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## IFMSA Policy Document Health of LGBTQIA+ individuals

**Proposed by the Team of Officials**

**Adopted at the IFMSA General Assembly August Meeting 2019, in Taipei, Taiwan.**

### Policy Statement

#### Introduction

Equity and non-discrimination for all people are core principles of human rights, but are still not recognised by law in many States; where systemic and cultural cis- and hetero-normativity impinge on the freedom and safety of LGBTQIA+ individuals. The lack of adequate, accessible, and affordable health services acts as structural oppression leading to poorer health outcomes. LGBTQIA+ people are at higher risk for physical and mental health conditions. In many countries, transgender people continue to be pathologized and it remains common practice to subject intersex children to unnecessary surgical and hormonal procedures which conform them to binary sex categories and may cause permanent injuries. Despite these key health disparities, medical schools severely miss- and under-represent LGBTQIA+ health issues, resulting in health professionals perpetuating discrimination, ignorance and being ill-equipped to provide appropriate medical care to LGBTQIA+ patients.

#### IFMSA position

IFMSA strongly uphold the human rights of all LGBTQIA+ people, including the right to health. We are alarmed by all forms of discrimination and violence based on sexuality or gender identity. We believe that LGBTQIA+ people should be able to access inclusive, respectful and culturally safe healthcare according to their needs. We also believe that medical schools have a responsibility to equip medical students with the skills needed to provide appropriate and sensitive health care to LGBTQIA+ people. Key stakeholders in the LGBTQIA+ community should be meaningfully involved in decisions relating to developing research and changing healthcare systems to address the diverse needs of the community. Together we can ensure that the right to health is realised for the LGBTQIA+ community.

#### Call to action

Therefore, IFMSA calls on:

#### Governments to:

1. Implement policies and strategies to ensure equity and non-discrimination for all LGBTQIA+ people;
2. Ensure that official documentation reflects gender and sex diversity, and allow people and to change the documentation if they choose;
3. Protect LGBTQIA+ individuals from violence and discrimination of any kind, including where homosexual acts are criminalised, decriminalising them immediately;
4. Commit to representation of LGBTQIA+ people within the Government bodies;
5. Actively engage with organizations representing the LGBTQIA+ population and include them in relevant decision making processes;
6. Ensure safe and discrimination-free access to health care services, mental health services and health education for all LGBTQIA+ people through inclusive and accessible infrastructure and appropriately targeted campaigns;
7. Enact laws to protect intersex children from non-medically necessary sex-assignment surgery;



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8. Initiate and support research into the health needs and health outcomes of LGBTQIA+ people.

#### **NGOs to:**

1. Be inclusive of LGBTQIA+ members within the NGO, considering their needs and opinions when designing internal policies and delivering services;
2. Address gaps in health and social services for LGBTQIA+ people including information on safe and inclusive clinicians;
3. Provide support to those facing discrimination and harassment due to their LGBTQIA+ identity;
4. Promote other initiatives supporting LGBTQIA+ individuals' health through sharing information with other organisations and advocating to government.

#### **Medical Schools to:**

1. Commit to protecting students against discrimination on the basis of sexual orientation and/or gender identity both at university and on clinical placements;
2. Create anonymous, transparent, accessible reporting process for students facing discrimination and/or harassment from healthcare professionals, or other students and support the creation of student peer support groups for LGBTQIA+ medical students;
3. Ensure that official documentation reflects gender and sex diversity, and allow students and personnel to change the documentation if they choose;
4. Ensuring the needs of the LGBTQIA+ community are explored in a positive and non-stigmatising way, and develop an evidence-based, intersectional and culturally safe health curricula;
5. Work with affiliated hospitals and other clinical placement providers to ensure consistency of teaching and culture around LGBTQIA+ health at all sites;
6. Implement an entity in charge of taking care of the mental health of the LGBTQIA+ students

#### **Health Professionals to:**

1. Take a personal responsibility to upskill in LGBTQIA+ health in order to meet patients' physical and mental health needs while keeping in mind an intersectional approach;
2. Actively oppose stigma and discrimination by other healthcare providers;
3. Conduct and support research in the field of LGBTQIA+ health;
4. Not engage in any non-medically necessary sex assigning procedures for intersex individuals without their full consent this includes any procedures for children.

