LITERATURE REVIEW:

Health Disparities for LGBTQIA+ People, an Emerging Neglected Global Health Crisis

MSF Transformational Investment Capacity: LGBTQIA+ Inclusion in MSF Health Settings

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Executive Summary

Globally LGBTQIA+ populations face **significant health disparities**, **especially in humanitarian settings where these challenges are compounded by limited healthcare infrastructure, legal barriers, societal and systemic discrimination and often heightened stigma**. Whilst representing a growing part of the population, with current estimates between 8-13% in overall population and higher numbers (>17%) in the youngest generations, LGBTQIA+ individuals encounter **numerous health risks that are often not well understood, recognized and treated by medical professionals, including a lack of inclusive healthcare protocols and policies.**

In **humanitarian context, additional barriers to care come into play**, caused by infrastructure problems, programming challenges, impaired healthcare systems, access negotiations, insecurity in war and conflict context, natural disasters etc. In such context the **marginalization and health risks for LGBTQIA+ people tend to increase, while their access to care decreases, even more so when looking at populations facing forced displacement**. Humanitarian actors focus on the most vulnerable and marginalized populations; yet **steps to include LGBTQIA+ individuals in their (medical) activities are largely dismissed**, thus, **stigmatization and denial of services is continued within humanitarian projects**. Altogether this is leading to an **overlooked and undocumented international public health crisis**.

Objective

Recognizing a gap in accessible, inclusive healthcare for LGBTQIA+ individuals in crisis environments, this report seeks to provide an evidence-based overview of health risks, barriers to care, and effective intervention strategies. It aims to inform healthcare professionals and humanitarian actors about practical approaches to reduce disparities and promote inclusive care for LGBTQIA+ communities.

Methodology

The report synthesizes findings from peer-reviewed studies, selected through extensive searches across academic databases (PubMed, MEDLINE, Embase, EBSCO, Scopus, Cochrane and Google Scholar) and supplemented by grey literature (governments and health institutes). The analysis employs a manual coding method to categorize and cross-reference findings, with emphasis on factors most relevant to humanitarian work.

Results

1. Epidemiology and Social Determinants

LGBTQIA+ populations, constituting approximately 9% of the global population, with notably higher prevalence in younger generations, experience notable disparities across demographics. **Socioeconomic status**, and **minority status**, including being a **migrant or refugee**, exacerbate these challenges. Factors such as **limited education** (due to bullying or impaired access), **employment discrimination**, and **homelessness** disproportionately affect LGBTQIA+ individuals, contributing further to lower overall health outcomes.

2. Intersectionalities

The report emphasizes how intersecting identities, such as **poverty, ethnicity, older age, disabilities**, exacerbate health disparities for LGBTQIA+ individuals due to increased exposure to discrimination and violence. **Conditions associated with LGBTQIA+ populations**, such as **HIV**, amplify stigma, thereby further limiting access to care.

Migrants and displaced LGBTQIA+ individuals often face discrimination from both service providers and other refugees, making it difficult to access even necessities. Identifying as LGBTQIA+ is increasing chances of (forced) displacement and therefore LGBTQIA+ are overrepresented amongst People on the Move. Yet

they lack inclusive care, legal protection, social support, inclusive healthcare, as well as heightened exposure to trauma and violence during displacement, especially if they are also detained.

3. Barriers to Care

LGBTQIA+ individuals frequently encounter **systemic and societal barriers** to accessing healthcare, including **criminalization of LGBTQIA+ identities**, **discriminatory healthcare practices**, and **lack of culturally competent providers. Lack of privacy, confidentiality and safe spaces,** also hinder healthcare access for LGBTQIA+ people, especially for migrants and refugees. Historically **medicine pathologized variation in sexual orientation and gender identity**, though international scientific consensus abandoned this approach, some cultures, religions and policies still refer to this approach. **Health workers often have their own biases and prejudices** that they need to overcome. For healthcare workers in regions where LGBTQIA+ individuals are criminalised, **perceived legal risks and indirect stigma** may unrightfully deter them from providing essential medical services.

4. Health Disparities

The **"minority stress model"** is used to explain how LGBTQIAA+ people (and other minority groups) are impacted by the **chronic exposure to stigma, violence, harassment and exclusion**. Minority stress and **internalized stigma** can result in **chronically elevated levels of stress that increase the risk for cardiovascular issues, affect the immune system, and increase risk of certain cancers**. These stressors are further exacerbated in environments where LGBTQIA+ identities are criminalized, limiting healthcare access and amplifying these health risks.

LGBTQIA+ populations, particularly in environments of heightened societal stigma, exhibit **elevated rates of depression and anxiety. Clinical depression affects up to 50% of LGB individuals**, with even higher rates among *transgender populations*, **where gender dysphoria and social rejection play significant roles**. **Substance abuse** is a coping mechanism among LGBTQIA+ individuals, especially in settings with extreme minority stress. **High rates of trauma-related stress**, especially among *transgender women and gay men*, are linked to exposure to **hate crimes, violence, and harassment, and elevate PTSD risk.**

Lesbian and Bisexual women are at **higher risks for breast-, ovarian- and cervix cancer, obesity, cardiovascular diseases, STI's and HIV**, which underlines the need for proper screening policies. **Unintended pregnancies and sexual and gender-based violence (SGBV), including intimate partner violence**, occur frequent in *lesbian and bisexual women* (up to 61% experience SGBV), and needs for contraception and safe abortion care should not be overlooked.

Among *Gay and Bisexual men* an **increased HIV prevalence** persists, especially in regions with limited access to preventive services, such as parts of Sub-Saharan. Also (sexually) **transmissible diseases, such as chlamydia, gonorrhoea, herpes, mpox and meningococcal meningitis** occur more frequently. They are at **increased risk of anal and oropharyngeal cancer (especially those with HIV), and victimisation (hate crimes including rape) and chronic (mainly cardiovascular) disease.**

Transgender people face unique health risks, often associated with barriers to gender-affirming care, high rates of victimization. Worse health outcomes are associated with environments that inhibit the possibility for (social) transitioning and lack of gender affirmation (of social network and care providers). Transgender individuals are also **at risk of cardiovascular disease (impacted by hormone therapy), cancer (depending on their present organs and sexual behaviour), and might be at risk of side effects of hormone treatment.**

Intersex conditions are rare (1 in approximately 4500 live births), but importance of proper assessment, avoiding rushed decisions and emphasis on health of the neonate critical. Clinicians should be alerted on the risk of a life-threatening condition called **salt wasting crisis**, related to adrenal dysfunction connected to gonadal anomalies. Side effects of **steroid therapy, malignancies related to gonadal conditions and victimisation are important long-term risks.**

Asexual individuals face issues with **lack of recognition, limited access to relevant sexual education and adapted sexual and reproductive health services**. Research data is extremely scarce.

5. Best Practices

Cultural Competency and Inclusive Language: Health workers need to be sensitised for LGBTQIA+ inclusion, informed about the significance of the topic, confronted with their own biases and supported in self-regulation thereof. Recurrent training for healthcare providers on culturally sensitive language and practices can significantly reduce stigmatization. Tailoring communication to respect LGBTQIA+ identities—such as respecting preferred names, identities, pronouns—is crucial.

Training and Guidance: Technical training and provision of guidelines and protocols about health disparities and recommended preventative and curative interventions will support to normalize LGBTQIA+ people in the medical environment and increase quality of care.

Privacy and Confidentiality: Establishing safe spaces where LGBTQIA+ individuals feel secure in disclosing health needs is critical. This includes creating gender-neutral facilities and maintaining confidentiality protocols to protect LGBTQIA+ patients from potential discrimination or legal exposure.

Peer and Community Support: Engaging local LGBTQIA+ organizations can aid in building trust with affected individuals. Peer-led initiatives within LGBTQIA+ communities provide valuable insights and improve healthcare access for marginalized groups.

Digital Health Solutions: Remote platforms allow LGBTQIA+ individuals in restrictive regions to access confidential mental health support, counselling, and basic healthcare, which are especially valuable in crisis and post-conflict contexts.

6. Considerations for Humanitarian Contexts

In humanitarian settings, factors such as criminalization of LGBTQIA+ identities, security threats, and limited resources amplify health risks. LGBTQIA+ individuals in these environments often conceal their identities for safety, leading to unmet healthcare needs. The report emphasizes the need for **adaptable, context-sensitive interventions** in refugee camps, where LGBTQIA+ people may lack access to specific resources. **Legal protections and advocacy efforts** are recommended to reduce stigma and improve access to care within humanitarian operations.

Recommendations

- **Integration of LGBTQIA+ Health Needs:** Treating LGBTQIA+ healthcare as an integrated aspect of all interventions avoids isolating this population, encouraging holistic care that respects individual dignity and autonomy.
- **Training:** Humanitarian organizations should implement LGBTQIA+ competency training programs to equip healthcare providers with the skills to offer inclusive, nonjudgmental care, particularly in regions where LGBTQIA+ identities are criminalized or heavily stigmatized.
- **Community and Peer-Based Outreach**: Working with local LGBTQIA+ organizations helps foster cultural understanding and builds trust with LGBTQIA+ patients. Engaging community members in planning and service delivery fosters sustainability and allows for better adaptation to local needs.
- **Safe Spaces and Confidential Care:** Establishing secure, confidential settings in healthcare facilities, refugee camps, and other crisis settings ensures LGBTQIAA+ individuals can seek care without fear of exposure or discrimination. Integrating legal aid services and secure referral pathways can enhance support for LGBTQIA+ individuals in crisis.
- **Research and Data Collection:** Addressing the lack of data on LGBTQIAA+ health disparities, especially in humanitarian contexts, is essential. Developing standardized metrics and conducting intersectional research on health outcomes in crisis settings can help tailor interventions to the unique needs of LGBTQIA+ populations. Additionally improved geographical spread, variety in topics and stratification between subgroups is needed in research to fill the knowledge gap on LGBTQIA+ health.

- **Policy Advocacy:** Efforts should focus on advocating for decriminalization and legal protections for LGBTQIA+ people in high-risk regions. Collaboration with local governments, NGOs, and LGBTQIA+ rights groups can bolster these efforts, ultimately enhancing healthcare access.

Conclusions

The findings underscore the need for a **paradigm shift** in how humanitarian actors approach LGBTQIA+ healthcare. **Disregarding the needs of LGBTQIA+ individuals exacerbate health disparities, perpetuates stigma, and undercuts public health objectives**. By adopting **inclusive practices** and **context-sensitive interventions,** humanitarian **organizations can reduce barriers to care and improve health outcomes for one of the most marginalized populations**. These recommendations encourage the sector **to integrate LGBTQIA+ health into mainstream public health interventions**, upholding the humanitarian principle **of impartial care for all.**

1 Introduction: On Inclusivity and Language

"Language has immense power to shape our world and lived realities including the power to signal respect, safety, and inclusion—or the opposite." (Soled, 2022)

The journey towards inclusivity in healthcare may encompass more than language alone, yet it is our main tool to exchange ideas and transfer concepts and to frame the future in objectives and strategic plans. Therefore, to reach **equitable access to dignified care for LGBTQIA+ people**, the power of language cannot be underestimated. In what we say and what we write, in the forms and tools we use, a part of our world is shaped.

As the use of language on many occasions becomes automated it may take effort and humility to be confronted, to unlearn and relearn. Perseverance is needed to adapt to inclusive language until fluency develops. Everyone plays a critical role in choosing language that communicates respect and helping others to do so. Everyone can contribute to shape an inclusive world that allows an equitable future for all.

While the contents of this report are medical, they will be transferred through language, and as language plays a key role in applying inclusive practice, those elements cannot be completely separated. In writing, certain choices between different terms were made. The terms **LGBTQIA+** or **SGM** were used when referring to the diverse group of people that do not identify as cisgender or heterosexual. LGBTQIA+ stands for **Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and the + represents other identities not yet included in the preceding letters**. **SGM stands for Sexual and Gender Minorities**, referring to all possible combinations of varieties of sexual orientation and gender identity, however this term is often more descriptive and further removed from how people identify themselves. These acronyms may not completely resonate with every individual identity; yet for the purpose of this report all are meant to be included. When other terms are used it is to be specific in indicating (clinically) significant differences between for example identities, behaviours or conditions. To ensure a clear understanding of relevant terminology a comprehensive glossary follows to explain the definitions applied in this report. Depending on where in the world this information is applied, other terms may be more appropriate or relevant, and it is advisable to engage with local experts to find the most appropriate wording.

The LGBTQI+ Inclusion project team is available for recommendations if unclear or inappropriate wording is detected, or to be educated if terms seem outdated or lacking entirely. As well for anyone that perceives crucial content is missing. The language around LGBTQIA+ identities is rapidly evolving so what is appropriate today may be outdated or inappropriate tomorrow.

This report should be a **living document**, **shaped by the language and concepts that are meaningful to support the conversations, discussions and decisions that it aims to serve**.

2 Glossary of Acronyms, Abbreviations and Relevant Terminology

- Adverse Childhood Experiences (ACEs): encompass traumatic events occurring during childhood (age 1-17), which can negatively impact a child's development and lead to long-term health and mental health challenges. It can include emotional, physical and sexual abuse, neglect, impact due to dysfunctional household (substance abuse, exposure to relative with mental disease, criminal record etc). ACEs can disrupt a child's brain development and affect their physical and mental health as they grow into adults.
- Affirmed gender (affirmed identity): Affirmed gender refers to a person's gender identity, or the gender by which they wish to be known, which may differ from the sex they were assigned at birth. It's a term used to replace older phrases like "new gender" or "chosen gender," emphasizing that it's a person's authentic identity rather than a choice.
- Aphallia: Aphallia, also known as penile agenesis, is a rare congenital condition characterized by the absence of a phallus (penis) and associated with a normally developed scrotum and bilateral palpable testes (usually not affecting the fertility).
- Asexuality: People who identify as asexual experience little or no sexual attraction to others. Asexual people, or “aces,” often identify somewhere on a spectrum that includes their emotional, spiritual and romantic attraction to other people. Next to “ace” people can identify as “aro” referring to aromantic, and “abro” indicating asexual and aromantic. The opposite (sexual and romantic) is indicated as “allo”.
- Bisexualilty: The term “bisexual” is used to describe a person who experiences emotional, romantic and/or sexual attractions to, or engages in romantic or sexual relationships with, more than one sex or gender.
- Biphobia: Biphobia is prejudice, fear, or hatred directed toward bisexual people, often based on negative stereotypes or denial of bisexuality as a valid sexual orientation.
- Congenital adrenal hyperplasia (CAH): the medical name for a group of genetic conditions that affect the adrenal glands. The adrenal glands are a pair of walnut-sized organs above the kidneys. They make important hormones, including Cortisol. This controls the body's response to illness or stress. It is most common cause of female intersex disorder of sexual development (DSD), a group of conditions where the development of chromosomal, gonadal, or anatomical sex is atypical.
- Cisgender: "Cisgender" refers to individuals whose gender identity aligns with the sex they were assigned at birth, in contrast to transgender individuals whose gender identity differs from their assigned sex.
- Cloacal extrophy: Cloacal exstrophy is a rare and complex birth defect where abdominal organs, including the bladder and intestines, are exposed outside the body due to a failure in the lower abdominal wall to close properly during foetal development.
- Criminalisation: in criminology, refers to the process by which behaviours and individuals are transformed into crime and criminals, often through legislation or judicial decisions. The action of turning an activity into a criminal offence by making it illegal or turning someone into a criminal by making their activities illegal.
- Deadname/Deadnaming: A deadname is a name that a trans+/nonbinary person no longer uses. Usually, it is the name assigned at birth. When someone uses this name, whether intentionally or not, it is referred to as deadnaming. Deadnaming is considered offensive and hurtful.

