributor:		Organisation:	
Name of contributor:		Organisation:	
Name of contributor:		Organisation:	
Name of contributor:		Organisation:	

Finally, we would also like to [transfer you a fee to compensate you for your work](#). Please therefore state here your [bank account details](#) so that ILGA-Europe can arrange for this to be paid upon receipt of the completed form.

Name of Bank	
Bank Identifier Code (BIC):	
Account name:	
Sort Code:	
Account Number:	
Any other information:	

Rapid-review template references used

- Arksey, H. and O'Malley, L. (2005). Scoping studies: Towards a Methodological Framework. *International Journal of Sociological Research Methodology*, 8: 19-32.
- Fish, J. and Lockley, A. (2015). *Improving the Cancer Journey*. Leicester: De Montfort University.

Appendix 1: Completed example

1. What is known about the health inequalities faced by LGBTI (lesbian, gay, bisexual, trans and intersex) people as it relates to healthcare settings?	
About the document/grey literature identified	Description/explanation
Title of document:	Improving the cancer journey for lesbian, gay and bisexual people living with cancer
Authors:	Fish, J & Lockley, A
Publisher/produced by:	Hope Against Cancer and De Montfort University
Date published/produced:	2015
Type of document (e.g. report, leaflet, flyer, evaluation, complaints data, training module, policy documents, guidance etc.)	Research Report
What level is the document referring to? (local/regional/national)	Regional– Leicester and North West UK.
Target group(s) – L.G.B.T.I – please be precise	LGBT people (not Intersex)
Target group(s) – If relevant, which vulnerable LGBTI sub-populations are referred to? (e.g. young, elderly, refugees, immigrants, disabled, socially isolated, those in poverty etc.)	LGBT people diagnosed with Cancer – adults.
Document available in a national language or English?	English
Website link to the document (if in English)	None available
Content of the document/grey literature	
Please provide a short summary of the document in English (e.g. max 300 words). If a study, please try and include the main aim of the study, methods used (e.g. interviews, survey), sample size, LGBTI profile, which health issue, main findings, and conclusions.	<p>Research suggest that LGBT people have higher risks and increased prevalence of some cancers in comparison to the general population. However, LGBT people reported less positive patient experiences in relation to accessing care and treatment. Limitations in accessing treatment and care have been noted by LGBT people in relation to provision of information, psychosocial support, a lack of dignity and respect, and a lack of pain management. The document presents research to gain an understanding of the nature of LGBT patients' support networks, their need for information and their experience through the cancer pathway. Using semi-structured interviews with 17 participants, the study aimed to improve the health and well-being of LGB people during treatment for cancer and contribute to their quality of life in survivorship</p> <p>Main findings were: In relation to provision of information, there are both benefits and risks associated to LGBT people disclosing their sexual orientation to medical professionals. LGBT people feared inappropriate questioning and experienced anxiety about revealing their sexual orientation in the healthcare setting. Disclosure of their identity is associated with health benefits and LGBT patients are likely to be more satisfied about communication with health professionals. Disclosing their identity meant same-sex partners could be included in treatment decisions. Discrimination was perceived by participants as less obvious and more nuanced in the hospital environment since introduction of the Equality Act in 2006.</p>

<p>What are the key health inequalities identified by the document?</p>	<p>Gay and bisexual men are twice as likely to be diagnosed with anal cancer, while rates of cervical cancer amongst bisexual women are more than twice that of other women. Research reveals higher mortality from breast cancer amongst lesbian and bisexual women. LGBT people may have poorer post-diagnosis care and lower quality of life with cancer due to the lack of formal support groups and health information targeted specifically at LGBT people.</p>
<p>What type of data (if any) is presented (e.g. from a questionnaire, survey, interviews, complaints data etc.)?</p>	<p>17 Individual interviews either face-to-face or via phone. A semi-structured interview schedule was used to collect data. Interviews were digitally recorded and transcribed.</p>
<p>What kind of healthcare setting is referred to? (e.g. GP, hospital, private clinic, mental health etc.)</p>	<p>Community settings and national health services (NHS) cancer treatment services.</p>
<p>What kind of healthcare worker is referred to (e.g. nurses, clinicians, psychologists, surgeons etc.)?</p>	<p>Nurses, doctors, psychologists, oncologists.</p>
<p>Are there any key quotes, statements, or examples provided in the document that might be useful as 'stimulus' or discussion material in a training module for healthcare professionals on LGBTI issues, inequalities and access to healthcare health professionals on LGBTI access to healthcare?</p>	<p>Some of the most positive descriptions of sexual orientation being introduced are those where the clinical practitioner raised the question of the patient's orientation without waiting for the patient to disclose, or where the clinical practitioner also discloses their own sexual orientation to the patient:</p> <p><i>'They said: 'Oh...you are missing the Pride Parade aren't you because you're in here? So they obviously picked up the fact that I was gay but the response was just brilliant, there was no nastiness, no animosity. It was really open and it was good... I was really feeling at ease with it.'</i> (Gay man participant 14)</p>
<p>Anything else to add?</p>	
<p>Any other comment?</p>	<p>N/A</p>