#### **Health Institutions to:**

1. Take disciplinary action against health personnel found guilty of harassment/discrimination towards LGBTQIA+ people;
2. Ensure that official documentation reflects gender and sex diversity, and allow patients and personnel to change the documentation if they choose;
3. Up-skill doctors and health professionals on intersectional LGBTQIA+ health issues and conduct anti-bias training on LGBTQIA+ health and social issues for all health professionals.
4. Ensure safe and discrimination-free access to health care services for all LGBTQIA+ people through inclusive and accessible infrastructure

#### **Health Students and IFMSA members to:**

1. Implement policies and strategies to create an inclusive and empowering environment for LGBTQIA+ members;
2. Empower medical students to combat stigma and discrimination within health care and education by developing skills to advocate medical schools to implement LGBTQIA+ health in the medical curriculum and design and deliver trainings on LGBTQIA+ health.



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## Position paper

### Background information

*Terminology discussion.* For the purpose of this document, the abbreviation LGBTQIA+ refers to Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and/or other sexual or gender orientation, identities or forms of expression. This acronym was chosen above others only due to its prevalence of use and relative inclusivity. We acknowledge this terms limitations and stress the importance of using and respecting the names, terms and pronouns that people identify with and use to refer to themselves.

### Discussion

For the purpose of this policy statement, we also deem it necessary to clarify the following:

- 'sexual orientation' is intended as each person's capacity for profound emotional and/or sexual attraction to, and/or intimate and sexual relations with individuals who are of a different gender, the same gender, genderless, or more than one gender [5];
- 'sex' refers to a person's biological status at birth and is typically categorized as male, female, or intersex. Indicators used to define biological sex include sex chromosomes, gonads, hormones, internal reproductive organs, and external genitalia [5].
- 'Transgender' An umbrella term for people whose gender identity differs from the sex they were assigned at birth. The term transgender is not indicative of gender expression, sexual orientation, hormonal makeup, physical anatomy, or how one is perceived in daily life [6].
- 'Intersex' Describing a person with a classically non-binary combination of hormones, chromosomes, and anatomy that are used to assign sex at birth [6].
- 'Cisgender' An adjective that means "gender identity the same as their sex assigned at birth" [6]
- 'Gender expression' refers to attitudes, feelings, and/or behaviors that a culture associates with how a person acts to communicate gender within a culture. Examples are clothing, verbal communication, and interests. A person's gender expression is not necessarily consistent with socially prescribed gender roles, or their gender identity. Behavior that is compatible with cultural expectations is referred to as gender-normative; behaviors that are viewed as incompatible with these expectations constitute gender nonconformity [5].
- 'Gender identity' is each individual's deeply personal experience of their own gender and can be influenced by how we relate to attitudes, feelings, behaviours a given culture associates with a person's biological sex [5].

### Human rights and legal frame

Basic Human Rights are universal and indivisible, and so necessarily include all LGBTQIA+ people [7]. The right to equality and non-discrimination are core principles of human rights, enshrined in the United Nations Charter, The Universal Declaration of Human Rights (UDHR) and human rights treaties [1]. Basic Human Rights include the following rights: right to life; physical integrity; freedom from torture; the right to liberty, freedom of association and assembly, freedom of expression, the right to health, employment, education, housing and other economic, social and cultural rights [8]. There are a range of violations of fundamental human rights that individuals face on the basis of their sexual orientation or gender identity. These include various forms of violence like mob attacks, sexual violence, torture, killing or the application of the death penalty. Another form of human rights violation is discriminatory treatment, such as in-humane or degrading punishment both in detention and medical settings and discriminatory laws criminalising, for example, consensual same-sex conduct between adults or cross-dressing. These violations also include arbitrary and discriminatory restrictions on the freedoms of assembly, association and expression of LGBTQIA+ persons, discrimination and denial of care in health care settings and the discriminatory treatment of LGBTQIA+ persons in education, employment and



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housing. Within the LGBTQIA+ community people face many different forms of human rights violations, including discrimination based on intersecting factors such as sex, race, able-bodiedness, age and class [9].