- Difference of Sex Development (DSD): encompass a range of conditions that affect the development of reproductive organs and sexual characteristics during foetal development, they can be caused by genetic factors, hormonal imbalances, or other factors that disrupt the normal processes of sex development. It may be identified at birth or ad puberty or adulthood, frequently linked to infertility. While "intersex" was previously used, the term "DSD" is now the preferred and more inclusive term (occasionally disorder of sex development, difference preferred over disorder).
- Female Assigned at Birth: often abbreviated as AFAB refers to a person whose sex was assigned as female when born, typically based on their external genitalia, and is used to describe the difference between sex and gender.
- Gay: sexually or romantically attracted to people of one's own sex (used especially of a man), or for non-binary identifying people attracted to men.
- Gender: the male sex or the female sex, especially when considered with reference to social and cultural differences rather than biological ones, or one of a range of other identities that do not correspond to established ideas of male and female. The concept of gender can vary by society and can change over time. Gender refers to the socially constructed characteristics of men and women, such as roles, norms, and behaviours, that are labelled by a society as male or female.
- Gender diverse: is an inclusive umbrella term referring to individuals whose gender identity, expression, or perception falls outside the traditional binary of male and female
- Gender expansive: describes someone whose gender identity or expression extends beyond the traditional binary of male and female, encompassing a wider range of identities and expressions.
- Gender expression: the way in which a person expresses a gender identity, typically through their appearance, dress, and behaviour.
- Gender fluid: denoting or relating to a person who does not identify as having a single unchanging gender.
- Gender identity: a person's innate sense of their gender (chiefly used in contexts where it is contrasted with the sex registered for them at birth. An individual's gender identity can be the same or different from their sex assigned at birth. Gender identity is one's innermost concept of self from the perspective of one's gender. It can be described as an internal self-label, and thus it can be unrecognized by others. Gender is often thought of as a male/female binary, meaning that individuals identify as either male or female. However, gender is an umbrella term, and many identify outside of this construct, including no gender. Gender identity encompasses transgender identities (trans women and trans men), nonbinary, gender-queer, intersex, etc.
- Genderqueer: denoting or relating to a person whose gender identity does not correspond to conventional binary gender distinctions.
- Gonad: the part of the reproductive system that produces and releases eggs (ovary) or sperm (testicle/testis).
- Gonadectomy: is the surgical removal of the gonads, which are the reproductive organs (testes in males and ovaries in females), resulting in the loss of gonadal production of sex steroids.
- Gonadotrophy: is a specialized cell type in the anterior pituitary gland that synthesizes and secretes gonadotropins, specifically follicle-stimulating hormone (FSH) and luteinizing hormone (LH), which are essential for reproductive function

- Heteronormativity: the privileging of heterosexuality as the normative human sexuality. It assumes the gender binary and that sexual and marital relations are most fitting between people of opposite sex.
- Heterosexual: a person who is sexually or romantically attracted exclusively to people of the other sex.
- Homophobia: dislike of or prejudice against gay people.
- Homosexual: a person who is sexually or romantically attracted to people of their own sex.
- Intersectionality: the interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.
- Intersex: People who are intersex have reproductive or sexual anatomy that doesn't fit into an exclusively male or female (binary) sex classification. Intersex traits might be apparent when a person's born, but they might not appear until later (during puberty or even adulthood). At present commonly referred to as Difference of Sex Development (DSD).
- Karyotype: the number and visual appearance of the chromosomes in the cell nuclei of an organism or species.
- Lesbian: a woman who is physically and romantically attracted to other women. But you can also identify as a lesbian if you're nonbinary – someone whose gender identity falls outside the two categories of man and woman – and you're attracted to women.
- LGBTQIA+: Frequently used acronym referring to lesbian, gay, transgender, queer, intersex, asexual and the '+' symbol indicates the recognition of the fact that this list is not exhaustive and more sexual and gender minority groups than those specifically mentioned are included. This acronym can change depending on time, region, country, subculture etc.
- Lived Name: A name (often a first name) that someone uses that differs from their legal name. There are many reasons someone may have a lived name that differs from their legal name. Some trans and nonbinary people may use a lived name to affirm their gender identity. "Preferred name" has also been used; however, it has been largely replaced by lived name. "Preferred name" suggests that using someone's lived name is optional, which can lead to deadnaming.
- Male Assigned at Birth also known as AMAB, refers to an individual whose sex was assigned as male when born, typically based on their external genitalia.
- Men Having Sex with Men (MSM): individuals assigned male at birth who engage in sexual activity with other people assigned male at birth, regardless of their sexual orientation or identity (differentiating between sexual behaviour and sexual orientation)
- Micropenis: A micropenis or microphallus is an unusually small penis. A common criterion is a dorsal penile length of at least 2.5 standard deviations smaller than the mean human penis size for age.
- Micro-aggression: a statement, action, or incident regarded as an instance of indirect, subtle, or unintentional discrimination against members of a marginalized group such as a racial or ethnic minority.
- Minority stress: the additional stress experienced by members of stigmatized groups due to prejudice, discrimination, and other adverse social conditions stemming from their minority status.

- Misgendering: Attributing a gender to someone that is incorrect/does not align with their gender identity. Can occur when using pronouns, gendered language, or assigning genders to people without knowing how they identify.
- Mosaicism (or genetic mosaicism): is a condition in which a multicellular organism possesses more than one genetic line as the result of genetic mutation. This means that various genetic lines resulted from a single fertilized egg.
- Non-binary: Some people don't identify with any gender. Some people's gender changes over time. People whose gender is not male or female use many different terms to describe themselves, with nonbinary being one of the most common (sometimes spelled with a hyphen, as “non-binary”), it includes identities such as gender-queer, agender, androgynous, etc.
- Non-conforming (gender non-conforming): "non-conforming" means not conforming to or complying with established standards, norms, customs, or expectations. It can apply to various contexts, including gender, quality, and more. As it can be considered degrading to apply this term to someone else it is mostly used when someone choses by themselves to identify as non-conforming.
- Omnisexual: involving or characterized by diverse forms of sexuality; attracted to more than one gender. People who identify as omnisexual are attracted to those of all gender identities and sexual orientations. Omnisexuality is in the category of multisexuality, which includes people who are attracted to more than one gender.
- Outing: Exposing someone’s lesbian, gay, bisexual transgender or gender non-binary identity to others without their permission. Outing someone can have serious repercussions on employment, economic stability, personal safety or religious or family situations.
- Pansexuality: the romantic, emotional, and/or sexual attraction to people regardless of their gender. Like everyone else, pansexual people may be attracted to some people and not others, but the gender of the person does not matter.
- Phenotype: the set of observable characteristics of an individual resulting from the interaction of its genotype with the environment.
- Post-traumatic stress disorder (PTSD): a mental health condition that's caused by an extremely stressful or terrifying event — either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event.
- Queer: is an umbrella term for people who are non-heterosexual or non-cisgender. Originally meaning 'strange' or 'peculiar', queer came to be used pejoratively against LGBT people in the late 19th century. From the late 1980s, queer activists began to reclaim the word as a neutral or positive self-description.
- Questioning: describes individuals exploring or unsure about their own sexual orientation, gender identity, or both. It can describe the process of a person determining their sexual orientation and/or gender identity; or refer to questioning the default presumption of heteronormativity and gender binarity in society.
- Sex: either of the two main categories (male and female) into which humans and most other living things are divided based on the external impression of, and/or function of their reproductive organs. In other words, the biology someone is born with, including genetic, hormonal, anatomic, and physiological characteristics. Related terms include "sex assigned at birth," "natal sex," "biologic sex," or "birth sex."
  Sex characteristics result in being labelled as female or male gender at birth. These sets of

biological characteristics are not mutually exclusive, as there are individuals who possess both, but these characteristics tend to differentiate humans as females or males.

- Sex assigned at birth refers to the initial classification of an infant as male, female, or intersex, based on physical characteristics observed at birth, and recorded on birth certificates.
- Sexual behaviour: encompasses all activities that gratify an individual's sexual needs, including physical practices, attitudes, experiences, desires, and related psychological and social phenomena, whether solitary or with a partner. Sexual behaviour can change over time. Studies surveying self-identified lesbians show a wide range of sexual behaviours (eg, same-sex partners, opposite or different sex partner, or both). Additionally, a current partnership may not reflect an individual's previous sexual behaviour. Behaviour may not be concordant with self-identification, for example, a self-identified lesbian can also be attracted to, and engage in, sex with men and/or individuals who identify as nonbinary, transgender, etc.
- Sexual and Gender Diversity (SGD): encompasses the wide spectrum of human experiences related to sexual orientation, gender identity, and gender expression, recognizing that these are not limited to traditional binary categories
- Sexual and Gender Minority (SGM): is a term used to describe individuals whose sexual orientation or gender identity differs from the societal norm of heterosexual and cisgender.
- Sexual orientation: an enduring personal pattern of romantic attraction or sexual attraction to persons of the opposite sex or gender, the same sex or gender, or to both sexes or more than one gender.

  Sexual orientation is self-defined and refers to one's inherent emotional, romantic, and sexual attractions to other people. Thus, a single sexual event or desire does not define one's sexual orientation. Historically, sexual orientation has been thought of as one of several categories including heterosexual, lesbian or gay, and bisexual. However, many perceive their attractions as more fluid (readily reshaped) than this and do not identify within these categories.
- Stigmatisation: the action of describing or regarding someone or something as worthy of disgrace or great disapproval. The act of treating someone or something unfairly by publicly disapproving of them by negative labelling and characterisation of people. Internalised stigma, also known as self-stigma, refers to the process where individuals who are part of a stigmatized group, like those with mental illness, internalize negative societal attitudes and beliefs about their condition, leading to self-doubt and a diminished sense of self-worth.
- Sexual Orientation, Gender Identity, and Gender Expression (SOGIE): encompassing characteristics that are common to all human beings; and can differ beyond the binary. Sometimes SOGIESC (the above including Sex Characteristics).
- Transgender: denoting or relating to a person whose gender identity does not correspond with the sex registered for them at birth. Often, transgender people desire medical assistance to medically transition from one sex to another; those who do may identify as transsexual. Sometimes shortened as "trans" or "trans. Transgender individuals may choose to receive hormone therapy and/or undergo various gender-affirmation surgeries, or not. Transgender is a gender identity and should not be confused with sexual orientation.
- Transfeminine: refers to individuals assigned male at birth (AMAB) who predominantly identify or express themselves as feminine, encompassing both trans women and AMAB non-binary people.
- Transitioning: A series of processes that some transgender people may undergo to live more fully as their true gender. This typically includes social transition, such as changing name and pronouns,

medical transition, which may include hormone therapy or gender affirming surgeries, and legal transition, which may include changing legal name and sex on government identity documents. Transgender people may choose to undergo some, all or none of these processes.

- Transmasculine: denoting or relating to a person who was assigned female at birth but whose gender identity is in some way aligned with or characterized by masculinity.
- Transmen: a person who was assigned female at birth but who lives and identifies as a man; a transgender man.
- Transwomen: a person who was assigned male at birth but who lives and identifies as a woman; a transgender woman.
- Trauma informed: A trauma-informed approach recognizes the widespread impact of trauma and understands potential paths for healing, recognizing signs and symptoms in staff, clients, and others, and integrating knowledge about trauma into policies, procedures, and practices to prevent re-traumatization.
- Two Spirited (2S): a term used by some Indigenous North Americans to describe individuals who embody both masculine and feminine spirits, representing a traditional third-gender social role within their communities.
- Victimisation: is the state or process of being victimised or becoming a victim. The field that studies the process, rates, incidence, effects, and prevalence of victimisation is called victimology.
- Virilisation: or masculinization is the biological development of adult male characteristics in young males or females. Most of the changes of virilization are produced by androgens.
- Women who have sex with women (WSW): refers to female individuals engaging in sexual activities with other women, regardless of their sexual identity or orientation.

3 Background

LGBTQIA+ people are estimated to represent between **8% and 13% of the world's overall population** (Ipsos, 2024). However, their (in)visibility in society, is largely variable depending on regional legislations, cultural or religious stigmatization and violations (ILGA, 2024). Across all regions LGBTQIA+ people have increased health risks, due to a **multifactorial interlinked cascade** consisting of specific **increased physical and mental health risks**, which are **often not recognized and inadequately responded to by care providers** (Williams, 2020). On top of which they have less access to and receive a lesser quality of care, whilst being **exposed to an increased risk of violence, less access to support of authorities and social services, lower socioeconomical status, systematic and/or political discrimination/criminalization and/or stigmatization and marginalization** (WHO 2020).

Healthcare providers report difficulties serving this group, due to **perceived gaps in knowledge on the medical technical, legal aspects or being uncomfortable with the topic, hindered by unprocessed prejudices or being unfamiliar with appropriate language** (Bass, 2023). Medical professionals rarely receive training on LGBTQIA+ inclusive care, protocols and guidelines are often lacking. Moreover, evidence for effective, safe and harm-reducing health interventions for LGBTQIA+ people is sparce. **Not many studies focus on the health state and care of these groups,** even fewer focus on differences between the subgroups amongst them or look further into other intersectionalities (HRW, 2021).

Negative initial experiences in the healthcare system can have detrimental impact on everyone's further choices to avoid or delay future care and thus shape their future health state and experience, including the quality and length of life. Much potential, especially within **preventative care**, is being missed by failing to implement more inclusive care principles in health structures and services, starting with emphasis on **inclusion of marginalized groups in health education**. Improved awareness, attitude and knowledge of care providers and non-medical staff can reduce barriers for LGBTQIA+ patients' ability to access respectful and appropriate healthcare.

When focusing on **humanitarian context**, **several additional barriers to care come into play, caused by infrastructure problems, programming challenges, impaired healthcare systems, access negotiations, insecurity in war and conflict context, natural disasters etc**. In such context the **marginalization and health risks for LGBTQIA+ people tend to increase, while their access to care decreases, even more so when looking at populations facing forced displacement**. While many humanitarian actors focus on the most vulnerable and marginalized populations according to their principles; in **practice steps to include LGBTQIA+ individuals in their (medical) activities) are largely dismissed**. Even more so, there are many examples of stigmatization and denial of services being continued within humanitarian projects when LGBTQIA+ people seek care. For example, in displacement camps in Africa and the Middle East, but this experience is shared by LGBTQI+ refugees in Europe (IOM, 2019) and the US.

The combined effect of **societal marginalization and health disparities creates a largely invisible public health crisis affecting LGBTQIA+ people worldwide** (Nelson, 2007). Throughout the last decade(s) research on the health situation of LGBTQIA+ people and a few potential interventions has grown. Yet **healthcare providers and policy makers are lagging in acknowledging and/or acting on the severity and scale of this health threat**, which is affecting not only LGBTQIA+ individuals themselves, but also the societies and communities they live in (e.g., communicable diseases, indirect burden of mental health diseases etc) (WHO, 2022).

As LGBTQIA+ people **are often marginalised by their own community, as well as by violent groups, host community and aid providers, such layers of marginalization, exclusion, lack of protection from authorities contributes to making them**, in many cases, **more vulnerable than other vulnerable groups in humanitarian emergency settings** (such as armed conflict, natural disasters or disease outbreaks). They are more likely to see their **health disparities increase in circumstances of displacement**; the **humanitarian sector should need to acknowledge the strong imperative to address the ongoing marginalization of this group in their advocacy efforts and medical programs.**

To increase literacy about this **silent public health emergency**, this literature review aims to give an overview of existing data on LGBTQIA+ demographics, associated health risks, and barriers to care of LGBTQIA+ people. Additionally, it provides an overview of existing evidence on **meaningful health interventions and recommendations** for further improvement of access to care, decreasing marginalization and highlight further research needs, and where possible, **adapted to humanitarian work**.

4 Methods

This literature review is meant to fill a perceived knowledge gap within the medical humanitarian sector, more specifically within MSF. An initial literature review was executed in August 2022, but the field of LGBTQIA+ specific research (medical and non-medical) continues to grow, quantitatively and qualitatively, hence a need to not only update but to maintain a repository that allows for new research and approaches to be added to this knowledge base.
In fact, within MSF, inadequate care delivery to LGBTQIA+ patients (including discrimination by medical providers) has been observed. Although it is hard to quantify, it should also be assumed that LGBTQIA+ patients remain underrepresented and unrecognized and that the organization (MSF) is missing a very vulnerable group amongst the populations they are aiming to reach. To test this hypothesis, a baseline study on awareness of LGBTQIA+ presence and criminalization amongst MSF project teams was performed (Iammarino, 2023).

This helped formulating the main question:
How can Humanitarian Medical interventions reduce the barriers to care and the resulting health disparities of LGBTQIA+ patients and deliver more inclusive care?
Broken down in the sub questions:
-who are LGBTQIA+ patients (what are their epidemiological characteristics)?
-what are the barriers to care (structural, patient and provider level)?
-what are the health disparities for LGBTQIA+ patients (and their causes)?
-what are meaningful interventions to these disparities (medical, education, health promotion, advocacy, policy, research)?
-what special considerations exist for LGBTQIA+ care in humanitarian context

The following **search terms** were used for an initial search in PubMed:
LGBT OR lesbian OR gay OR bisexual OR transgender OR intersex*
AND
humanitarian OR armed conflict OR war OR disaster OR NGO
With **16752 results.**

Which led to the combination of the following search terms after finetuning based on results of the initial search:

LGBT OR lesbian OR gay OR homosexual OR transgender OR transsexual OR travestite OR transwomen) OR transmen OR transyouth OR genderqueer OR genderfluid OR non-binary OR asexual OR intersex OR hermaphrodite OR queer OR sgm OR sogie OR gender diverse*
AND
stigma OR criminalization OR discrimination OR marginalization*
OR "barriers to care" OR "challenges" OR "accessibility issues" OR "access problems"
OR "health risks" OR "health disparities" OR "health challenges"
OR "humanitarian crisis" OR "humanitarian disaster" OR conflict OR war OR "natural disaster" OR "low income" OR "low resource" OR "humanitarian aid" OR "forced displacement" OR "people on the move" OR "displaced population" OR refugees OR "asylum seeker"
OR "humanitarian intervention" OR "medical intervention"

These search terms were used to seek peer reviewed studies via screening of abstract and title on PubMed, MEDLINE, Embase, EBSCO, Scopus, Cochrane and Google Scholar. References of the key studies were also cross checked to reduce chances of missing relevant titles. The search was then expanded by using the same terms to find grey literature via Googles search engine (which was filtered for the last 5 years and relevance), before a selection via hand search was made.

Through this search a total of **1896 articles** were found. Results were further filtered with the following criteria:
-Inclusion: clinical trial, systematic review or meta-analysis.
-Exclusion: other study and article types
Which resulted in a remainder of **637 articles** for a title/abstract screening with the following in and exclusion criteria:
-Inclusion: study about LGBTQIA+ or any subgroup or combination thereof, describing
-Exclusion: focus on PrEP, PEP or ART regimen, historical rather than medical

The remaining **361 articles** were read in depth and summarized, collected in a literature library categorized per topic as well as alphabetically. This data overview was extracted into excel, Literature Library _v3.xlsx, , with details of the study and author and the key findings. This overview allowed a first rough analysis, identifying relevant subject matter and the (potential) interlinks, inspiring additional topics to consider in the final review.

This review aimed to provide an **overview of existing knowledge on the health determinants of the LGBTQIA+ population, including barriers to care, resulting health disparities, underlying causes, and evidence-based interventions—particularly those relevant to humanitarian contexts**. Main topics were further divided into subtopics and cross-referenced where relevant.

Manual coding was used to organize findings, identify links, and make comparisons. The report includes the most relevant findings, prioritizing recent, reliable sources with strong evidence, relevance to the review questions, and applicability to humanitarian contexts. Knowledge gaps identified during the process were noted for discussion.

5 Results

5.1 Epidemiology

5.1.1 Prevalence and Demographics

To understand the scale of the individual health loss and global public health impact addressed, it is important to understand the numbers of LGBTQI+ people represented in society. Worldwide an average of roughly **9% of people identify as LGBTQ+** (Ipsos, 2024). This includes **3% identifying as lesbian or gay, 4% as bisexual, 1 % as intersex or asexual and 1% as transgender**. Exact figures vary, depending on data collection methods, region and generation. Political, religious, cultural and socio-economic factors influence people's self-reported identity (ILGA, 2023). Currently not all countries have estimates available, the Middle East and North Africa remain largely underrepresented.