## Hate crimes

Recent research reveals that, over the course of their lifetimes, about one in four transgender people, and one in five lesbian, gay, and bisexual North Americans will experience violent hate crimes. [10] A spate of violence against trans people has claimed the lives of at least 369 individuals between October 2017 and September 2018 in USA. [11]

Lesbian, gay, bisexual, transgender, queer, intersex, asexual, and plus (LGBTQIA+) people face psychological and physical violence motivated by hateful attitudes towards their sexuality or gender identity. Violence may be executed by the state, as in laws inflicting physical punishment for homosexual acts, or by individuals engaging in intimidation, mobbing, assault, or lynching and murder [12][13]. Violence against LGBTQIA+ people is classified as a hate crime internationally, and in western countries can be especially connected with conservative or religious leaning ideologies that condemn homosexuality as immoral [12].

Sometimes, hostility directed at LGBTQIA+ people is stoked by the very governments that should be protecting them. A state-sponsored campaign in Chechnya led to the targeting of gay men, some of whom have been abducted, tortured and even killed. In Bangladesh, LGBTQIA+ activists have brutally murdered, with the police and government taking little interest in delivering justice to the families of victims [14].

Victims of anti-LGBTQIA+ hate crimes are severely under-supported by both the criminal justice and health care systems. Fewer than half of all anti-LGBTQIA+ hate crimes are reported to the police, and the most common reason victims give for not reporting cites fear of harassment and further victimization at the hands of police. Likewise, only 14% of all victims seek medical care, despite the fact that hate crimes more often result in injury to victims than other crimes. Again, fear of discrimination from medical providers plays a critical role in the decision not to seek medical care. [15]

## Discrimination across cultures and countries: Intersectionality

Contrasting to the western gender binary, in many cultures, the concept of diverse gender identity in particular has been long acknowledged. Transgender individuals are known as *bakla* in the Philippines, *xaniths* in Oman, *serrers* to the Pokot people in Kenya, and *hijra*, *jogtas*, or *shiv-shaktis* in South Asia. Today's international terminology fails to capture this rich history [16]. Many cultural traditions relating to transgender individuals such as the two-spirited role in the Coast Salish territory of Indigenous American people, have been lost through the devastating effects of colonization [17]. Despite this acknowledgement, many transgender individuals from non-western communities, at best have a prescribed role, and at worst, and more commonly, face social exclusion [18].

There is significant diversity amongst the LGBTQIA+ community, with each individual's identities intersecting to create their unique experience and susceptibility to certain forms of discrimination. When appreciating the impact of bullying on LGBTQIA+ youth, it is important to acknowledge these diverse experiences. The queer identity of any one individual should not be assumed as the sole nor primary cause of violence they face [19]. Historically, research and health care provisions for the LGBTQIA+ community have disregarded LGBTQIA+ people with disabilities, diverse body shapes, or

those who are older [20], black, or part of an ethnic or religious minority. Queer has been been synonymous with young cis white gay men, rendering others invisible [21].



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As society continues to navigate and integrate LGBTQIA+ experiences into oppressive, limited systems; very often queerness is misrepresented. To counteract this and the overarching western perspective, there must be continuous effort to reclaim the queer narrative to better represent the diversity of this community [22].

## **Discrimination in the healthcare setting**

Discrimination against LGBTQIA+ people in healthcare settings and wider society is mutually reinforcing: social discrimination is reflected in healthcare institutions, and health based discrimination and poorer outcomes perpetuate difficulties faced by LGBTQIA+ people in their wider lives. LGBTQIA+ people experience a diverse range of medical conditions both related to and not related to discrimination. In all instances, they reserve the right to be treated with respect and have access to high quality healthcare. There is a lack of research and readily available evidence-based data with which to guide education and recommendations in this area: the body of literature on LGBTQIA+ health issues is relatively small, with the majority concerning itself with HIV and Sexually Transmitted Infections (STIs) in men who have sex with men (MSM) [23].

Barriers to LGBTQIA+ people accessing healthcare include financial concerns, refusal of care, harassment and violence (or fear of harassment and violence) and lack of provider knowledge, with patients often having to teach their healthcare provider about their own needs [24]. This often leads to reluctance of LGBTQIA+ patients to discuss this aspect of their healthcare needs with their healthcare provider. This further reinforces specific forms of care such as appropriate contraception counselling or medical and/or surgical transition, not being met [24]. These patients also report using alcohol and drugs to cope specifically with the stress created by social discrimination and mistreatment [24][25]. This is compounded by a lack of culturally safe providers of alcohol and drug treatment services, which creates a barrier for those seeking help to curb their use of alcohol and other drugs [26].