It remains unclear and hard to quantify how linguistic, social, political, legal, and religious constructs influences actual experienced and reported sexual orientation and gender identity. However, compiling survey data of various studies from different regions, shows a **negative relation between lower income, political/religious/legislation/cultural values conservatism,** and numbers of people (1-17%) identifying as SGM (Ipsos 2023). An Ipsos survey from 2023 found an average of 9% of people identifying as LGBTQ+ across 30 responding countries (including: Brazil 15%, Mexico 12%, South Africa 8%, Turkey 4% and Japan 1%) (Ipsos 2023).

Younger generations are more likely to identify as LGBTQ+. For example, a study in America found 7% of overall respondents versus 17% of under 30s identifying as gay, lesbian or bisexual (Pew, 2022). The Ipsos survey found similar numbers when comparing Gen-Z, 18% to Baby boomers 4% (Ipsos 2023). In conservative contexts, where LGBTQI+ identities are most likely restricted or criminalised, the differences between generations are even more pronounced.

When **fearing stigmatization and criminalization** people will be less likely to live an open life and be visible and recognizable in their community (OECD, 2023). In Latin America, Spain, Australia, New Zealand, and South Africa sexual minorities and gender diversity is most visible. While the visibility of the LGBT+ community is lowest in Japan, South Korea, Turkey, Romania, Hungary, and Poland (Ipsos, 2023).

Despite the variation in exact numbers per region and generation, it is safe to say **LGBTQI+ persons are represented everywhere across the world and could be part of any clinical interaction in any provider-patient relation.**

5.1.2 Social Determinants of Health

Social determinants of health, such as housing instability, discontinued education and/or unemployment, and poverty, **disproportionately affect LGBTQIA+ populations**. Furthermore, many of these determinants are interlinked with each other and with **multiple interlinked health risks** (such as substance abuse, transactional sex, prostitution or sex work, victimization and suicide attempts).

5.2.1.1 Education

Studies in US, UK and Europe show that **more than half of LGBTQ+ students** (13 to 20 years of age) **feel unsafe at school due to their sexual orientation or gender identity** (Kosciw, 2021). Up to 70% report hearing prejudicial remarks at school (almost 60% reports hearing prejudice from teachers). Direct verbal harassment happened to 60%, physical harassment or assault to 22% and 9% respectively, only in the last year. SGM youth are unlikely to report incidents (< 40%) as they are convinced no action will be taken, and indeed of the ones that do report > 60% were told to ignore the incident (Kosciw, 2021). These experiences lead to anticipated discrimination in workspace and negative interpretation of work

opportunities (Croteau 1996). Not only is **victimization at school associated with decreased school engagement and academic achievement, but it also affects long-term health and behavioural risk factors**.

Currently **regions with stronger anti-LGBTQIA+ sentiment are underrepresented in data on SGM educational experience and attainment**. The few studies available indicate negative impact of LGBT+ stigmatization on school attendance and results also in for example Thailand, Peru, Guatemala, Chile and China (UNESCO, 2014) (Caceres, 2013) (UNESCO, 2015).

Globally, educational attendance and attainment are lower for LGBTQ+ people compared to cisgender heterosexuals, with worse outcomes in countries where structural discrimination leads to exclusion from education (UNESCO, 2016) (Badgett, 2014). Impact is strongest on lesbian and bisexual women and especially transgender individuals (Carceres, 2013). **The impact seems stronger for those who experience (and express) their SGM identity earlier in live** (Valfort, 2017) as they have **greater exposure risk to negative experiences** (Pearson, 2016).

5.2.1.2 Employment and income

Direct and indirect discrimination at workplace, including reduced changes on employment when open about sexual orientation or gender identity, lead to **higher unemployment rates and lack of or lower income, leading to increased poverty** (Badgett, 2021). **Poverty increases mental and physical stress, worsens housing instability and reduces chances of healthy choices and access to care and health insurance** (Murray, 2006).

The unemployment rate in the USA among LGBT people was 15.4% during the COVID-19 pandemic, compared to 11.5% among non-LGBT people (Badgett, 2021). Also, in South Africa studies report significantly higher unemployment rates among LGBT individuals, especially for transgender people (the Other Foundation, 2016) and 18% of them reported they had been denied work because of their sexual orientation or gender identity. In the European Union (EU FRA, 2017) 21% of LGBTQI+ respondents reported experiencing discrimination at work or while seeking employment in the past 12 months. Both in the UK and in the USA the **percentage of LGBTQIA+ people living in poverty is about 5% higher** than the general population (Human Rights Campaign, 2020) (University of Manchester, 2021).

5.2.1.3 Homelessness

Due to familial rejection, bullying and/or workplace discrimination, LGBTQIA+ people, especially transgender individuals, are more likely to become homeless even as teenager or adolescent (Albert Kennedy Trust, 2020). Youth may run away or even be forced to leave home, with **less or no chances to find protection in the social system** (depending on the country), US studies show SGM youth to be **twice as likely to become homeless** compared to their peers (Morton, 2018) (McKinnon 2021).

In many countries, **housing discrimination laws** do not protect sexual and gender minorities, making them more vulnerable to **economic instability**, which exacerbates health disparities. In Latin America (UN, 2020) LGBTQ+ individuals face significant barriers to securing stable housing, often resulting in higher rates of homelessness and inadequate living conditions (OHCHR, 2020).

5.2.1.4 Insurance

In addition, LGBTQIA+ individuals are **less likely to have stable health insurance, particularly in countries without universal healthcare systems**.

In 2020 a study in the USA reported up to **16% of LGBTQIA+ people avoid seeking medical help due to past negative experiences in medical environment, and those with insecure housing or jobs are less likely to prioritize healthcare and insurance.** As much as 22% of LGBTQI+ individuals reported not

being medically insured, compared to 12% of non-LGBTQI+ adults (Kaiser Family Study, 2020), reportedly because of low income and unstable employment.

In Latin America, LGBTQI+ people often are **excluded from health insurance coverage due to discriminatory practices**, with studies in Brazil and Mexico highlighting significant gaps in access to health services for this population (Malta, 2019)

This indicates that even in places where overall healthcare system is functional for most people, LGBTQI+ individuals are less likely to have access and may **rely on humanitarian sector for access to care even in relatively stable contexts.**

5.1.3 Intersectionalities

Health disparities are **exacerbated further when considering intersectionalities that compound the impacts for identities that experience multiple forms of discrimination**, i.e., such as being a poor LGBTQIA+ female person of colour with a disability.

It is relevant to consider that **certain health conditions that exist in increased prevalence within the LGBTQIA+ populations, increase the stigma towards the community, creating a vicious intersectionality**. The clearest example is **HIV**, not only are seropositive gay men stigmatised both for being gay and for being seropositive, but also the perceived association between homosexuality and HIV, is increasing the stigmatization to gay men and HIV patients, **regardless of the sexual orientation or the HIV status** (Mayer, 2010).

5.1.3.1 Poverty and Minority

Being LGBTQIA+ and **belonging to a lower socioeconomic class** within a society or **originating from lower- or middle- income country on a global level**, **reduces health outcomes** compared to LBTQI+ peers from higher class or higher income countries. Additionally, **belonging to an ethnic or religious minority increases discrimination and worsens health outcomes**. For instance, Black and Latinx LGBTQIA+ populations in the U.S. face both racial and sexual orientation discrimination, in Latin America, ethnic minorities and displaced LGBT individuals reported significantly increased levels of violence, including exploitation and sexual assault (IRC, 2020). Equally in most European countries, LGBTQI+ people from ethnic and religious minority groups, face disproportional discrimination compared to their 'white' peers (FRA, 2024).

5.1.3.2 Migrants, Refugees, Asylum seekers and People on the Move

Discrimination is even more so if they are from **migrant background and particularly if they are currently on the move** (Yarwood, 2022). Not only does this further **increase their health risks**, but it also simultaneously **decreases their access to social support structures, healthcare and protection services** (ActionAid, 2009). An IOM study shows 56% of LGBTQ migrants in the EU felt discriminated against and were significantly more frequently denied access to shelters and healthcare services due to their sexual orientation (IOM, 2019). In the Middle East, particularly in Lebanon and Jordan, LGBT refugees often face discrimination from both service providers and other refugees, making it difficult to access even necessities (Lebanese Center for Human Rights, 2020). In Southeast Asia, LGBTQIA+ refugees face severe legal hurdles, including lack of legal recognition of their gender identity, which reduces their access to protection and services.

Identifying as LGBTQI+ is **increasing changes of forced displacement**, **whether internally or internationally** (OHCHR, 2022). To date there are **no official numbers on the prevalence of SGM amongst migrants or asylum seekers**. Conservative estimations come to 5%, yet researchers agree that these numbers are an **underrepresentation of reality, due to fear of being reported**. It is expected LGBTQI+ people are **overrepresented amongst People on the Move** (HAI, 2014), **due to the increased violence**

and criminalization they are facing in over 70 countries, and it is expected this discrepancy will increase (OHCHR, 2022). For example, at least **70% of LGBTQI+ migrants in Sub-Saharan Africa reported being exposed to violence during displacement** (UNHCR, 2020). Yet despite being a particularly vulnerable group amongst migrants, with special protection needs, these **needs are likely to remain unseen or unmet** (Shaw, 2022). This group is at exceptional risk of discrimination and violence throughout the entire trajectory of migration, including **corrective rape, imprisonment, abuse and torture** (Beck, 2012). Additionally, their (**perceived) risk of repercussions heightens their barriers to seek support from health or other authorities or services** (FRA, 2024) (WHO, 2021).

5.1.3.3 Detention

Another specifically jeopardized group are incarcerated SGM, **either in formal prisons or arbitrary detention (as migrants often face), they are at increased risk of victimization by their fellow detainees and/or guards and less likely to receive appropriate care** (Trimble, 2019). It's important to note that LGBTQIA+ people, adult and youth, are **overrepresented in prisons.** This is attributed to a **combination of profiling, stigmatization and discrimination by authorities and society and the obstacles LGBTQIA+ individuals face when escaping abusive and traumatic situations**. Once imprisoned they are subject to higher levels of violence by fellow inmates and guards and have less access to (appropriate) care or protection (Jones, 2021).

In North America, LGBT+ migrants, particularly those in detention centres, face **extreme mental health challenges**, with 58% reporting symptoms of severe anxiety and depression (Center for American Progress, 2020). Also, they are more likely to be **detained for longer periods and face higher rates of deportation compared to non-LGBT asylum seekers** (Human Dignity Trust, 2020).

5.1.3.4 Age, Disability, Neurodiversity

Other disproportionately disadvantaged intersectionalities are the **elderly** who are likely to hide from surroundings, tend to receive non-inclusive care and carry the burden of lifelong stigmatization (Frederiksen-Goldsen, 2013); **people with mental and/or physical disabilities** who are likely to have their sexuality, and with that their sexual orientation and/or gender identity denied (Human Rights Campaign, 2022); and **neurodiverse LGBTQIA+ people** (who are less likely to find therapy and tools that is adequate and LGBTQIA+ friendly) (Gayatri, 2024).

5.2 Barriers to Care

5.2.1 Structural barriers in healthcare systems and society

Across the world many countries, cultures and/or religions stigmatise LGBTQIA+ individuals, including **discrimination, criminalization and victimization on individual and systematic levels** (Human Rights Watch, 2024)). In many cases **legal and political barriers** exist that not only directly but also indirectly affect the **health of LGBTQI+ individuals** (Burack, 2021).

This can vary from the **administrative hurdles** transgender people may face, to **policies banning gender affirming care** (Spade, 2015). Or **anti-LGBTQI+ legislations** cutting people off from essential services, including HIV screening and treatment (Nakweya, 2024), as is the case in many countries in Sub-Saharan Africa. There is a **general lack of medical guidance and protocols** (especially on trans care) and with **no international standard, medical policies differ a lot,** and the legal framework and restrictions vary a lot from country to country (Boon, 2021). The lack of legal protections and inclusive policies can lead to **health disparities by limiting (safe) access to services and resources.** Some states in the USA approved policies that allow or encourage health workers to refuse LGBTQI+ patients based on their

sexual orientation or gender identity (ANA, 2023). Additionally, a lack of clear policies or actions protecting LGBTQI+ against hate speech persists and moreover, in various countries (religious) leaders and policy makers even contribute to it, which leaves LGBTQI+ population in a vulnerable place in society in a **time of increased frequency and severity of hate crimes** against LGBTQI+ people (FRA, 2024) (Outright, 2023) whilst **new anti-LGBTQIA+ legislations are being actioned** (Nakweya, 2024) (Amnesty, 2011).

5.2.1.1 Criminalisation

Furthermore **at least 70 countries worldwide** (Human Rights Watch, 2024) **have laws in place that sentence consensual sex between same-sex adults**, **with penalties varying from fines to incarceration and even death penalty (including 37 countries where MSF has projects at the time of writing)**. **At least 9 countries outlaw forms of gender non-conformity.** Where laws and policies are more restrictive, the openness and the level of stigmatization and discrimination of LGBTQI+ individuals tend to be higher, both in society and in healthcare (Ayala, 2016). Some countries include **laws targeted against allyship, including "acts supporting or promoting LGBTQI+ people".** How wide such laws can or will be applied is often not clear and it can severely **impact the willingness of people to support LGBTQI+ people or deliver services, including legal aid, protection and medical services**. Regular service providers may fear retributions and reduce their availability, leaving care for LGBTQI+ people to NGO and grassroots initiatives rather than regular services (Serelto, 2022).

Criminalisation **worsens the health disparities of LGBTQI+ individuals, reduces their access to healthcare and other services and increases their risk to be victimized** (Star, van der, 2023). Where law and public opinion are against them, fear of further prosecution prevents LGBTQI+ people from seeking support from police or legal services if their rights are violated. And when they do seek help, they are less likely to receive respectful and adequate assistance (Williams Institute, 2015).

Social support and community involvement are crucial for mitigating health disparities. The presence or absence of supportive networks, both on individual and community level but also on higher structural level can influence mental health and access to resources. LGBTQIA+ people are more likely to be or feel isolated within their families, communities and societies, especially where criminalization is higher, and thus receive less benefits of social support (Copenhaver, 2019).

5.2.1.2 Research gap and data omission

Lack of standardized data collection increases and perpetuates health inequalities as it continues to conceal the scale of health disparities LGBTQIA+ people are facing and therefore halts the imperative to act (HRC, 2019). Most health systems do not include data on sexual orientation or gender identity (other than legal sex), leaving the health situation of LGBTQIA+ people mostly **invisible for researchers unless specific data is collected for research that includes LGBTQIA+ population in the study design** (Munz, 2024). Even if such data is collected, **difficulties to disclose can impact outcomes, especially if the reason it is collected is not well explained**. **Lack of unified and adequate terminology** can result in **biased data that is poorly comparable and risks alienating the survey subjects** (HRC, 2019).

As LGBT populations are also significantly **underrepresented in health research**, it remains **hard to address the existing knowledge gap** (Institute of Medicine, 2011). Improving quality of care needs **evidence** to support the development of guidelines, protocols and training material to ensure tailored evidence-based care that is taking into consideration special risks and needs of LGBTQIA+ individuals. This underrepresentation leads to unclarity on the generalisability of study outcomes to LGBTQ+ populations and can feed into conclusions that may not be applicable to them (Kelly, 2022). Still, too little is known about the specific health needs and health disparities currently known of this population, there may be additional health risks for them that are not yet discovered or improperly demonstrated and therefore are unlikely to be recognized by researchers or physicians.

Geographical spread of existing research and data is uneven, as most research is concentrated in regions that are more protecting and less criminalizing LGBTQIA+ people such as North America and Western Europe, much less is known about LGBT people in Africa, Middle East and Asia (UNAids, 2014). Worldwide subgroups and intersectionalities amongst LGBTQI+ populations are underrepresented in data and overlooked in research or are suffering from inconclusive date due to small sample sizes (Subramaniapilla, 2024).

The last decade has seen a steep increase in the amount and diversity of studies on LGBTQIA+ related health issues. Yet a mismatch persists between the focus areas of the research and areas where the burden of the health impact is highest (Lo Moro, 2024) and the focus of the research. **Transwomen and/or bisexual women, especially if of colour and/or from migrant background and involved in sex work (or transactional sex) are by far the most vulnerable group.** However, **most of the existing research involves white heterosexual adult MSM in high resource settings and often focusses solely on HIV related health issues or interventions.**

Lack of funding for health research focusing on LGBTQIA+ people has allowed their **invisibility in the medical research world to continue.** Political and societal stigma create hesitation for governments and organisations to allocate funding, while simultaneously researchers face stigmatization when attempting to investigate LGBTQ matters and have difficulties to receive funding (Fenway Health, 2020). With stigmatisation and distrust in healthcare and society in general, it may lead to **high barriers for LGBTQIA+ people to disclose, both for healthcare documentation and for research purposes, especially in countries with severe criminalization** (Rattay, 2019). This mostly relates to fear for direct discrimination and indirect fear of data breaches and the potential consequences.

5.2.2 Perceived barriers in access to care by LGBTQIA+ patients

5.2.2.1 Pathological Model associated with medical Stigma

Until quite recent "homosexuality" along with "gender dysphoria" and "hermaphrodism" were all considered **psychological and/or physical disorders.** Only in 1973 "homosexuality" was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Drescher, 2015). "Gender identity disorder" or "gender dysphoria" is still included in the latest version, though recognized separately from "gender nonconformity" or "gender diversity" (Maddux, 2015). **"Intersex"** or **"Disorder of Sex Development"** are the latest terms, replacing "hermaphrodism" or "congenital eunuch", **yet still labelling the condition as a disorder** (Wichtel, 2018).

This **historical pathologic model contributed structurally to stigmatization of sexual minority individuals by society as a whole and within the medical community specifically** (Institute of Medicine, 2011**). Despite the de-medicalisation**, **some cultures and religions continue to perceive SGM as unnatural or undesirable and have various levels of anti-LGBTQIA+ laws or practices in place, sometimes criminalizing allyship as well and/or lacking protective laws ensuring (medical) care for LGBTQI+ individuals** (OHCHR, 2024). In the USA, 25% of LGBTQI+ individuals reported being denied healthcare services due to their sexual orientation or gender identity, compared to 8% of heterosexual individuals (Williams Institute, 2020). When looking more specifically at mental health issues (which LGBTQI+ individuals are 1.5 times more likely to experience compared to heterosexual adults) only 36% of LGBTQ/adults report receiving the mental health services they need, compared to 47% of non-LGBTQ adults (National Alliance on Mental Illness, 2020).

According to a global review by the World Health Organization, LGBTQI+ individuals are more likely to **avoid seeking healthcare services due to stigma and discrimination**, with 54% of LGBTQI+ people in low- and middle-income countries reporting barriers to healthcare access compared to 30% of the general population (WHO, 2020).

5.2.2.2 Fear, low expectations and discontent

Depending on the background of the patient and the local legislations **additional fear of reporting or other repercussions may form another barrier to access care**. This continues to be true for LGBTQI+ migrants even if they moved to regions with more LGBTQI+ friendly legislations and higher levels of sociopolitical acceptance (Yarwood, 2022).

LGBTQI+ patients are also **less likely to report or address their discontent with the care** they are receiving, **yet are often not convinced of the knowledge, experience and skills of their provider on LGBTQI+ related health issues or counselling** (Medina-Martinez, 2021).

Barriers to care more specifically for LGBTQI+ **migrants are language barriers, lack of understanding of the care system (or lack of access to it), culture differences leading to fear and or difficulties to adequately disclose and express sensitive topics** (Lee, 2019) (Wijtsma, 2024).

Additionally, **judgmental or insensitive encounters with health care providers and a cisgender heteronormative approach further deter health-seeking behaviours** (Kerker, 2006) (Arbeit, 2016). Moreover, **such encounters contribute to patients' reluctance to disclose sexual orientation** (Austin, 2013) and **related physical or mental health issues, reducing the chances on adequate care for the signs and symptoms people are facing** (Brooks, 2018) (Quinn, 2014).

5.2.2.3 Medicalisation

For transgender people, to this day, it **is still very difficult to receive care without risking or needing to be 'diagnosed'**. Although gender diversity is not a mental illness, the **difference between gender dysphoria and diverse gender identity is poorly understood in society and amongst medical providers** (WPATH, 2022) (Tuerk, 2011). Until recently, **sterilizing and irreversible surgical interventions were required to change one's sex marker in official documents and registers** and is still practiced by some providers (ILGA Asia, 2023). Access to adequate 'trans care' often requires a level of medicalization that is perceived unpleasant by trans people, with **few medical professionals educated or competent in trans care**. Where specialized care exists **waiting lists** are often lengthy (Wijtsma, 2024).

People with **intersex condition or Difference in Sex Development** (DSD) are another subgroup facing exceptionally **high levels of misunderstanding** (in- and outside of medical setting), stigma, and with high levels of medicalization of their condition historically, including interventions lacking proper patient consent or assent (Sandberg, 2022). **Irreversible and potentially mutilating surgical interventions, sometimes with high risks of complications** (impacting continence and sexual function) are not exceptional, especially in conservative settings these practices continue. In societies with strict gender roles there is a high pressure on caregivers to present the sex and assumed gender of their child, increasing the risk of rushed decisions before the child reaches an age to be able to assent (Haghighat, 2023). This can create negative medical experiences in (early) childhood, continued medicalization due to surgical complications later in life, and increased risk on gender dysphoria due to (mis)assigned sex of rearing, accumulating in increased barriers to care (Cools, 2018).

5.2.3 Perceived barriers in care provision to LGBTQIA+ patients by healthcare workers

5.2.3.1 Knowledge gap and education

Healthcare providers from USA, UK, South Africa, and Europe report various barriers they perceive to provide quality care for LGBTQIA+ people, with a **knowledge gap being the most reported one** (Stenzel, 2020) (Serelto 2022). This leads to a reduced quality of care not only due **to incomplete understanding of risks, needs and relevant diagnostics and interventions, but also because it impacts the attitude of the healthcare worker and thus the patient-caregiver relationship** (Gentile, 2021) (Maird, 2023).

Most providers report their **curriculum had none or too little attention** on LGBTQI+ care (Makadon, 2006) (Obedin, 2011) (Kuehn, 2011) (Wang, 2023), was too generically mentioned, with little depth and too little time spent on the subject (Serelto, 2022) (Ramsey, 2022). In the USA, most providers report the need to be **more educated in how to avoid stigma and discrimination, how to create an inclusive environment, provide affirmative care, and to gain knowledge of specific health disparities** (Health LGBTQI, 2023). Broader training needs include suicide prevention and theory and practice of PrEP administration.

5.2.3.2 Legal aspects and fear thereof, financial complications

Inadequate knowledge about legal aspects of providing care to LGBTQI+ people and/or fear for legal consequences form another important barrier, **especially in countries where anti-LGBTQI+ legislations are common** (Kiss, 2020) (Ayala, 2016). Some countries have policies or laws that **encourage or allow providers to refuse care to patients based on their sexual orientation or gender identity** (Yarwood, 2022). Or certain **specific services are banned or prohibited to all or subgroups of people** (Yarwood, 2022). Societal implications and the fear thereof may pose barriers as relevant to providers as direct legal consequences. Providers tend to report a **risk of their personal or professional safety** as a barrier to provide care, especially in very restricted settings, however there is very little data to objectify such risks.

Lack of **insurance coverage or subsidies and fees** for LGBTQI+ care can be blocking as well, especially when it involves uninsured and or undocumented people as will often be the case in migrant care (Health LGBTQI, 2023). Or in some cases lack of clarity over what is and is not covered already forms a blockage for providers.

Providers also reported **inadequate clinic or hospital layout and lack of confidential spaces** as a barrier (Serelto, 2022), as well as insecurity about the **appropriateness of their services** for LGBTQI+ patients or the **perception that LGBTQI+ people can be more adequately supported elsewhere** (Jonas, 2018).

Lack of guidance, guidelines, protocols and supportive policies is also an issue health workers face across many regions and contexts (McNeil, 2021). For health workers **in low resource settings the additional barrier is that some diagnostic and/or intervention materials indicated may not be available and that the little guidance that exists is designed for higher resource settings.**

5.2.3.3 Biases and Prejudice

Lastly many providers have yet to face and challenge **their own biases, anti-LGBTQI+ sentiment or prejudices** (Bjarnadottir, 2019), that will, if not properly self-regulated, add to the burden of stigmatization LGBTQI+ people experience (Wesley, 2023) (Bristol, 2018). They may **wish to refer to colleagues with more experience with population, but this is not always an existing option.**

Apart from **insecure, dysfunctional or outright negative attitudes** that may arise from internal biases, they feed in to a **'don't ask, don't tell' culture**, where **medics avoid asking about sexual orientation or gender identity. Medics underestimate the willingness of patients to disclose**. In a study in USA almost 80% of emergency physicians felt that patients would refuse, while in contrast only 10% of patients reported they would refuse to disclose (Haider, 2017). In fact, **patients who disclose their sexual orientation to their health care providers may feel safer discussing their health and risk behaviours** as well (Klitzman, 2002), allowing patients to be affirmed in their identity and their physician to understand the individual health risks better.

In a survey amongst LGB youth in the US, 64% reported they would disclose if their provider "would just ask", while 65% had not been asked and not disclosed to their provider (Meckler, 2006). **These numbers are unlikely to be reproduceable in conservative and restricted settings where disclosure**

represents higher risks, **though insufficient research exists to know if this can be mitigated with proactive assurance about confidentiality and data protection principles**.

5.3 Health Disparities

A vast variety of health disparities have been studied and described amongst LGBTQIA+ people, some of which are more obvious and better understood than others. While **some of these health risks are more related to the impact of stigmatization and criminalization itself, other conditions relate to risk behaviour and exposure**. Many **health issues and risk factors are interlinked**, underlining the complexity of the impact of marginalization on LGBTQIA+ people and their health status.

While some mechanisms are relevant for all subgroups or identities, it is important to recognize the **differences between the subgroups** and understand the risk profiles of each group separately. Therefore, after a discussion of some general principles, those subgroups and intersectionalities will be addressed separately to provide a systematic overview of relevant health issues.

There is no disease that is unique for LGBTQIA+ people, yet it is relevant for clinicians to understand the risk profile of each patient linked to gender identity, sexual orientation and behaviour and have an overview of the relevant investigations and interventions.

5.3.1 General Health Issues

The **minority stress model** has been proposed to better understand the stressors that minority groups are exposed to and how this **stress manifests itself, becomes internalized and translates into health risks**. It was originally used to explain high levels of mental health problems various minorities groups face; however, it offers potential to better understand (some of the) physical health risks as well.

One of the main drivers of health disparities among LGBTQIA+ individuals is stigma and discrimination. Studies have shown that LGBTQIA+ people are **more likely to experience violence, harassment, and social exclusion** due to their sexual orientation or gender identity (Decker, 2018).

The minority stress model poses that this **constant exposure to discrimination results in chronically increased stress levels, which activates a cascade of negative health effects** (Kiss, 2020). It **exacerbates mental and physical health conditions** such as **depression, anxiety**, but also it **affects the immune system, increases the risk of cardiovascular diseases and certain cancers.**

With increased exposure time the **stigmatization becomes internalised, and the anticipation of rejection already increases stress levels**. Internal stigma or self-stigmatization refers to "the shame and expectation of discrimination that prevents people from talking about their experiences and stops them seeking help" (Gray, 2002). It also includes **internalised homophobia, or transphobia, and negative self-perception** (Kiss, 2020). **Concealment of true identity over time** also tends to increase a person's stress levels, as well as anticipation of or the process of coming out itself (Williams, 2021).

In a similar way **"adverse childhood events"** (ACE) are thought to play an important role in the negative health effects of LGBTQIA+ people. The term ACEs is used to **describe various forms of abuse, neglect, and household dysfunction experienced during childhood** (CDC, 2020). Exposure to these traumatic events is associated with a range of **chronic negative outcomes in adulthood** such as heart disease, diabetes, and depression (Felitti, 1998).

The cumulative effect of multiple ACEs exacerbates these risks, creating a cycle of poor health outcomes. For example, a systematic review found that each additional ACE increases the likelihood of developing depression by 1.4 times (Hughes, 2017). When an individual is exposed to four or more ACEs their lifetime risk on all sorts of acute and chronic diseases significantly increases**. LGBTQI+ youth report higher rates of ACEs compared to their heterosexual peers**. For example, **LGBT youth are 120% more**

likely to experience family rejection (Dube, 1999) and up to **3x more likely to experience sexual or physical abuse** (Andersen, 2013) which are classified as ACEs.

Due to stigmatization, negative past experiences and reduced access, LGBTQIA+ people often **underutilize clinical care services and present later for health care** than their heterosexual peers. This **delay impacts the clinical image and the prognosis at moment of presentation and diagnosis, as well as the treatment** (Jaffee, 2016) (Jennings 2019). In addition, **differential risks for disease** can arise because of behaviours that may be more common among SGM.

5.3.2 Mental Health Risks

As described above LGBTQIA+ people face mental health challenges due to the **intersection of minority stress, societal stigma, discrimination, and marginalization. Rejection by family and community** is an important contributing factor, influencing both the **risk to develop mental illness and the capacity to recover**. The **increased risk to experience violence** and the direct mental impact of these attributes' challenges contribute significantly to the mental health burden in LGBTQI+ population (Kassing, 2021). **Specific mental health issues, as well as their prevalence and severity, vary across subgroups and regions.**

Likelihood of mental illness should be assessed adequately in each LGBTQIA+ patient, even when presenting with physical symptoms initially. Deeper assessment can be done when indicated, it is important to use inclusive counselling and health education material.

5.3.2.1 Depression and Anxiety

LGBTQIA+ individuals, particularly those in hostile social environments, **experience higher rates of depression and anxiety** compared to their heterosexual and cisgender counterparts.

Lesbian, gay, and bisexual (LGB) individuals are more likely to experience clinical depression (up to 50%) and generalized anxiety disorder (Moagi, 2021).

In *transgender populations*, studies show rates of depression (84%) and anxiety (68%) even higher, often due to factors such **as 'gender dysphoria', social rejection, and difficulties in accessing gender-affirming healthcare** (Restar, 2024). Gender dysphoria is the discomfort a person experiences due to incongruence between their 'personal sense of their own gender' and their 'sex assigned at birth'. This term replaces the diagnostic label of gender identity disorder and aims to separate a person's diverse gender experience from the level of discomfort or distress related to it (Garg, 2023).

Bisexual individuals often face unique challenges due to 'biphobia', even from within the LGBTQIA+ community. Bisexual individuals report higher rates of mental health distress and depressive symptoms compared to gay and lesbian people, driven by **a sense of isolation and rejection from both heterosexual people and from within LGBTQI+ communities** (Feinstein, 2023).

Intersex people face medical trauma due **to non-consensual surgeries and stigmatization of their bodies**. Many intersex individuals report depression, anxiety, and 'body dysmorphia', driven by feelings of being misunderstood and mistreated within both healthcare and social settings (Esteban, 2023) (Rosenwohl, 2020).

Asexual individuals face both **stigma and misunderstanding related to their sexual orientation**, that can cause mental health issues. They are at high risk of isolation and may have problems finding a partner due to their asexuality. Research about asexuality is limited but highlights the need for mental health support that is affirming of asexual identities and addresses specific challenges faced by asexual individuals (Lech, 2024).

5.3.2.2 Suicide and Self-Harm

Suicidal ideation and self-harm rates among LGBTQIA+ populations are alarming. A study in the U.S. found that **LGBTQI+ youth are 4 times more likely to attempt suicide** than their cisgender heterosexual peers (Johns, 2020), for **adults the rate is about 1.5 to 2.5 times higher** (Ramchand). **Transgender youths and adults** are leading in rates of suicide and suicidal attempts and ideations, explained similarly to their increased depression and anxiety rates. Also, **bisexual individuals** are at increased risk compared to average amongst LGBTQI+ people.

Self-harm rates amongst LGBTQ+ people are increased as well, up to **twice as high** compared to heterosexual cisgender population (Quarschie, 2020) especially in **youth**, and especially in **transgender individuals.**

Gay male adolescents experience increased incidence of body dysphoria and eating disorders (Parker, 2020). Sometimes also steroid or overuse of proteins occur to alter their body appearance. **WSW, especially bisexual women are at increased risk of binge eating disorder**.

5.3.2.3 Substance Abuse

LGBTQIA+ individuals, especially when experiencing **severe minority stress**, may use substance abuse as a **coping mechanism**. While doing so in itself is only a way to deal with being emotionally overwhelmed by continuous strenuous circumstances, it does expose people to the **risk of evolving into dependence and abuse**. Early studies are likely to overestimate true substance abuse amongst LGBT+ people, as they mainly used bars and nightclubs to recruit participants (Hughes, 2016). Recent studies have shown overall figures of alcohol and drug abuse amongst the LGBT+ population are **not so much higher than general population, though the discrepancy is bigger in adolescents** (Marshall, 2008). However, the **number of alcohol and drug related problems (such as intoxication, overdose, blackouts, amnesia, organ damage and psychological issues) are significantly higher amongst LGBTQI+ population** (Kelly, 2022) (Marshall, 2008).

Gay and bisexual men are likely to engage in **heavy alcohol and illicit drug use** compared to heterosexual peers (Institute of Medicine, 2011) (a combination which also increases chances of unsafe sexual behaviours). The combination of alcohol, methamphetamine, cocaine and sex, a trend that became known as **'chemsex'**, forms a **health risk not only to those directly involved as it is associated with condomless sex in serodisconcordant partners** (Frosch 1996) (Oldenburg, 2016) (Vosburgh 2012) (Kelly, 2022). It is thought that the drugs are used to **release inhibitions and or overrule fear of rejection related to internalized stigma** (Cochran, 2006). *Lesbian and bisexual women* are more sensitive to **tobacco and marijuana as well as analgesics abuse** (Barger, 2021). Stress, anxiety and depression rates are predictive factors.

5.3.2.4 Post-Traumatic Stress Disorder (PTSD)

As mentioned above LGBTQIA+ individuals have an increased risk on ACDs as well as higher rates of lifetime violence and trauma due to their SGM identity: they are at high risk to experience hate crimes, harassment, and sexual violence. Any of these events can lead to a trauma that persists and leads to PTSD. An accumulation of traumatic events, even if of themselves not very severe, increases the risk of PTSD (Flores, 2020). Particularly in **transgender women and gay men, who may face high rates of physical assault, PTSD levels are high** (Ramos, 2023).

5.3.2.5 Regional Differences in Mental Health Outcomes

In countries like the **United States and Canada,** LGBTQI+ individuals report high levels of mental health concerns, particularly depression, anxiety, and suicide attempts. However, access to mental health

services is generally better than in other regions, although disparities persist due to discrimination in healthcare settings (Bränström, 2024).

LGBTQI+ populations in **Latin America** face significant challenges due to widespread social stigma in combination with high levels of violence (Mendoza, 2019).

Mental health outcomes in **Western Europe** are generally better, thanks to more inclusive social policies and better access to healthcare. However, in Eastern Europe, LGBTQIA+ individuals face more intense stigma and legal discrimination, resulting in worse mental health outcomes. The contrast between more progressive and conservative countries within the region highlights the importance of legal protections for LGBTQI+ populations and the negative health impact of criminalization (Pachankis, 2019) (Bränström, 2024). Contrasts are exacerbated by differences in levels of access and quality of mental health care across the region.