Even when patients do discuss their LGBTQIA+ identity with their healthcare provider, disparities between health systems create inconsistencies in data collection in clinical settings and on electronic health records (EHRs). This creates difficulties for national and international health agencies in collecting reliable data about the overall health of LGBTQIA+ populations [27]. Standardised questions, such as those already used in many countries for similar demographic data, would allow more reliable data and information on health care trends of LGBTQIA+ people's health outcomes compared to heterosexual and cisgender people's health outcomes [27]. For example, there is evidence that lesbian, bisexual and transgender women are much less likely to get routine cervical cancer screening. Any preventative healthcare interventions targeted at these populations to reverse this trend would require reliable record-keeping which does not currently exist [27].

However, in order to generate this data for inclusion in EHRs, healthcare workers must first be culturally safe and comfortable in discussing LGBTQIA+ identities. Many physicians do not regularly discuss sexual orientation and gender identity with their patients when taking a sexual history or completing a mental health assessment, and do not believe they have adequate skills to do so [28]. This may be partially due to implicit biases against LGBTQIA+ people [29]. It is also important to note the negative impact that bias and discrimination have on LGBTQIA+ medical students who witness discrimination against their community in their workplace [30].

Surgeries on intersex infants are normalised and ongoing in many countries despite advances in understanding of sex and gender, increased accuracy in diagnosis of intersex conditions, and ongoing international activism by intersex people [31].

## **Health needs of the LGBTQIA+ population**



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LGBTQIA+ individuals are subject to structural oppression which manifests as poorer health outcomes. Lack of provision of adequate, accessible, and affordable services for LGBTQIA+ people has wide reaching psychosocial consequences causing significant physical and psychological health issues [32]. These include certain clinical conditions including mental health conditions, substance abuse, polycystic ovary syndrome, and infertility [2][3].

### ***Mental health***

LGBTQIA+ people face higher rates of depression, anxiety disorder, eating disorders and suicidal ideation, particularly LGBTQIA+ youth [33][34][35]. A Scottish survey revealed that 3% of gay men have attempted suicide; 44% of bisexual men thought about suicide in 2011. 41% of participants of the U.S. National Transgender Survey had attempted suicide at least once in their life [24]. Studies and surveys have managed to relate these conditions to discriminatory attitudes towards LGBTQIA+ people, together with pathologization by the medical field and lack of inclusive and specific health services [36].

### ***Transgender individuals' health needs***

Transgender people continue to be pathologized and given unnecessary or incorrect mental health diagnoses, even when they are not experiencing distress. Although DSM-5 removed “gender identity disorder” as a psychiatric diagnosis, gender dysphoria remains. This is defined as an incongruence between biological sex and gender identity causing psychological distress. Even when distress is not experienced by a person who is transgender, they are incorrectly labelled with this diagnosis. In 2018 WHO introduced the ICD-11, which recognises the difference between the term “gender dysphoria” with “gender incongruence”, and includes incongruence in conditions related to sexual health and not to mental health [37]. Transgender individuals report reluctance in seeking health care, due to the fear of or past discrimination. There is a perceived and real lack of specific competencies in the medical personnel [38]. The adjustment and coping mechanisms that are employed by LGBTQIA+ people, to survive in systems that criminalize and pathologize, are often unhealthy. Feeling alienated from the LGBTQIA+ community—more prevalent amongst other marginalised groups such as a culturally and linguistically diverse people—is also a predisposing factor [36]. Thankfully, 74% of trans people report an improvement both in physical and mental health after the transition (not necessarily medical) [39].

Transgender individuals who undergo gender confirmation surgery have to face risk connected to continuous hormonal therapy such as tumours, coagulopathies, hyper or hypotension and many others, resulting in a need of a continuous health support throughout their lives which most clinicians are unaware of. Also, risk of prostate cancer in Male to Female individuals and of gynaecological cancers in Female to Male individuals who don't undergo hysterectomy must be considered [40]. Medical conditions relating to the reproductive organs of transgender people are almost always ignored, which results in a significant burden of preventable illness and death.

### ***Lesbian, gay and bisexual women's health needs***

There is evidence of higher rates of overweight and obesity among lesbian women, with higher rates of related clinical conditions; on the contrary, gay men are more inclined to bulimia and anorexia, often related to unrealistic beauty standards [41][42]. People who identify as bisexual have the highest rate of eating disorders. Also, there is a significant rate of drug abuse, which has been related to marginalisation [33] [43][44][45][46].