In **Africa and the Middle East**, LGBTQI+ individuals **face extreme levels of violence, social exclusion, and legal discrimination, often leading to mental health issues such as PTSD, depression, and suicidal ideation.** In some regions, **homosexuality and gender nonconformity are criminalized, which forces LGBTQIA+ people to conceal their identities and increases their levels of stress and anxiety** (Bränström, 2024). **Availability of quality mental health services in many Sub-saharan countries is low in general, let alone LGBTQIA+ inclusive mental health care. Little research describes mental health status of LGBTQIA+ people in these regions, and knowledge about the difference between subgroups is sparce**. It seems mental health outcomes for transfeminine individuals is particularly bad, potentially due to the strict social role patterns in these regions.

5.3.3 Physical Health Risks

The physical health risks faced by LGBTQIA+ people are **multifaceted** and often **interlinked**, they are shaped by a combination of societal discrimination, barriers to healthcare, and specific vulnerabilities related to identity. These **health risks vary significantly between subgroups and across different regions due to cultural, legal, and healthcare access factors.**

The subgroups described below are not exhaustive but reflect a selection that is clinically relevant to highlight specific medical issues, respecting the fact that current research and evidence is incomplete and that individuals may fall in multiple of the described subgroups.

5.3.3.1 Lesbian and Bisexual Women

For a significant time after homosexuality among men had been described as a disorder, same sex female orientation or sexual behaviour, was not recognised as such. Mostly because there was little note of female sexuality in general, though regional and cultural differences existed. In 19th century the phenomena of female assuming different gender roles and sexual behaviour became more recognised and classified as a disorder. The word lesbian (from Greek poems of Sappho, an ancient, presumably lesbian, poetess) was applied, next to female homosexuality, and describes both sexual orientation and behaviour. Although orientation and behaviour do not always coincide, and where medically relevant, behaviour should be asked rather than assumed.

Cancer: Lesbian and bisexual women may be at **higher risk of certain cancers, particularly breast cancer and gynaecological cancers** (Tundealo, 2023). This is partly due to lower rates of preventive screenings like Pap smears and mammograms. Studies suggest that **stigma and discrimination in healthcare settings deter them from accessing regular screenings** (Tracy, 2010). Not only do they have difficulties to get screening but even after diagnosis they have **less access to cancer treatment**. **Higher stress levels** as well as **obesity and alcohol** use contribute to increased prevalence. Additionally, **lower oral contraceptive use and nulliparity increase risks** on breast cancer and ovarium cancer. It is advised to apply same screening regimen as in heterosexual cisgender women. Especially for the Pap smear,

clinicians should realize that diverse sexual behaviour or gender expression does not eliminate the risk for cervical cancer (Bailey 2000). SGM women have an **increased risk on HPV**, the virus often causing cervical cancer. The same pap smear screening regimen should be offered to everyone born with a cervix. For ovarium cancer no additional screening is advised, unless if familial risk factors are present, however the increased risk should be kept in mind, and preventative oral contraceptives can be discussed (Peitzmeier, 2014).

Obesity: Lesbian and bisexual women are **more likely to be overweight or obese**, studies show a 20% higher prevalence compared with heterosexual women (Stevens, 2023). Binge **eating disorders** also are more frequent in lesbian and bisexual women. Presumably **chronically increased stress levels are the root cause, combined with increased prevalence of depression and alcohol use.** However, a more **culturally informed explanation of the rejection** of the slim heteronormative cis female body image amongst the lesbian community may contribute as well (Roberts, 2022). The associated risks of obesity (diabetes, cardiovascular diseases) should be highlighted when counselling SGM women for weight loss.

Cardiovascular Disease: Lesbian women are more likely to smoke **tobacco and use alcohol, experience chronic stress and obesity**, which are all risk factors for cardiovascular diseases. As a result, **hypertension and various heart diseases** are more common in lesbian and bisexual women. Additionally, **disparities in healthcare access** reduces the chances of early detection and preventative care (such as antihypertensive treatment) (Carceres 2021).

STI/HIV: Studies seem to indicate **increased risk on STIs, including HIV, in lesbian and bisexual women, especially those who have (also) sex with men** (Nankikana, 2016). Transmission rates between women are limited (but not excluded), leading to the current advice to **base STI screening on symptoms and behavioural risk factors** (Bauer, 2001). Transmission between women includes trichomoniasis, HIV, HPV, herpes simplex virus, hepatitis C, syphilis, chlamydia, and bacterial vaginosis (BV) also via sex toys and fingers transmission is possible (Bauer, 2001). Preventatively apart from safe sex, **HPV vaccination should be offered**, HIV negative individuals with substantial risk (sex work, (changing) partners with unknown state, recent STI), **Hepatitis A and B vaccination can be considered for SGM women with additional risk factors** (for example sex work or injectable drugs) (Tao, 2008).

Sexual and Gender Based Violence: Lesbian and bisexual women are at **increased risk to experience sexual and gender-based violence, intimate partner violence (IPV) particularly**. IPV refers to actual or threatened psychological, physical, or sexual harm by a current or former partner or spouse. According to surveys IPV (rape, physical violence, and/or stalking) is experienced by 61 percent of bisexual women, 44 percent of lesbian women, and 35 percent of heterosexual women (Corey, 2022). All women should be screened for IPV, a trauma-informed approach should be adapted and if screened positive support should be given to plan safety measures and assess medical and referral needs.

5.3.3.2 Gay and Bisexual Men

While in the Western world the term ‘gay’ is widely used and recognized across many languages and cultures, not all men who have sex with men would identify with this term (Bonvicini, 2003). Historically the term homosexuality was used to describe mostly male but also female individuals, but since this word has been so often misused in hate speech and verbal abuse, in many countries it has been replaced with other terms (such as gay). It is important to recognize people from various languages and cultures may not use the same definition and wording, and understand the difference between sexual orientation and sexual behaviour, as not all men romantically attracted to men also has sex with them, and not all men that have sex with men are romantically attracted to men (National Academies of Sciences, 2020). Also gender identity may vary independent from sexual attraction and behaviour. Most medical research about LGBTQIA+ related health issues is focused around MSM (and HIV/STIs). Therefore,

it is a practical term to use in relation to evidence-based medicine, yet not particularly an appropriate term to use towards a patient.

Some MSM struggle with **cognitive dissonance, stigma, and internalized homophobia** related to their sexual behaviour and may not identify as MSM or as any sexual minority. Others may identify as such internally but have not (yet) disclosed or chosen not to, due to fear of stigma, rejection and criminalization (Pallerla, 2022). Some do not even consider same-sex acts at all as sex or are in denial about their own acts. **Stigma, oppression, and stress related to sexual desire, sexual activity, and sexual identity may result in riskier sexual behaviour and influence the risk for sexually transmitted infections (STIs) and certain cancers**. Understanding a patient's sexual orientation, including one's identity, behaviour, and desires, if the patient can disclose to a trusted clinician, greatly impacts the ability to provide holistic quality care.

HIV/AIDS: Gay and bisexual men continue to face a **disproportionately high risk of HIV/AIDS and other STIs** such as syphilis and gonorrhoea, especially in regions where access to preventive services (e.g., pre-exposure prophylaxis or PrEP) is limited (Arreola, 2023). Globally, new HIV infections are decreasing, but **>60% of new infections are amongst men who have sex with men** (CDC, 2022), rates are particularly high in regions like sub-Saharan Africa and Eastern Europe, where **healthcare access may be restricted or criminalized** (Nakweya, 2024). In western countries Black MSM minority groups tend to have the highest infection rates, related to diminished access to care and delayed testing and recognition of HIV in this group. The high viral load in this group also increases the transmission chances per single encounter. Successful intervention can best be achieved with a combination of preventative measures, of which **universal screening, PrEP, and harm reduction approaches** are key to allow patient-informed decisions for risk management (Mermin, 2012). Ensuring HIV care for all MSM that have HIV and ensuring annual screening for all sexually active MSM is essential. Direct access to ART after HIV infection is a meaningful way to control viral load in the individual and therefore reduce the morbidity and minimizing the transmission risk. PrEP should be advised for men with significant exposure risk, and PEP for those after relevant exposure, serosorting of sex partners can be advised to reduce risk of spreading within community (Paz-Bailey, 2016). Though condoms are reducing transmission risks in anal and vaginal intercourse when used correctly, it must be understood that **many MSM prefer condomless sex and therefore other prevention options should be offered**. Also, advice on safer practices for oral sex and sex toys should be offered (CDC, 2013) (Paz-Bailey, 2016)**.**

STIs: MSM also have **increased risk on other STIs, especially syphilis**. In the US in 2020 the new diagnosis of chlamydia, gonorrhoea and syphilis decreased in 2020, yet **most of the diagnosis are in MSM** (CDC, 2022). Men that are seropositive have an even higher risk on other STIs (especially bacterial ones). Risks of transmission for herpes, chlamydia, gonorrhoea and syphilis are significant in oral, vaginal and anal intercourse. If condom use is not preferred the option of **pericoital antibiotic prophylaxis** can be considered (Grant, 2022). Doxycycline is the advised drug for this, however currently little is known about long term effects on individual and community level. Especially with regards to AMR this should be carefully considered. Some studies on longer term effects are currently ongoing in USA and Canada and guidelines are in development. **For those sexually active a yearly screening** (HIV, chlamydia, gonorrhoea, syphilis) is advised, except if in a mutually monogamous relationship for minimum one year with equal HIV status. **Sexual history taking is needed to decide whether anal, genital and/or oral swaps should be taken**. In **MSM with various partners and unknown HIV status, screening interval should be reduced to 3 months**. For Hepatitis A and B, a single screening is indicated and Hepatitis C one time as well, but annually for MSM on PrEP. **Immunizations are recommended for Hepatitis A and B, HPV (ideally before becoming sexually active)** (CDC, 2020).

Mpox: A recurrent outbreak of the last years is Mpox, previously referred to as 'monkeypox' but renamed due to the stigmatizing naming of this zoonotic disease. The outbreak of 2022 in Europe and

USA affected almost only MSM. Mpox can be transmitted via sexual and other intimate contact, the current (2024) outbreak is spreading from DRC and surrounding countries, is more contagious, and seems less associated with MSM. Vaccines are currently available and to prevent further impact globally it is advised they will be distributed where needed most and equal amongst risk groups. **LGBTQI+ individuals diagnosed with any STI over the last 6 months are described as risk group for Mpox and prioritized for vaccination**. (Acharya, 2024)

Meningococcal Meningitis: In USA, Europe and Canada cluster infections of meningitis infections have been recorded, leading to the recommendation to **vaccinate MSM against meningococcal meningitis** (CDC, 2012).

Cancer: **Anal carcinoma** is more common in MSM, especially in men with HIV, but it has also been found in those without HIV infection. It starts with HPV infection and develops gradually from dysplasia into carcinoma like cervical HPV infection. Although **no official screening protocols exists, due to the increased risk some centres advise yearly screening for anal interepithelial lesions and anal HPV in MSM that have receptive anal sex. Oropharyngeal cancer** is also associated with HPV, and MSM seem to have increased risk, yet no special screening is recommended so far (Oliver, 2018). **Some other types of cancer (such as bladder, kidney and skin) seem to occur with increased prevalence in gay and bisexual men as well, though correlation is not yet understood** (Tundealao, 2023)

Cardivascular risk: **Minority stress** can induce physiologic changes including **metabolic dysregulation and cortisol function and related impaired cardiovascular health.** It is also associated with **substance use** (including tobacco and alcohol) especially in persons of colour, which increases the risk of cardiovascular disease again (National Academies of Sciences, 2020). HIV positive MSM that are on ART have additional risk. **No increased CVD screening frequency is advised, yet regular screening should be encouraged.**

Violence and victimisation: Rates of intimate partner violence amongst MSM are like heterosexual partners (Liu, 2021), however **youth are at increased risk of dating violence**. Little screening is done for youth or adult MSM IPV and facilities to protect survivors after reporting are seldomly available for men.

Sexual assault among gay men is often underreported due to victim shaming and bias among some law enforcement officers (Willis, 2014). **SGBV programs are often unprepared** to deal with (gay) male (and especially gay male) victims of sexual assault and rape and even some legal definitions of rape exclude male victims. Clinicians need to consider the high prevalence of violence and hate crimes against gay men, discuss with patients whether they have ever been physically or emotionally assaulted so that appropriate trauma-informed interventions can be deployed.

5.3.3.3 Transgender and Gender Diverse Individuals (TGD)

In general children get assigned their gender at birth based on genital anatomy, or even prior based on genitals on ultrasound or chromosome tests. In fact, the concept of sex and gender are mixed up in this case, with the majority sex and gender assignment and gender identity matching, thus for most people this is not an issue. **Some children have a gender identity that does not align with their assigned gender, either because it is the opposite or because their identity is not binary and/or fluid** (Spack, 2012) (Vries de, 2012) (Hewitt, 2012) (Olson, 2019), they are called 'transgender' or 'gender diverse' (TGD).

Development of gender identity is a gradual process throughout childhood and adolescence, usually stabilizing itself before or around puberty age. It is a very vulnerable process, especially if a youth discovers their experience of gender is different from the majority and from what is expected. Even more so when they become aware of stigma and or criminalization. A clinician therefore may have additional special responsibilities to fulfil depending on the age and stage of gender identity development and/or transition the TGD patient is in (Olson 2019). 'Genderplay' and 'gender diverse expression' in childhood are more common and do not always persist in adolescence and adulthood. Persistent, consistent and insistent expression of non-traditional gender identity towards puberty age, usually remains.

Ambivalence and fluidity in gender expression does not contradict the genuine identity of a gender diverse individual and should not hinder access to treatment.

The **TGD youth needs an affirming environment**, both in the form of family acceptance and other social settings, to freely explore and express themselves in their authentic form, or even to discover what that is (Durwood, 2017) (Olson, 2018) (Olson 2019). The clinician can play a role in guiding the family and the youth through this process by providing information and assurance, increasing acceptance and support capacity. In case of mental health issues, such as low self-esteem, self-loathing, depression, self-harm, suicidality or victimization, appropriate and inclusive treatment must be provided promptly. In case of less supportive family situation separate counselling for caregivers should be considered.

In **any TGD patient, the individual needs and goals in gender development and/or transition should be explored to map an appropriate treatment plan** and ensure referrals or multidisciplinary teams can be made accordingly were needed and possible. Needs for physical and mental interventions vary, as does the wish for transition and whether this should include hormones, surgery and other medical steps (Lykens, 2018). While multidisciplinary teams are successful, they are very rare, usually have long waiting lists and not accessible everywhere. Care via primary healthcare with consulting specialists can offer an alternative (Bonifacio, 2019) in combination with online counselling which has proven positive results in rural settings (Ranikine, 2023).

In formation is needed aboutwhich trans care treatments are allowed or prohibited under law, along with requirements for official transition (changing sex marker birth register), if possible.Legal implications for caregivers vary from country or even region. It is advisable to be aware of local laws (Warling, 2022). This may result in patients accessing medications online and starting treatment without medical supervision, meaning that without baseline and control investigations, uncontrolled regimen and dosing increases complication risks (Garofalo, 2006) (Rotindi, 2013). When transition is made from youth to adult care this should be done with thorough handover and care.

Mental health interventions: Level of 'gender dysphoria', the discomfort with the birth assigned gender, is different for everyone as is the level of 'body dysphoria' (which may or may not co-occur). Also, what is needed for people to alleviate the dysphoria is not the same (Vance, 2014). The subject of trans care is still young in medicine and research, but **gender-affirming approaches** are currently preferred. This evolves around **active promotion of exploration, creating safe settings for self-definition and using a patient's own wording and guidance in the treatment process** (Hill, 2010) (Olson, 2018) (Bonifacio, 2019) (Rafferty 2018). Gender diversity is not an illness, and it may be needed to inform caregivers, patients or (medical) colleagues about this. In some cases, **psychotherapy can be useful to integrate gender diverse experiences into the assigned gender**. However, for others changes in gender role and/or gender expression may be indicated (Tuerk, 2011), which might include hormones and/or surgery, but **could also be limited to social transition into the affirmed gender.**

Harmful approaches: Evidence is growing that **wait and see** (watchful waiting, expecting it is a phase) approaches, **redirection** (eliminate gender-diverse desires and steer back to assigned gender), and **reparative therapy** (religious conversion therapy) are harmful and therefore **should not be provided any longer** (Rafferty, 2018).

Phenotypic interventions: Social transitioning allows the TGD person to live in their affirmed gender by creating a congruent phenotype through **name, pronouns, clothing, hairstyle, make-up, binders, protheses, packers etc., yet it is a completely reversible intervention**. Studies show overall decreased rates of dysphoria and depression however individual safety factors need to be considered and expected to be outweighed if there are legitimate concerns. It may help to plan actions in case of bullying, rejection or other anticipated retributions in advance (Reilly, 2019) (Simons, 2013). Sometimes (partial) social transition is used as a **try-out phase** (usually between 7-14 years of age) to decide less reversible components of transition, retransition is very uncommon (less than 4%). **Individual needs should guide**

the transition process, and the provider should be aware not all trans people require steps beyond phenotype alterations, also the order of steps can vary (Lykens, 2018).

Medical documentation: While in context with rather **hostile legislations it is advisable to offer the option of excluding any SGM notion from the medical file.** In other contexts, clinicians may be asked to support with medical documentation required for name and/or gender change, it is good practice to be aware of local requirements.

Hormone interventions: Some TGD may require additional steps to regulate their gender dysphoria, one or multiple hormonal interventions may be considered. When the gender identity is persistent and consistent from childhood into early puberty it seldomly subsides. **Suppression of puberty (gonadotropin-releasing hormone analogues, GnRH)** can help to block or delay the irreversible development of secondary sexual characteristics, which otherwise tend to increase gender dysphoria in most TGD people (Cohen, 1988) (Spack, 2012) (Hembree, 2017) (Edwards, 2012) (Chen, 2023) (Steensma, 2013). **Ideally suppression should be started upon start of puberty** (entry into Tanner stage 2). Depending on if the individual is non-binary or transgender different regimens in duration and dosage can be considered, to allow outcomes matching the envisioned transition, for example to reach a more androgynous effect (Xu, 2021) (Cochetti, 2020). Wanting and receiving puberty blockers is associated with **lower depression and suicidality rates** (Turban, 2020).