LGBTQIA+ people experience a similar or higher rate of family violence than non LGBTQIA+ people: 1 in 3 Australian LGBTQIA+ people have experienced intimate partner violence and LGB women are more likely than heterosexual women to experience sexual coercion [47][48][49][50]. Despite this, there is a continued underestimation of this problem, lack of support services and poor training of health professionals [47].



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For lesbian and bisexual women compared to other women, there is also evidence for higher rates of breast and other gynaecological tumours, due to the impact of oppression on health determinants and higher rates of risk factors such as lack of childbearing and breastfeeding [33]. Lesbian and bisexual women also experience a lack of support during pregnancy, due to the fact that pregnancy and parenthood services are often based on mother-father dynamics [51].

### ***Sexually Transmitted Infections (STIs), and HIV***

Gay and bisexual men have higher rates of HPV infections, due to the fact that this is usually considered a “female issue”, leading to a lack of awareness and prevention campaigns such as vaccination campaigns [34].

Men who have sex with men (MSM) and transgender individuals are key populations in the HIV response. Stigma, discrimination, criminalization, a lack of health services, and sexual exploitation expose these individuals to risky behaviours and lack of support when needed. Overall, HIV infection risk is 27 times higher among MSM and 49 times higher among transgender individuals than in the general population [52]. A study conducted in four Southern African countries found that lesbian and bisexual women who reported rape by men, often with the aim to “correct” their sexual orientation, faced disproportional rates of HIV [53][54].

### ***Intersex Individuals' health needs***

In many countries it remains common practice to subject intersex children to unnecessary surgical and hormonal procedures to make them conform to binary sex stereotypes. These procedures are often irreversible and may cause permanent infertility, pain, incontinence, loss of sexual sensation, and lifelong mental suffering, including depression [4][55]. Due to their age, these children are regularly left out of the decision making process and cannot give their free and informed consent. These procedures may violate their right to physical integrity, to be free from torture and ill-treatment, and to live free from harmful practices. These procedures are often justified on the basis of cultural and gender norms and the wish for integration of intersex children into society. Some procedures may be performed on the basis of alleged health benefits. However, there is weak and contrary evidence for any medical or psychological indications of surgery that assigns the child a binary sex and often alternative solutions that protect physical integrity and respect autonomy are not offered by medical professionals, or rejected by parents of intersex children [4].

Discrimination can make financially viable healthcare more difficult to obtain for LGBTQIA+ people. Besides from higher rates of poverty amongst LGBTQIA+ people, obtaining health insurance in the USA is more difficult for LGBTQIA+ people as many employers offer health coverage for employees' spouses, but not for their same-sex partners. Most employee health policies refuse to cover surgery and hormone treatment for transgender patients, despite a 2008 AMA resolution calling for such coverage.

### **LGBTQIA+ in the medical curriculum**

Medical schools throughout the world, severely miss- and under-represent LGBTQIA+. This results in health professionals perpetuating discrimination, ignorance and being ill-equipped to provide appropriate medical care to LGBTQIA+ patients. Surveys have revealed that medical students would like more teaching than the median of 5 hours devoted to LGBTQIA+ care throughout medical school [56][57].

Where issues facing LGBTQIA+ individuals are discussed, they make serve to reinforce stereotypes. The greater prevalence of STIs and substance use among men who have sex with men and transgender individuals, and higher rates of depression, anxiety, smoking, and alcohol use among LGBTQIA+ people as a group is often highlighted in medical curriculum without addressing the nuances



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and causes of such trends. As a result, medical practitioners may view a transgender patient as mentally unstable simply because they are transgender, or may focus too heavily on HIV testing for an HIV-negative male patient who identifies himself as gay, regardless of their actual sexual practices or presenting symptoms.

Thorough teaching is needed to best support LGBTQIA+ patients. As outlined by guidelines including those published by the Association of American Medical Colleges, medical curriculum for LGBTQIA+ should leave medical students with the following: an awareness of the spectrum of sexual orientation, gender expression and identity; knowledge of appropriate questions to ask about someone's sexual orientation and gender identity; knowledge of inclusive language and correct terminology; understanding of barriers to care and social determinants of health for LGBTQIA+ people; and knowledge of specific ways to make an inclusive and safe space for LGBTQIA+ students, such as visible representation [58][59].