Eventually **gender-affirming hormones (GAH)**, testosterone for transmen and oestradiol for transwomen, may be introduced to **promote development of secondary sexual characteristics of the affirmed gender** (Lavender, 2023) (Spack 2012). Almost all youth starting with GnRH analogues continues with GAH, if not and GnRH is stopped endogenous puberty will occur. Ideally introduction of GAH is timed concordant with peer puberty stage, the effects occur gradually and are (partially) irreversible. Access to GAH for those wishing to receive it is associated with **reduced suicidality** (Green, 2020) (Olsavsky, 2023). If GAH is started after puberty is completed, it will not undo the secondary sex characteristics but will promote development of characteristics of the other sex. Both GnRH analogues and GAH **need to be titrated on individual dose and frequency and come with different forms of administration**. GnRH is titrated mostly on effect on puberty development (if puberty progresses dosage should be increased), endogenous hormone levels are monitored together with weight and height (desired height outcomes should be considered in puberty suppression) and bone density. Usually decreased bone density levels in GnRH are improved again when GAH is started.

Contraindications for GAH in transfeminine individuals are oestrogen-sensitive cancers, increased thrombosis risk should be monitored and mitigated but is not a contra-indication. For **transmasculine individuals, testosterone sensitive cancers, severe liver function impairment and polycythemia are contra-indications**. If on **GAH therapy respectively testosterone or oestradiol levels should be monitored, combined with liver and renal function, glucose, lipids and HbA1c** (Hembree, 2017). As hormonal therapy can come with fluctuations in mood (induced by changing hormone levels) it is strongly advisable to pair with **mental health therapy**, if multidisciplinary treatment is not available the clinician needs to be well informed about physical and mental aspects of hormone therapy (WPATH, 2022).

Transgender individuals undergoing hormone replacement therapy (HRT) may face specific health risks, such as an increased risk of cardiovascular disease, thromboembolism, and liver complications from the long-term use of hormones like oestrogen or testosterone (Hembree, 2017). This underlines the **need for monitoring to allow preventative measures** when complications arise, overall, the **beneficial effects of hormone treatment outweigh the risk for most patients**.

Surgical interventions: Possibility of surgical interventions may differ per country or region, but it is **important to assess the needs for it**. Many surgical changes are irreversible, and some practices stem more from gender marker change than anything else. Most interventions are aimed at directly visible futures, such as breast removal or enhancement, cheek bone structure, nose and chin (Olson, 2018).

Rarely biological genital organs are altered in genital reconstruction surgery, as it may influence the capacity to have enjoyable sex and is a long process that can have other complications as well. **Gonadectomy** is usually done when GAH hormone therapy is started.

Fertility: It is important to emphasize that **pregnancy can occur as long as reproductive organs are in place and involved in sexual activity, even when using GAH**. Exogenous testosterone alone does not prevent pregnancy. **Contraception should be offered for those who want to avoid pregnancy** (Light, 2014). **Long-acting contraception for trans-masculine individuals has the additional benefit of amenorrhea**. On the other hand (potential) child wish should be discussed ideally before initiation of hormone therapy and needs for preservation of fertility should be considered. It is possible for transgender individuals to have genetic children; the likelihood differs per case and advise needs to be **tailored to the individual** (Light 2014) (Obedin 2016).

Violence and Physical Assault: Transgender women, particularly those of colour, face **extreme rates of violence and homicide**, especially in regions with hostile legal frameworks. As much as 47% of transgender persons were sexually assaulted at least once in their lives. They are also nearly twice as likely to experience intimate partner violence. This directly leads to poorer physical health outcomes, with many **suffering from trauma-related injuries**. Unfortunately, due to the same hostile legal frameworks, likelihood of safe support from police and medical services is lowest where the need is highest.

Cardiovascular Health Risks: TGD people face an **elevated risk of cardiovascular diseases** (CVD). **Minority stress and associated mental health conditions**, accumulated trauma due to adverse childhood events contribute to this risk. **Lifestyle factors like smoking**, often higher in the transgender population, contribute to this risk. In remote and rural settings where CVD screening and risk management is less available, the negative impact is higher (WPATH, 2022). **Hormone replacement therapy can increase CVD risk, especially for transfeminine people**. **Oestrogen can increase the risk of thromboembolic events**, such as deep vein thrombosis and pulmonary embolism, especially when dosage is badly controlled. **Testosterone therapy**, for transmasculine people, can lead to increased **haematocrit,** which may indirectly raise the risk of **thromboembolic events**. Long-term effects of testosterone on **lipid profiles** might increase the risk of heart disease as well. Routine cardiovascular monitoring, including regular blood pressure checks and lipid profiles, should be part of standard care for transgender people on hormone replacement therapy. Smoking cessation programs specifically tailored to transgender individuals are also critical to reduce accumulative risk effects.

Cancer: All individuals with a cervix, especially when sexually active, have risk of HPV infection which can evolve into cervical carcinoma. However, **transmen may be denied screening, increasing the risk of late diagnosed infection or carcinoma**. Both for transmen and transwomen cancer screenings should be based on the **present organs and their risk profile based on (sexual) behaviour** and not based on their gender identity (WPATH, 2022).

Bone Health: Hormone replacement therapy with testosterone can impact bone density, and without proper monitoring, transgender men may be at an increased risk of **osteoporosis**. While testosterone generally supports bone density, inadequate levels of oestrogen, especially after oophorectomy, can lead to bone loss. Also, **transwomen after gonadectomy are at risk if replacement therapy is not properly dosed or interrupted** (Hembree, 2017). To mitigate risk, bone density should be monitored, and vitamin D and calcium supplements can be offered.

Sexual Health and HIV: Transgender women, **especially those engaged in sex work**, are at high risk for HIV and other sexually transmitted infections (STIs). Factors contributing to this increased risk include limited access to healthcare, discrimination by healthcare providers, and socioeconomic vulnerabilities. In some regions, HIV prevalence among transgender women can be as high as 40%. Some HIV services do not recognize transgender women as a risk group and tests or screening may be denied, expanding access to PrEP (pre-exposure prophylaxis) and PEP (post-exposure prophylaxis) is crucial in

reducing HIV transmission rates. Additionally, sexual health education that is inclusive of transgender experiences, and sex behaviours, along with routine STI screening, should be standard care (CDC, 2022).

Healthcare Access and Discrimination: Transgender individuals experience **disproportionately frequent challenges to accessing healthcare (even compared to other LGBTQIA+ individuals)**, including discrimination by staff and patients, being denied access to relevant screenings, denied to SRH/maternity/gynaecology department, or assigned a hospital ward non congruent with their affirmed gender. Additionally, they often receive incorrect or incomplete treatment or advice due to knowledge gaps. These barriers often lead to delayed care or avoidance of healthcare settings altogether, **exacerbating existing health conditions** (WPATH 2022). Training healthcare providers in transgender-inclusive care practices is essential to reducing discrimination and improving health outcomes. Policies that protect transgender individuals from discrimination in healthcare settings can also help ensure that transgender women receive the care they need.

5.3.3.4 Intersex or Difference of Sex Development (DSD)

When a child is born with **genitals not typically male or female in appearance, or seemingly not congruent with the chromosomal sex**, they are currently referred to as having a Difference (or Disorder) in Sex Development. This occurs in about 1 out of 4500 live births (Lee, 2006), about 1,5% of the population self-identifies as intersex (Blackless, 2000). The term DSD is criticized by scientists for being too broad and unspecific, patient groups do not identify with 'disorder' as it is too negative, 'difference in sex development' is better accepted and remains the current medical/scientific consensus. The term 'intersex' was reclaimed and is still commonly in use, especially in street language, while terms as 'hermaphrodite' and 'pseudohermaphrodite', 'natural eneuch' are considered inappropriate and stigmatizing (Ahmed 2021).

Initial Care: The clinician responsible for initial care and evaluation of an infant with a suspected DSD should determine an accurate diagnosis yet avoid premature assignment of gender/sex. One common DSD condition, **congenital adrenal hyperplasia (CAH), is associated with life-threatening salt-wasting crisis in the first days of life, if anticipated timely this should be prevented** (Lee, 2006). A workup to guide gender assignment and informing and supporting the family through this process is crucial. Health of the baby should be the central point of attention, if there are health concerns, they prevail in priority over DSD. Be clear that even if surgical interventions are indicated and performed, being DSD **is more than an anatomical condition and is lifelong** (Diamond, 1997).

Salt-wasting crisis: As mentioned above individuals with CAH (those with more severe mutations) have a significant risk to develop a salt-wasting crisis in the first 10-20 days of life (earlier in rare causes of CAH). This presents with vomiting, diarrhea leading to hypotension, hypovolemia and shock if not adequately handled (Donaldson, 1994). Any child with atypical genitals should be suspected of CAH, with monitoring of electrolytes (serum and urine), plasma glucose and steroid precursors. Hyperkalemia (can be with hyponatremia, metabolic acidosis, hypoglycemia). **If CAH is diagnosed lifelong monitoring and treatment is needed to prevent salt wasting crisis.**

Evaluation: History should include prenatal history (maternal or fetal issues during pregnancy, any tests/findings, previous pregnancies), family history (congenital illnesses), consanguinity (Bever van, 2023). Thorough physical examination is needed, to exclude other congenital malformations and describe in detail the genital aspect, which may help to deduct the categorization of the DSD (Srivastava, 2023). Features may include **bilaterally non palpable testes, microphallus, scrotal or perineal hypospadias, clitoromegaly, palpable gonads in the labioscrotal folds or posterior labial fusion** (Straaten van der, 2020) (Ea, 2021). Laboratory tests ideally include karyotype (or other rapid assessment of chromosome set), -17-hydroxyprogesterone (infants without palpable gonads), to screen for CAH (21-hydroxylase deficiency). Serum electrolytes (repeated every 24 to 48 hours, to monitor salt-wasting until CAH is

excluded), cortisol, LH, AMH, testosterone (Lee, 2006). Additional tests can be done for other causes of CAH in infants with salt-loss. Abdominal and pelvic ultrasound is advised to detect if gonads, uterus, and vagina are present. Multigene testing is the next step if previous tests are not conclusive. The outcomes together may direct DSD into one of the three main categories: XX DSD, XY DSD or Sex Chromosome DSD.

Categorization and management:

46 XX DSD: CAH is the main cause of atypical genital development in these infants, often caused by 21-hydroxylase deficiency, but rarer causes occur. This usually presents with virilization of the neonate without palpable gonads. In rare occasions it may show as normal external male genitalia without palpable gonads. As the associated salt-wasting crisis can be fatal CAH should be assumed and the infant monitored accordingly until proven otherwise (Speiser, 2001). Alternatively gestational hyperandrogenism, aromatase deficiency, testicular DSD and ovotesticular DSD can be caused by gonadal overproduction of androgens. In these cases, female gender identity is commonly the outcome. Glucocorticosteroids can be used to suppress androgyn production. Feminizing surgery may be considered but remains disputed between specialists and experience experts; clitoroplasty can be delayed until the child is of age to be informed and assent, surgical construction of urogenital tract should be delayed as well unless severe health risks are associated with the anatomy (Diamond, 2014). In case of 46 XX with male phenotype management choices are more complex and should be considered on case-by-case basis (Gonzales, 2016) (Lee, 2006).

Ovotesticular DSD (previously 'true hermaphroditism'): Infants with absence of ovarian tissue, but with primordial follicles and testicular tissue most commonly an ovotestis (a gonad with both ovarian and testicular tissue intermixed). Often occurring with 46 XX genotype (Sircili, 2014).

45X/46XY mosaicism: Gonadal dysgenesis due to mosaicism is the second most common cause and comes with a highly variable phenotype, depending on the level of mosaicism. It can include phenotypically normal males (majority of patients, often undiagnosed), males with severe hypospadias, males with female genitalia (Hughes, 2012). Descended, but commonly infertile gonad may occur right sided. Male gender identity is likely, yet mostly even if a scrotal testis is present, they are infertile. If the phallus is unresponsive to androgen stimulation, surgical outcomes tend to be poor (Kolesinska, 2014).

46 XY DSD with atypical genital anomalies: This can be caused by defects of testicular development, uncommon forms of CAH (risk of adrenal crisis) and various rare conditions (Reiner, 2004). These include disorders of androgyn synthesis, complete androgen insensitivity syndrome (external female genitalia, often female gender identity), or partial androgen insensitivity syndrome (atypical male genitalia; microphallus, severe hypospadias or undescended testes). Male identity is likely, delayed virilization can happen in puberty and they are likely responsive to androgyn treatment.

46 XY DSD with severe genital anomalies: The genetical explanation of these anomalies are currently not (yet) described, phenotypes may include infants with micropenis, penile agenesis (aphallia), and cloacal exstrophy. These cases are rare and complicated and surgical considerations should focus on health risks of the anatomy and functionality (Garaffa, 2014).

Sex of Rearing: Parents and family may suffer from uncertainty about the gender/sex of the infant and especially in more conservative religious or cultural contexts with strong division gender roles, the pressure may be high to make a swift conclusion. However, it can take months until direction can be given with more certainty, and it will never be truly predictive for gender identity (which seems primarily innate). Therefore, for the long-term wellbeing of the individual rushed decisions should be avoided (Ahmed, 2021).

The type of DSD needs to be assessed, and family should be counselled that the atypical appearance is uncommon but explainable (it can be phrased as 'over developed' or not 'fully formed') and informed about concept of gender identity that gradually develops (Lee, 2006). Depending on the type of

DSD the 'prognosis' of the gender identity is more or less trustworthy, at best it will be possible to give an evidence-based guess, but it will never be certain (Warne, 2008). Advise on sex of rearing should explain this (in)predictability. Adult psychosocial and psychosexual function (including potential fertility) should be considered. Degree of virilization may be a marker of androgen exposure (Loch, 2019). Parents of more ambivalent cases can be counselled to raise their child with 'wait and see' approach with a non-gendered name (Moshiri, 2012), although eventually the choice of the parents needs to be accepted and supported. Culturally appropriate support and advise needs to be given tailored to the educational level of the parents.

Long-term issues: Psychosexual and psychosocial support: Long-term support for adjustment to the impact of DSD, aid in decision-making should be offered for DSD individuals and caregivers, choices may change as the child develops. Additionally, patients have increased risk of developing depression, anxiety, body dysphoria and other mental health issues related to the minority stress and potential medical traumas. This should be screened to allow early treatment. Special care should be given to transition from paediatric to adult care (Ernst, 2018).

Ongoing medical concerns: Children and adults with DSD have an **increased potential for malignancy in retained gonadal tissue**, the risk depends on the type of DSD. Based on the patient's phenotype and histology of testicular material advise may be given on monitoring and surgery (indication and optimal age of surgery are highly variable).

Other health risks include effects of sex steroid exposure and decreased bone density which need to be carefully monitored.

Violence: Statistics for intersex individuals are less commonly reported, yet available data indicate that they face **high levels of physical and sexual abuse**. Intersex people are vulnerable to violence both within healthcare settings (e.g., non-consensual medical interventions) and in social contexts due to societal ignorance and stigma.

5.3.3.5 Asexual individuals

Asexuality should be understood as a legitimate sexual orientation that comes with its own specific implications for healthcare. **Healthcare providers need to be educated about asexuality to provide appropriate and sensitive care**, especially regarding **reproductive health and mental health** (Schneckenberger, 2020). This group is very poorly represented in data collection and research; thus, little is known about health risks and interventions.

Sexual education: Asexual persons often receive inadequate sexual health education that does not reflect their experiences. A report from the Asexual Visibility and Education Network (AVEN) provides resources for healthcare professionals to better understand the needs of asexual individuals and the importance of comprehensive sexual health education (AVEN, 2021).

Reproductive Health: Asexual individuals may have specific reproductive health needs, including discussions around contraception and sexual health. An article emphasizes the necessity for healthcare providers to engage in open discussions about these needs without assuming sexual desire or activity (Rogers et al., 2020). The challenge lies in addressing the topic (which tends to be avoided) yet without making assumptions.

5.3.3.6 Special Considerations for LGBTQIA+ Youth:

The components of preventive health and health maintenance for sexual minoritized youth are the **same as for all adolescents yet special attention is needed for appropriate risk management.** Additionally, **the clinician can play a role in planning the disclosure process and coping or mitigating stigmatization and discrimination and security risks at home, at school, and in society. Privacy and confidentiality are essential in consultation, documentation and environment** (Laiti, 2019).

Psychosocial history: Components of the adolescent psychosocial history relevant for risk reduction include strengths, home situation (family cohesion and chosen family), other support systems, education and employment (presence of bullying or harassment), eating, social activities (use of electronic media to meet partners), intoxications, sexuality and specific sexual (risk) behaviours, symptoms of depression, anxiety, and suicidality, safety at home, at school, and in interpersonal relationships (Clark, 2024). Additionally, the **stage of outing, and potential risk of (further) outing should be explored.**

Recommended screening: For sexually active youth **annual screening for chlamydia, gonorrhea, and syphilis is recommended**. More frequent testing for adolescents positive for an STI is indicated. **HIV screening** at least annually for sexually active MSM and other youth at increased risk (who or whose sex partners had more than one sex partner since their last HIV test) (CDC, 2020).

Immunizations: SGM youth should receive immunizations as recommended for all children and adolescents, additional advice includes **hepatitis A vaccine, hepatitis B vaccine, human papillomavirus (HPV) vaccine, meningococcal vaccine, and, for those who are behaviorally at risk (eg, sexually active MSM), mpox vaccine** (CDC, 2020).

Anticipatory guidance: Anticipatory is based on reinforcement of strengths, health promotion, information about healthy dating relationships, prevention of HIV and STI, contraception, and counselling about intoxications (alcohol, tobacco, drugs).

5.3.3.7 Special considerations for LGBTQIA+ Reproductive health:

Sexual dysfunction and libido: Little is known about sexual (dys)function in SGM compared to cisgender heterosexuals and the few studies available are difficult to compare due to difference in design. However, clinicians **should be prepared to support SGM with sexual problems and non-judgmental advice based on the individuals' sexual practices** (Mijas, 2021).

Parenting: SGM encounter special obstacles in fulfilling their desires to become parents, including homophobic stigmatization and potential rejection by family. Even though **psychosocial development of children raised by LGBTQIA+ parents show no differences in sexual or gender identity, personality traits, or intelligence compared with children of heterosexual parents** (Thornton, 2021).

The desire to become parent should not be assumed based on sexual orientation or gender identity. Options, biological or other, to become parent vary regionally and local LGBTQIA+ organisations may be important support. In case of (desired) pregnancy, essential lifestyle advice and providing adequate tests and supplements are crucial as in any other pregnancy. Partners regardless of their gender should be welcomed and respected during all visits pre-, peri- and postpartum. Some of the health risks influence pregnancy as well and should be taken in consideration during antenatal care.

Transgender people using hormone therapy should be warned that gender dysphoria may worsen during pregnancy if hormone treatment is interrupted. Transgender men who become pregnant and give birth do not appear to be at increased risk for poor obstetric outcomes. A study observed a lower rate of caesarean birth, similar rates of preterm birth yet **higher rates of chronic medical conditions including anxiety and depression** (Thornton, 2021).

Unintended pregnancy: LGBTQIA+ people have less access to low-cost gynaecologic care as it is frequently provided via family planning clinics. Need for contraception should be considered based on individual sex behaviour, history and needs (Bowling, 2019). SGM women have a higher risk of unintended pregnancy than heterosexual women and **63 percent of SGM women reported they had had at least one abortion in their life** (Huang, 2024). Therefore, this possibility should exist in the mind of the clinician and appropriate support for safe abortion care followed by contraceptive counselling should be offered.

SGBV: LGBTQIA+ people have reported more **severe victimization and higher rates of sexual revictimization** (Lopez, 2021). Trauma informed and culturally competent care is crucial to assess individual care needs; **special attention should be given to protection needs and possibilities** (to note that safe places are often limited to women). **Studies show pregnancies in lesbians are almost 20x more**

likely to be the result of forced sex (including 'corrective rape') compared to pregnancies in heterosexual women (Jones, 2018) (Lagila-Molla, 2024).

Bisexual and transgender individuals should not be overlooked as risk groups for SGBV, and need for **termination of pregnancy should be assessed in anyone capable of being pregnant. Migrant populations (especially if detained), youth, SGM involved in transactional sex and transgender people are especially at risk for unwanted pregnancy as their changes on SGBV are higher while their access to care tends to be lower** (ICRC, 2022) (Caputi, 2020).

5.3.3.8 Regional Differences in Physical Health Outcomes

In a global comparison, **Canada and the USA** tend to offer less problematic access to care for LGBTQI+ individuals, including specialized services like PrEP and HRT (Albuquerque, 2016). However, huge regional differences exist (especially rural areas have worse access and less inclusive services). And even in those countries, discrimination still leads to significantly poorer health outcomes among SGM, particularly among transgender individuals and people of colour (Fish, 2021). HIV rates among MSM remain higher in communities with limited healthcare access, such as rural areas (Sulistina, 2024). Recent years have seen a steep increase in anti-LGBTQIA+ bills in the USA, including ones directly affecting healthcare. This is likely to increase discrimination and worsen health disparities in the respective states, especially for transgender people as they are targeted the most (Das, 2023) (HRC, 2023).

In **Latin America** LGBTQI+ individuals face **higher rates of violence, particularly transgender women and gay men**, who are vulnerable to physical assaults and homicide (Barrientos, 2024). The region also struggles with disparities in access to healthcare, particularly for transgender individuals, who may face stigma or legal barriers when seeking care (Munoz, 2024). HIV and other STIs are prevalent, especially in Brazil, which has one of the highest rates of HIV among gay and bisexual men in the world (Cabieses, 2023).

In **Europe** as a whole, violence against LGBTQIA+ people has increased in frequency and severity, even in countries that tend to be more inclusive. In **Western Europe**, where LGBTQIA+ rights are generally better protected, health services tend to be more accessible (the Netherlands pioneering in transgender care for example), and health outcomes are relatively positive (Kiely, 2024). However, in **Eastern Europe**, where anti-LGBTQIA+ sentiment and laws are increasingly more prevalent, LGBTQIA+ individuals face substantial barriers to healthcare. HIV rates are increasing in certain Eastern European countries, especially among young MSM due to limited preventive services and stigma (O'Dwyer, 2024) (Kiely, 2024).

For LGBTQIA+ individuals **Sub-Saharan Africa and the Middle East** are **extremely hostile environments**. Due to criminalization of homosexuality, it is increasingly dangerous for individuals to seek healthcare services (Nakweya, 2024). As a result, HIV prevalence is high among MSM, and access to life-saving treatments, like antiretroviral therapy (ART), is often limited. Transgender individuals in these regions are particularly vulnerable to violence and refusal of healthcare or absence of indicated health services.

In **Asia**, in countries like India and China, transgender and gay individuals face significant health risks due to societal stigma and discriminatory laws. However, in some parts of Southeast Asia progress has been made, for example in Philippines and Thailand (Wolter, 2022), transgender health services are becoming more accessible. Despite this, LGBTQIA+ individuals in much of Asia still face challenges such as limited access to gender-affirming care and lack of mental health services (Alibudbud, 2024).

5.3.4 Impact of LGBTQIA+ Health Disparities on Society

The health disparities experienced by LGBTQIA+ people lead to **poorer physical and mental health outcomes, higher mortality rates, and decreased quality of life** (Hatzenbuehler, 2014). Health disparities among LGBTQIA+ people affect the broader society by **increasing healthcare costs, burdening**

public health systems with a higher load of preventable diseases, and undermining public health goals, such as reducing HIV transmission (Sullivan, 2021). Additionally, the marginalization of LGBTQIA+ people **diminishes social cohesion and contributes to inequality**.

LGBTQI+ individuals are disproportionately affected by mental health issues, including depression, anxiety, and suicide, exacerbated by societal stigma and lack of access to appropriate mental health care. Increased risk to contributes to broader societal issues such as **homelessness, substance abuse, and unemployment** (Meyer, 2003). This can be seen as a response to the social marginalization, discrimination, and family rejection many LGBTQI+ individuals face (Jun, 2019). Elevated rates of drug and alcohol abuse in these communities are associated with broader social issues, including **increased crime rates, overburdening of public health resources, and strained social services**. Especially in countries were hostile legislations **increase the likelihood of LGBTQIA+ people living outside of the system.**

HIV/AIDS disproportionately affects men who have sex with men (MSM) and transgender women, particularly in regions like Sub-Saharan Africa and Eastern Europe, where LGBTQI+ people are heavily stigmatized and face criminalization. Lack of access to inclusive healthcare and preventive services fuels the **spread of the virus, and other infectious diseases along with it, creating public health crises that can affect the wider population** (Stannah, 2021).

6 Interventions

6.1 Inclusive language and inclusive practice

6.1.1 Initial Approach

As there is no common characteristic or profile that identifies a person as a lesbian, gay, bisexual, transgender, queer, intersex and/or other (LGBTQIA+), **clinicians should avoid assumptions about a patient's identity. They should rather adapt an open approach until they know what they need to know.** Apart from the terms used in this report to describe SGM and various subgroups, it is **advisable to learn about local and regional cultural and language preferences** related to SGM and refer to people with the words they prefer. To understand SGMs' specific concepts, language, health issues and needs within their local communities and adapt medical activities it can be helpful to host **focus group discussions** (Ginsburg, 2002) (Hoffman, 2009).

It is essential all patients are treated with **empathy, nonjudgmental attitudes, and openness** (Society for Adolescent Health and Medicine, 2022). Steps to create a welcoming environment for clinical care can include **training of frontline staff regarding unique care needs of sexual and gender minority patients, creating gender-inclusive intake forms and patient files, and resource materials (health promotion, health education), and using gender-inclusive language** (Brooks, 2018).

6.1.2 Cultural Competency

Cultural competency focuses on **effective communication**, supporting quality health care provision to patients from diverse backgrounds. It is crucial to acknowledge that **everyone has their own implicit biases**. **Recognition and often intervention is needed to self-regulate these biases** (Sabin, 2015). **Cultural differences** should be accepted, education on effective approaches to cultural sensitivity may help, learning to welcome individual perspectives as valuable. **Additional training is required to enhance active listening, open-minded questioning, emotional self-regulation and the ability to recognize and adapt to communication styles of others** (Roberts, 2018). From the intake form, the triage, the waiting area, the consultation, diagnostics, dispensary until they leave the clinic, an open approach should be

maintained, respecting the patient's full identity regardless sexual orientation, gender identity and sexual behaviour.

Creating an **environment of professionalism, ensuring confidentiality**, is crucial to allow people to **disclose** themselves and their problems. Also, **non-clinical staff around a care facility, should be aware of cultural competency, as their interaction with a patient may be equally impactful.**

6.1.3 Trauma Informed Care

Care providers need to understand the LGBTQI+ population is at high risk of negative outcomes because of bias, stressors, violence, and other challenges they face at increased level compared to the average population. Therefore, it is essential to integrate principles of trauma informed care into LGBTQI+ inclusive care interventions. **'Trauma informed care' refers to service systems that understand the causes and consequences of trauma, and that promote healing and resilience for patients and their relatives** (Fisher, 2012). This does not mean to indicate all LGBTQI+ individuals are traumatized or suffer mental issues, but to highlight that this approach is answering adequately issues many of the LGBTQI+ population are facing due to high exposure to trauma and its effects.

Trauma-informed care is guided by six core principles, all of which ideally are reflected in each care intervention, in a balance adequate to the specific context. **Safety**, referring to ensuring both physical and psychological safety for individuals, staff, and the environment. **Trustworthiness and transparency,** building trust through **open communication**, **honesty**, and **consistency** in actions and interactions. Involving **'Peer Support'**, recognizing the value of lived experiences and providing opportunities for individuals to connect with and support each other. **Collaboration and mutuality**, which means working with individuals, families, and communities rather than "doing to" them. **Empowerment**, emphasizing autonomous choice, giving individuals control over their care and respecting their decisions. **Acknowledging cultural, historical, and gender issues**, recognizing the impact of these factors on trauma and recovery.

Healthcare staff need to be educated on a variety of topics, including **vocabulary and definitions relevant to LGBTQ e.g., sexual orientation, gender identity; identity development and related stressors; types of trauma specific to LGBTQ, such as harassment, stigma, violence, family concern/rejection; the impact of traumatic stress on all aspects of development; and the core principles of a trauma-informed approach** (Guelbert, 2023). Awareness of the experiences and needs of LGBTQ+ population has implications for the types of policies and procedures adopted practices should be regularly examined to eliminate those that are re-traumatizing. This includes creating rigid, punishment-driven environments; employing harsh approaches to discipline or programming that mimic abusive experiences; adopting crisis intervention practices or emergency procedures that are further traumatizing; treating people disrespectfully; and establishing policies that minimize an individuals' voice, choice, and control.

6.1.4 History Taking

For all patients at first encounter, ask their **preferred name and explore how they want to be referred to, this may include but is not limited to pronouns and gender identity** (best to ask open question so they can inform you about appropriate/preferred wording).

When relevant for consultation ask their sexual orientation, **whether they have a partner, and which gender their current partner has and if they are sexually active** (these can be guiding questions to design an appropriate sexual history taking). These questions should be formulated open, non-judgmental and in absolute privacy and confidentiality (Roberts, 2018).

Understand that these questions may be very triggering, especially in case of unrealized sexual desires, therefore it is important that **medical reasoning behind the questions is explained. Pro-actively**

offering the option to keep it out of medical documentation, helps to avoid non-disclosure bias out of fear of consequences.

Sexual history: When a sexual history is taken, the level of detail should be guided by **what is relevant for the patient's medical evaluation**, **it should be made clear to the patient beforehand that the clinical relevance is the only purpose** (McDowell, 2020. **Open non-judgmental questions** need to be asked to allow meaningful sexual history taking in SGM: about amount, frequency, sex and gender of partners, sexual practices (which organs, from whom go where), prevention (which methods and how) and history of sexually transmitted diseases, if applicable prevention of unintended pregnancy (Suarez, 2021). **Gender identity, sexual orientation and sexual behaviour may seem to intersect, but they should always be questioned separately, as one cannot be assumed based on the other (in fact this is also true for heterosexual cisgender patients)**. As behaviour may change it is important to take an updated history when future medical evaluation requires it and not assume diagnostics or treatment based on the past.

6.1.5 Physical Examination and Screening Tests

The key components of the physical examination are the same as for any other patient, and the focus of the physical examination **should be led by the patients age and the findings in (sexual) history taking**, **not by a patient's sexual orientation or gender identity**. The clinician should always be **alert for signs of physical or emotional discomfort**, while keeping in mind that may indicate a history of trauma, and provision of trauma-informed care may be indicated (Alpert, 2014). For **pelvic examination and genital external or internal examination in general, it is crucial to communicate clearly what the intention is and why, and to make sure the examination is indicated and consented**. Find ways with the patient to increase comfort level and offer **if they want to use their own hands where possible**.

Lastly, for **transgender or nonbinary/gender-queer and intersex individuals it is helpful to ask which organs they have and if they have any terminology they use for their genital anatomy prior to the examination.** Using **gender neutral language**, such as genital examination versus vaginal examination, etc can also be helpful (Suarez, 2021).

6.1.6 Forms and Documentation

Intake forms and forms for further documentation and referral, investigations etc should be using i**nclusive wording and categories** (Fenway Institute, 2024). They can be **adapted to local language** or allow fill-in options in case culture or language does not allow uniform terminology. There may be **regional differences in the appropriateness and security issues related to keeping data about a person's sexual orientation and gender identity**. In principle all medical data should be kept in absolute **confidentiality and data protection** is a high responsibility. However, since this data in most countries is not standardly collected the application of such should be considered with **optimal risk assessment and accurate strategies to keep data protected**. Also, the purpose, risks and benefits should be evaluated.

6.1.7 Health Structure and Safe Spaces

As **privacy and confidentiality are key to LGBTQIA+ inclusive care**, ensuring patient security and protection (both mentally and physically), it is crucial to **review the setup of a health structure and tailor and differentiate service delivery to their needs.** Where are the pitfalls and the points for improvement? Think of **waiting areas, places where patients and or staff interact, sanitary and other gendered facilities, consultation rooms and if relevant the division of in-patient wards and patient rooms.**

Consider the **patient flow** from arrival to departure and imagine where and when things can go wrong. LGBTQIA+ patients can be exposed to discrimination by system, in case they are denied certain specialties, wards or services, or in person when exposed in waiting areas/hallways/wards. Also, they may

feel **excluded if health education material** has nothing significant to offer for them (Kumza, 2015)). Depending on local context **visually inclusive signs can be used to non-verbally signal LGBTQIA+ friendly care.** Sensitized hosts/receptionists etc can be a solution to oversee waiting areas and ensure intervention in case needed (harassment from other patients). Depending on local context different possibilities may exist to bypass the binary gender division for toilets, bathrooms and wards if needed. Otherwise, an individual room may be more appropriate than a ward of the assigned instead of affirmed gender.

Routes to access certain services should be considered, for example contraception or SGBV via maternity will exclude a lot of vulnerable patients that may feel very exposed and even be denied in such facilities. Therefore, alternative options need to be designed. As well as (referral) options for safe spaces for LGBTQIA+ SGBV survivors that are not female.

Consultation and examination rooms should offer privacy as much as possible, both visually and audibly. Ideally privacy is a service that is per default in place and not only when a patient requests it, because essential situations will be missed (McClain, 2016).

When patients need to be referred, **safe passage without exposing and or disclosing them need to be ensured**. Utmost **meticulousness is needed concerning the information sharing, which details shared with whom and how (oral or written) and informed consent of the patient for each step of the referral is essential.**

In contexts where hostile legislation or extreme social stigmatization severely limit access of patients to providers and vice versa, setting up a **digital environment** might make a meaningful difference. Examples of such interventions are intake via social media or other contact applications (Seretlo, 2024), digital environments providing health promotion material, or online counselling (Gilbey, 2020).

6.2 Additional Interventions and Innovations

6.2.1 Promoting Resilience

Historically, LGBTQ+ research has focused on poor health outcomes or risk behaviours within the LGBTQ+ community due to minority stressors. However, researchers and the sexual and gender minority community themselves are increasingly turning attention toward **individual and community resilience**. Resiliency is defined as one's ability to adjust, recover, or overcome adversity or significant stress in one's life (Jurcek, 2022).

This shift in perspective allows health care providers, as well as patients, to consider a **strength-based approach** (Peel, 2023). Positive self-esteem, self-efficacy, cognitive ability to mediate stress, self-acceptance, proactive coping, self-care, shamelessness, and spirituality can improve an individual's resilience. Environmental factors are social support and connectedness, presence of positive LGBTQ+ role models, positive representation of LGBTQ+ populations in the media, family acceptance, positive school and/or work environments, having access to safe spaces, and social activism.

6.2.2 Health Workers Education

LGBTQIA+ cultural competency and knowledge about LGBTQIA+ related health risks, should be included in standard education curricula for all health care workers regardless their level of training (Yu, 2023). At workplace also **non-medical staff** in health facilities should be trained for **sensitization and cultural competence.** Clinical staff can be provided with regular refreshment or update trainings and in-depth trainings depending on what is relevant in the specific context or department. Also, LGBTQIA+ principles should be integrated in standard training, resources to normalize the topic as being standard part of medical education and professionalization.