As LGBTQIA+ health concerns begin to receive more attention in medical schools' formal curricula, it should be noted that student groups at many institutions are organizing co-curricular programs designed to teach their colleagues about LGBTQIA+ needs. While generally seen as stopgap or interim offerings, these student-driven co-curricular programs play a vital role in heightening awareness of the needs of these populations and speeding up formal curriculum change.



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## References

- [1] UN, "International Human rights law & Sexual Orientation & Gender Identity."
- [2] C. Meads, M. Pennant, J. Mcmanus, and S. Bayliss, "A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research."
- [3] M. King *et al.*, "A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people," *BMC Psychiatry*, vol. 8, no. 1, p. 70, Dec. 2008.
- [4] U. Free & Equal, "Intersex."
- [5] "Definitions Related to Sexual Orientation and Gender Diversity in APA Documents," The American Psychologist Association, 2015. [Online]. Available: <http://www.apa.org/about/policy/orie>. [Accessed: 15-Sep-2018].
- [6] "UN Free & Equal | Definitions." [Online]. Available: <https://www.unfe.org/definitions/>. [Accessed: 29-Jun-2019].
- [7] "OHCHR | Vienna Declaration and Programme of Action." [Online]. Available: <https://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx>. [Accessed: 29-Jun- 2019].
- [8] UN General Assembly, "Universal Declaration of Human Rights," United Nations, 1948. [Online]. Available: <http://www.un.org/en/universal-declaration-human-rights/>.
- [9] Ending violence and other human rights violations based on sexual orientation and gender identity Ajoint dialogue of the African Commission on Human and Peoples' Rights, Inter-American Commission on Human Rights and United Nations. 2016.
- [10] I. H. Meyer, "Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence.," *Psychol. Bull.*, vol. 129, no. 5, pp. 674–697, Sep. 2003.
- [11] "LGBT rights | Amnesty International." [Online]. Available: <https://www.amnesty.org/en/what-we-do/discrimination/lgbt-rights/>. [Accessed: 29-Jun-2019].
- [12] C. Stewart, *Greenwood encyclopedia of LGBT issues worldwide*. Greenwood Press, 2010.
- [13] D. Meyer, "An Intersectional Analysis of Lesbian, Gay, Bisexual, and Transgender (LGBT) People's Evaluations of Anti-Queer Violence," *Gend. Soc.*, vol. 26, no. 6, pp. 849–873, Dec. 2012.
- [14] "STATE-SPONSORED HOMOPHOBIA."
- [15] "Understanding and Handling Hate Crimes against Gay, Bisexual, and Transgender People | Scholars Strategy Network." [Online]. Available: <https://scholars.org/brief/understanding-and-handling-hate-crimes-against-gay-bisexual-and-transgender-people>. [Accessed: 29-Jun-2019].
- [16] A. Dutta and R. Roy, "Decolonizing Transgender in India Some Reflections."
- [17] S. Wesley, "Twin-Spirited Woman: Sts' iyóye smestiyexw slhá: li.," *Transgender Stud. Q.*, vol. 1(3), pp. 338–351, 2014.
- [18] S. I. Khan *et al.*, "Living on the Extreme Margin: Social Exclusion of the Transgender Population (&Hijra&) in Bangladesh," *J. Heal. Popul. Nutr.*, vol. 27, no. 4, pp. 441–51, Sep. 2009.



- [19] M. Price, "The Effects of Identity-Based Victimization on Youth: An Intersectional Examination of Mental Health, Academic Achievement, and the Impact of Teacher-Student Relationships."
- [20] J. McGovern, "The Forgotten: Dementia and the Aging LGBT Community," *J. Gerontol. Soc. Work*, vol. 57, no. 8, pp. 845–857, Nov. 2014.
- [21] J. Fish, "Navigating Queer Street: Researching the Intersections of Lesbian, Gay, Bisexual and Trans (LGBT) Identities in Health Research," *Sociol. Res. Online*, vol. 13, no. 1, pp. 1–12, Jan. 2008.
- [22] R. Mills, "Queer is Here? Lesbian, Gay, Bisexual and Transgender Histories and Public Culture."
- [23] A. J. Martos, P. A. Wilson, and I. H. Meyer, "Lesbian, gay, bisexual, and transgender (LGBT) health services in the United States: Origins, evolution, and contemporary landscape.," *PLoS One*, vol. 12, no. 7, p. e0180544, 2017.
- [24] "National Transgender Discrimination Survey: Full Report | National Center for Transgender Equality." [Online]. Available: <https://transequality.org/issues/resources/national-transgender-discrimination-survey-full-report>. [Accessed: 29-Jun-2019].
- [25] G. L. Greenwood and E. P. Gruskin, "LGBT Tobacco and Alcohol Disparities," in *The Health of Sexual Minorities*, Boston, MA: Springer US, 2007, pp. 566–583.
- [26] A. B. Mullens, J. Fischer, M. Stewart, K. Kenny, S. Garvey, and J. Debattista, "Comparison of Government and Non-Government Alcohol and Other Drug (AOD) Treatment Service Delivery for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community," *Subst. Use Misuse*, vol. 52, no. 8, pp. 1027–1038, Jul. 2017.
- [27] S. Cahill and H. Makadon, "Sexual Orientation and Gender Identity Data Collection in Clinical Settings and in Electronic Health Records: A Key to Ending LGBT Health Disparities," *LGBT Heal.*, vol. 1, no. 1, pp. 34–41, Mar. 2014.
- [28] R. L. Kitts, "Barriers to Optimal Care between Physicians and Lesbian, Gay, Bisexual, Transgender, and Questioning Adolescent Patients," *J. Homosex.*, vol. 57, no. 6, pp. 730–747, Jun. 2010.
- [29] K. Fallin-Bennett, "Implicit bias against sexual minorities in medicine: cycles of professional influence and the role of the hidden curriculum.," *Acad. Med.*, vol. 90, no. 5, pp. 549–52, May 2015.
- [30] N. Nama, P. MacPherson, M. Sampson, and H. J. McMillan, "Medical students' perception of lesbian, gay, bisexual, and transgender (LGBT) discrimination in their learning environment and their self-reported comfort level for caring for LGBT patients: a survey study," *Med. Educ. Online*, vol. 22, no. 1, p. 1368850, Jan. 2017.
- [31] S. Creighton and C. Minto, "Managing intersex.," *BMJ*, vol. 323, no. 7324, pp. 1264–5, Dec. 2001.
- [32] C. C. Gil-Borrelli, C. Velasco, C. Iniesta, P. de Beltrán, J. Curto, and P. Latasa, "Hacia una salud pública con orgullo: equidad en la salud en las personas lesbianas, gays, bisexuales y trans en España," *Gac. Sanit.*, vol. 31, no. 3, pp. 175–177, May 2017.
- [33] T. Poteat, "GLMA - Ten Things For Lesbians," 2012. [Online]. Available: <http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageID=691>. [Accessed: 06- Nov-2018].