6.2.3 Guidelines, Protocols and Recourses

More guidelines and protocols are needed about LGBTQIA+ care, especially about subgroups other than SGM and specific intersectionalities. More protocols adapting theoretical information to specific situations and contexts can be helpful as well (Bass, 2022). Notice of LGBTQIA+ related health risks (other than HIV in MSM) should be **more integrated into general guidelines**. Availability of existing guidelines should be more promoted, and a **systematic global approach** should be adapted to allow more efficient growth in guidelines on currently lacking topics and exchange information and tested practices.

6.2.4 Peer Support and Community Outreach

Especially where LGBTQIA+ populations face high access issues (or where care providers have difficulties accessing patients), peer-based interventions can prove effective. **Peers can help** establish **meaningful and respectful practices fit for local culture and language. They can help understand the context and its challenges, map relevant locations for patient interaction and times for clinic hours. They can make link to patients and invite them to clinic or lead care workers to them.** Alternatively, **peers may function as an in between link, where they help distribut**e **health education, advice and sometimes treatment to communities with access issues.** More and less complete modules of community outreach may be used to lower barriers to the clinic or to replace the need to come to the clinic (Pepping, 2024). Depending on the situation a different module or process may be needed.

When working with peers or community health workers it is important to realize **which part of the community they represent and who they (may) exclude**, to know what impact this has on the accessibility of the aimed activity and if needs to be mitigated. Creating **diversity in the team and understanding the context before selection is crucial**, **ideally the team should represent the diverseness in the community it is trying to reach.**

Peer and community outreach can play a role in health education as well. A good exchange of knowledge between medical setting and community is needed, to ensure **health education can be delivered that is sensitive of local culture and relevant for local beliefs and practices**. It is helpful to know what (mis)understandings are prevalent and what questions circulate, to address them adequately and specifically. Ensure health promotion material is appropriate for local context and is inclusive in content as well as language.

6.2.5 Digital Care

Difficulties in access, either due to stigma and criminalization or due to infrastructure or anything in between, can also be mitigated by digital provision of care. It could be used as a safe way to spread information about clinic services and hours in a discrete manner or spread health education and promotion to spread preventative messages. It can **reduce the threshold to establish the first contact, if contact information** is spread in a clear but private and confidential way (Gilbey, 2020) (Radix, 2022) (Seretlo, 2024). Various options exist to **counsel or even attempt history taking, examination and advice online** (Whaibeh, 2022). **Telemedicine** can allow higher level of consultation in the most remote areas, with specialist consultation in timely and resource efficient manner. Additional advantages are to **overcome geographical barriers and language issues**. However, it is less personal, and some providers have difficulties to see/trust the value (especially for mental health). On another hand, patients are usually rating digital services positively, due to convenience, increased availability, confidentiality and perceived safety (Bragazzi, 2023). Most patients would use digital services again and would recommend it to fellow LGBTQIA+ patients (Gilbey, 2020). Options of the digital world are just starting to be discovered and tested, more research should be done to develop appropriate safe and effective applications.

6.2.6 Research

Although research about LGBTQIA+ health risks and care has increased significantly in the last decade, resulting in a **steep increase in evidence-based practice and production of guidelines and protocols, there is still a lot more to cover** (Yeo, 2024). Especially research for **lesbian and bisexual women, transgender men, non-binary people is lacking behind**, though also t**ransgender women and DSD individuals (especially those with rarer conditions), deserve to be better researched** (Westwood, 2024). Some health risks might not yet have been detected, or meaningful screenings or interventions are not yet significantly proven in effectiveness (Delos Reyes, 2024). **More research from lower- and middle-income countries, ideally even including countries with strict hostile LGBTQIA+ legislations would be meaningful to create better comparisons. Also, research about emergency and crisis interventions is still young and small in number.**

Intersectionalities and stratification of subgroups should also be studied more, as there is little material about for example elderly, disabled, or migrant LGBTQIA+ health, or not significant due to too small sample sizes. Rarer conditions and or less frequent health issues remain poorly researched, which limits evidence-based practice and development of guidelines (Yarwood, 2022)

Long term effects of newer therapies require follow up research as well as poorly treatable conditions deserve more research for creative therapies. Also, studies focusing on ways to reach LGBTQIA+ population more effectively and reduce the variety of barriers to LGBTQIA+ (supgroups) are needed. Lastly research to preventative methods is crucial.

6.2.6 Preventative Interventions

As prevention is better than cure, both for individual life quality and for public health outcomes and costs, it is crucial to realize the scale of preventable disease burden in LGBTQIA+ population. Ensuring more welcoming and respectful inclusive approach in healthcare settings, with informed and culturally competent staff can be significant in encouraging LGBTQIA+ people to visit health facilities when indicated. Providers being better educated about existing risks will make better informed decisions on screening, prevention and treatment (Ginaldi, 2024).

Additional prevention can be achieved via more inclusive health education and health promotion material, spread in communities via public health initiatives but also as integrated part in school education etc (Thurston, 2024).

Moreover, strategies to reduces bullying and harassment in educational and employment settings, and to reduce stigmatization, discrimination and victimization on larger level in society, are needed to stop the perpetuation of the minority stress mechanism and all the associated harmful processes that lead to interlinked vicious circles of illnesses (Watson, 2024).

Healthcare and humanitarian sector can give a good example by making its own practices and structures more inclusive, ending discrimination by insurance companies etc. Medical research can impact by providing evidence of the disease burden and engaging in research to support evidence-based examples of inclusive practice and highlight the positive impact. However, to make more meaningful impact broader advocacy will be needed to induce changes of mindset in society and policy makers, ending criminalising legislations and improving accessibility of social support, safeguarding by authorities, protection structures etc.

6.3 Special Considerations for Humanitarian Interventions

Humanitarian action is grounded in principles of humanity, neutrality, impartiality, and independence, as outlined in the core humanitarian standards (Sphere Handbook, 2018). These principles compel humanitarian actors to **prioritize the most vulnerable populations and ensure that aid is**

delivered without discrimination. The exclusion of LGBTQIA+ people from humanitarian care violates these principles.

6.3.1 Humanitarian Principles

The principle of **impartiality dictates that humanitarian aid should be provided based on need, without discrimination**. LGBTQIA+ people often face significant barriers to care in crisis settings due to fear of violence, stigmatization, or legal repercussions. **Improving care for LGBTQI+ populations ensures that humanitarian actors are adhering to this core principle** (Barbelet, 2020).

Humanitarian crises, whether caused by natural disasters, armed conflicts, or political instability, often exacerbate vulnerabilities among marginalized populations, including LGBTQIA+ individuals (IRC, 2021). **These groups face unique challenges in accessing emergency care, protection, and support in crisis settings**. In many regions, LGBTQ individuals are marginalized even in stable conditions due to legal, social, and cultural stigmatization (Gaillard, 2017). **During humanitarian crises, these pre-existing conditions are often amplified, leading to neglect or outright exclusion from emergency interventions** (Arnold, 2020).

Humanitarian organizations must adopt **inclusive policies and legal frameworks** that explicitly address the needs of LGBTQI+ individuals. This includes non-discrimination clauses in the delivery of aid, healthcare, and protection services. To retain access, security and acceptance it is crucial for international actors to **adapt their strategies to context** (IASC, 2019). **Levels of internal versus external advocacy and communications promoting LGBTQI+ inclusion may vary as a result** (Brown, 2023).

Focus should remain on the humanitarian imperative of neutral and impartial care to marginalized populations in distress. Humanitarian actors should consider it their responsibility to stop taking part in the continued stigmatization and to try to compensate for the health disparities and allow equitable access to care (Brown, 2023).

6.3.2 Risk Assessment and Mitigation

One of the most significant risks humanitarian actors face when engaging in care for LGBTQI+ populations is operating in countries where homosexuality or transgender identities are criminalized (ILGA, 2024). In more than 70 countries, same-sex relations are illegal, and transgender people face legal restrictions or severe discrimination. Engaging with LGBTQI+ individuals in these contexts can result in legal repercussions for humanitarian workers or their local partners, although the extent of such implications is little known, as these risks are usually avoided (Gaillard, 2022).

In countries where LGBTQIA+ rights are politically sensitive, humanitarian actors might face government pushback, including restrictions on operations, withdrawal of funding, or expulsion from the country. Governments may view the provision of care to LGBTQIA+ individuals as a political statement rather than a neutral humanitarian act. Examples of people and organisations being accused of LGBTQIA+ activism being forced to stop their work, being prosecuted and sentenced or deported exist from various countries (HRW, 2023) (HRW, 2018). However, **if the local legal and political context is carefully monitored such risks can be mitigated.**

In many crisis settings, social and cultural norms may be deeply conservative, particularly regarding gender and sexual identity. Humanitarian organizations that engage in LGBTQIA+ care may face backlash from local communities, including protests, threats, or even violence. This can endanger both humanitarian staff and the LGBTQI+ individuals they aim to support (IASC, 2019). Therefore, a **good local understanding is needed to find ways to reach the needs of the LGBTQIA+ population without losing connection to the surrounding community** (UNHCR, 2024).

Medical ethics require that healthcare providers deliver care without bias or discrimination. The principles of beneficence and non-maleficence emphasize the need to maximize benefits and minimize

harm for all individuals. **Ignoring the healthcare needs of LGBTQI+ individuals in crisis settings can lead to poor health outcomes, thus violating ethical standards** (Nieder, 2020).

Providing LGBTQIA+ competency training for frontline workers is essential in preventing discrimination and improving the quality of care delivered. **All staff must be sensitized and trained to understand gender and sexual diversity and to approach LGBTQI+ individuals with dignity and respect** (IASC, 2019). Also, knowledge about specific health risks and appropriate interventions should be available in trainings and guidelines and consultation and support structures for staff with challenges should be in place. **Better educated staff will not only improve quality of care for LGBTQIA+ patients but allow better understanding of risks and allow more adequate and efficient risk mitigation strategy**.

6.3.3 Community Engagement and Local Actors

Interventions should be d**esigned with the vulnerabilities and needs of LGBTQIA+ individuals in mind, ideally allowing community members (including LGBTQIA+ people) input in the planning of the intervention, to increase adaptation to people's need and local context** (Gorman-Murray, 2018). Also, **research would benefit from studies set up with a community engagement strategy** (Obedin, 2024). **LGBTQIA+ care should be an integrated part of every intervention**, treating it as a stand-alone issue will reproduce the isolation of this patient group and will undermine a more holistic and comprehensive approach (Johansson, 2022).

Establishing safe spaces within refugee camps, shelters, and healthcare centres where LGBTQI+ individuals can access services without fear of violence or discrimination is critical (Seglah, 2023). These spaces should **include legal assistance, healthcare, and mental health services tailored to the needs of LGBTQIA+ people**. This is to ensure that LGBTQI+ individuals can access healthcare and make informed decisions about their treatment aligns with the principle of respect for autonomy (Arnold, 2023). Especially in humanitarian crises, where LGBTQI+ populations may fear disclosing their identity due to legal or social stigma, healthcare providers must create safe spaces that respect individual autonomy and encourage trust (IRC, 2021). The protection needs for LGBTQIA+ survivors of SGBV should not be overlooked when designing safe houses, especially if gender separations are made.

Working in collaboration with local LGBTQIA+ organizations and/or activist individuals can improve the cultural competency of humanitarian interventions and ensure that LGBTQIA+ individuals receive targeted care (Chernova, 2024). The initiatives in unofficial care LGBTQIA+ people are often already self-organising, learning from are empowering; and **expanding such initiatives may be more effective than starting something parallel** (Savage, 2024). **Local groups can provide insights into the needs and challenges faced by LGBTQIA+ individuals in their specific cultural and legal contexts. It can also be a meaningful way to create referral pathways and ensure sustainability.**

In some crisis settings, LGBTQIA+ individuals may be hidden due to fear of persecution, making it difficult for humanitarian actors to identify and reach them. This can limit the effectiveness of aid programs and exacerbate health and safety risks for LGBTQIA+ people. Collaborating with LGBTQIA+ community members as peer educators or community health workers may help **create a network, sometimes this can be facilitated via local LGBTQI+ organizations** (SSHAP, 2024).

Either way **discrete manners need to be developed that match local context and bypass legislations, to ensure messaging reaches LGBTQIA+ population without endangering them.** Utmost responsibility should be taken to avoid the risk of endangering a patient by increasing their exposure and disclosure risk linked to the healthcare visit. When engaging with the community it may help to explicitly encourage ‘anyone who felt they might be ‘different’ from others’ by promising contact in privacy and confidentiality (Blanchard, 2024).

6.4 Interventions on Policy and Advocacy Level

In recent years, many countries have enacted or strengthened laws criminalizing LGBTQIA+ identities and behaviours. These legal developments significantly affect LGBTQIA+ individuals' healthcare access, further entrenching stigma and discrimination within healthcare systems, as it increases the barrier for LGBTQIA+ people to seek care as well as it increases the barriers for providers to deliver care to this population.

One of the most effective interventions to improve healthcare access is **decriminalizing LGBTQI+ identities and introducing legal protections against discrimination** (Blyth, 2020). Decriminalization would reduce fear of seeking medical help, especially for those most vulnerable, like transgender people and gay men in HIV care.

International organizations should continue advocating for human rights and health equality in regions that criminalize LGBTQIA+ identities. **Global health organizations can play a role in ensuring that healthcare systems in these countries include LGBTQI+ people in their public health initiatives** (SSHAP, 2024).

7 Discussion

This report attempts to give an overview of meaningful information to improve LGBTQIA+ inclusive care in general and in Humanitarian contexts specifically. With a relatively large combination of search strategies, it was possible to provide a comprehensive overview of the literature despite the topic being relatively understudied, allowing for analysis of diverse subgroups within the LGBTQI+ community and its emphasis on intersectional factors like socioeconomic status, disability, migration, and conflict environments. The use of data from various sources, including high-income and some low-income settings, enables a multidimensional understanding of LGBTQI+ health disparities. However, **gaps in research are prevailing despite increased productivity on LGBTQIA+ health related issues the last years.**

Since most research is focused on high income settings, the **applicability of findings in humanitarian contexts with limited resources and various populations remains unclear**. Only **limited material is available to guide adapted policies to LGBTQIA+ inclusive interventions in low resource or emergency and migration settings**. The **report's recommendations would benefit from more granular data to support tailored interventions in specific humanitarian settings**, where healthcare resources are often limited and LGBTQI+ identities may be stigmatized or even criminalized.

Additionally, it **remains difficult to gather more detailed knowledge on health risks in LGBTQIA+ subgroups other than MSM on topics other than sexual health and HIV**. Recent years the topic gender diversity gained more attention in research and a small increase has been seen in focus on diverse subgroups and intersectionalities, or more in-depth stratification of data in studies that are looking on entire LGBTQI+ population. However often reliability of evidence remains limited due to low percentages of subgroups and small sample seizes, **which affects the overall depth and generalizability of the findings.**

Due to different methods of data collection and difference in terminology (used definitions and number of options) in the studies reviewed, **comparability is a challenge well**. Yet this report aimed to give an overview of facts that literature did not dispute on as much as possible. Reflections are given where data was insufficient. **Expanding research to gather data on subgroup-specific health risks and adapting methodologies to capture the lived experiences of LGBTQI+ individuals in resource-limited and culturally diverse contexts would enhance the practical utility of future reports.**

8 Conclusion

The challenges of **societal stigma, discrimination, victimization, and denial of human rights** faced by LGBTQIA+ people and compounded by stressors as **forced displacement, war and natural disasters** result in a **disproportionate burden for LGBTQI people with increased barriers to healthcare access and significant health disparities.** As **healthcare** itself is part of the cause and continuation of stigmatization and discrimination, LGBTQIA+ people are likely to avoid or delay necessary care even if they would have access. Lacking provider knowledge and provider attitude and bias even further reduce quality of care and effectiveness of screening and treatment.

Recognition of LGBTQIA+ individuals has significance with providing quality care, as it allows patients to be known and affirmed by their provider, and it allows the provider to be aware of potential health disparities such as SGMs' increased risk for adverse health outcomes, including depression, anxiety and suicidality, substance use, chronic diseases, HIV and other sexually transmitted infections (STI) and malignancies.

Cultural competency focuses on the ability to communicate effectively and provide quality health care to patients from diverse sociocultural backgrounds. **An open non-judgmental approach, not making assumptions about patient's sexual orientation identity or behaviours is fundamental in providing inclusive care. Professionalism, confidentiality, being aware of internal assumptions, and being able to self-regulate** is essential to achieve an unbiased approach that allows patients to show their true identity. This is crucial to allow a good patient provider relationship and allow the provider to understand the correct risk situation and manage prevention and treatment accordingly. Also, it prevents providers from perpetuating stigma and discrimination.

Due to **limited research on LGBTQIA+** health disparities and effective interventions, a lot may still to be discovered in this area. Some correlations are not (yet) significantly proven or poorly described, some phenomena are explained and quantified but not understood. However, all relevant studies that contributed to this report share one thing in common: **there was no single study found that did not underline the significance and severity of the health disparities faced by LGBTQIA+ people, both on individual level due to loss of quality of life and increased morbidity and mortality, but also as a burden on society and as a public health problem on global scale.**

More research will be needed to support development of integrated training modules for medical and humanitarian professionals, medical and mental health guidelines and protocols for low, middle and high research settings and inform about differences in populations across the world including differences between LGBTQIA+ subgroups and relevant intersecitonalities. Regular healthcare settings as well as humanitarian actors should act up on the evidence (even if limited) that is already now giving a strong imperative to act and offers plenty opportunities of meaningful counselling, prevention and treatment for those willing to educate themselves.

It is important to note that though the **scale and severity of the problem are significant**, most of the involved health conditions would be **preventable** if urgent steps are taken towards more **inclusive societies and equitable access to healthcare** for LGBTQIA+ people. **This invisible global public health crisis is created by humans, and it will depend on humans to reverse it.**

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