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- [34] R. J. Winn, "GLMA - Ten Things For Gay Men," 2012. [Online]. Available: <http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageID=690>. [Accessed: 06- Nov-2018].
- [35] "Depression in the Gay Community," Gay.com. [Online]. Available: <https://web.archive.org/web/20080907050524/http://www.gay.com/news/roundups/package.html?sernum=1355&navpath=%2Fchannels%2Fhealth%2Fspecial%2F>. [Accessed: 06-Nov-2018].
- [36] A. Guasp, "Gay and Bisexual Men's Health Survey Scotland."
- [37] "ICD-11 - Mortality and Morbidity Statistics." [Online]. Available: <https://icd.who.int/browse11/l-m/en/#/http%3A%2F%2Fid.who.int%2Ffid%2Fentity%2F90875286>. [Accessed: 06-Nov-2018].
- [38] L. Erickson-Schroth, *Trans bodies, trans selves : a resource for the transgender community*.
- [39] J. Mcneil, L. Bailey, S. Ellis, J. Morton, and M. Regan, "Trans Mental Health Study 2012 Main header 2 Contents," 2012.
- [40] "GLMA - Ten Things For Trans Individuals." [Online]. Available: <http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageID=692>. [Accessed: 06- Nov-2018].
- [41] M. B. Feldman and I. H. Meyer, "Eating disorders in diverse lesbian, gay, and bisexual populations," *Int. J. Eat. Disord.*, vol. 40, no. 3, pp. 218–26, Apr. 2007.
- [42] A. R. Smith, S. E. Hawkeswood, L. P. Bodell, and T. E. Joiner, "Muscularity versus leanness: an examination of body ideals and predictors of disordered eating in heterosexual and gay college students," *Body Image*, vol. 8, no. 3, pp. 232–6, Jun. 2011.
- [43] S. T. Russell, A. K. Driscoll, and N. Truong, "Adolescent Same-Sex Romantic Attractions and Relationships: Implications for Substance Use and Abuse," *Am. J. Public Health*, vol. 92, no. 2, pp. 198–202, Feb. 2002.
- [44] M. Eisenberg and H. Wechsler, "Substance use behaviors among college students with same-sex and opposite-sex experience: results from a national study," *Addict. Behav.*, vol. 28, no. 5, pp. 899– 913, Jul. 2003.
- [45] J. A. Ford and J. L. Jasinski, "Sexual orientation and substance use among college students," *Addict. Behav.*, vol. 31, no. 3, pp. 404–413, Mar. 2006.
- [46] J. R. Udry and K. Chantala, "Risk assessment of adolescents with same-sex relationships," *J. Adolesc. Health*, vol. 31, no. 1, pp. 84–92, Jul. 2002.
- [47] K. Lobel and National Coalition Against Domestic Violence (U.S.). Lesbian Task Force., *Naming the violence : speaking out about lesbian battering*. Seal Press, 1986.
- [48] "Submission No 46 INQUIRY INTO DOMESTIC VIOLENCE TRENDS AND ISSUES IN NSW Organisation: ACON."
- [49] R. O. de Visser et al., "Experiences of sexual coercion in a representative sample of adults: the Second Australian Study of Health and Relationships," *Sex. Health*, vol. 11, no. 5, p. 472, Nov. 2014.
- [50] M. Pitts, H. La Trobe University. Australian Research Centre in Sex, and Gay and Lesbian Health Victoria., *Private lives : a report on the health and wellbeing of GLBTI Australians*. Australian Research Centre in Sex, Health and Society, 2006.



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[51] A.-K. Larsson and A.-K. Dykes, "Care during pregnancy and childbirth in Sweden: perspectives of lesbian women.," *Midwifery*, vol. 25, no. 6, pp. 682–90, Dec. 2009.

[52] UNAIDS, "Miles to go - Closing gaps, breaking barriers, righting injustices," Geneva, 2018.

[53] T. Sandfort, M. S. Frazer, Z. Matebeni, V. Reddy, I. Southey-Swartz, and Southern African Lesbian and Bisexual Women Research Team, "Histories of forced sex and health outcomes among Southern African lesbian and bisexual women: a cross-sectional study," *BMC Womens. Health*, vol. 15, no. 1, p. 22, Dec. 2015.

[54] T. G. M. Sandfort, L. R. M. Baumann, Z. Matebeni, V. Reddy, and I. Southey-Swartz, "Forced Sexual Experiences as Risk Factor for Self-Reported HIV Infection among Southern African Lesbian and Bisexual Women," *PLoS One*, vol. 8, no. 1, p. e53552, Jan. 2013.

[55] C. L. Minto, L.-M. Liao, C. R. Woodhouse, P. G. Ransley, and S. M. Creighton, "The effect of clitoral surgery on sexual outcome in individuals who have intersex conditions with ambiguous genitalia: a cross-sectional study," *Lancet*, vol. 361, no. 9365, pp. 1252–1257, Apr. 2003.

[56] O. Taylor, C. M. Rapsey, and G. J. Treharne, "Sexuality and gender identity teaching within preclinical medical training in New Zealand: content, attitudes and barriers.," *N. Z. Med. J.*, vol. 131, no. 1477, pp. 35–44, 2018.

[57] J. Obedin-Maliver *et al.*, "Lesbian, Gay, Bisexual, and Transgender-Related Content in Undergraduate Medical Education," *JAMA*, vol. 306, no. 9, pp. 971–7, Sep. 2011.

[58] E. Coleman, "Sexual Health Education in Medical School: A Comprehensive Curriculum," *Virtual Mentor*, vol. 16, no. 11, pp. 903–908, Nov. 2014.

[59] Association of American Medical Colleges, "Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, Gender Nonconforming, or Born with DSD," 2014.