

## IFMSA Policy Proposal Health of LGBTQIA+ individuals

Proposed by Team of Officials

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## POLICY STATEMENT

### Introduction

Equity and non-discrimination for all people are core principles of human rights but are still not recognized by laws in many states, impinging 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. It remains common practice to subject intersex children to unnecessary procedures that conform them to binary sex categories and may cause permanent injuries. Despite these key health disparities, medical schools severely mis- 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

The IFMSA strongly upholds the human rights of LGBTQIA+ people, including the right to health. We are alarmed by all forms of discrimination and violence based on sexuality or gender identity. Moreover, we acknowledge that the responsibility to ensure equitable access to health services lies within healthcare systems which should promote health structures closer and more accessible to this minority, recognize and address specific health needs of LGBTQIA+ individuals, build capacities of the healthcare workforce on the matter, implement policies repealing discriminatory practices and ensuring safe environments, and ensure accountability measures for malpractice, violence and discrimination. We also believe that medical schools have a duty to equip medical students with the skills and knowledge needed to provide health care to LGBTQIA+ people in an adequate, responsive and sensitive manner. We emphasize that the LGBTQIA+ community should be meaningfully involved in decisions relating to research and changing healthcare systems to address the diverse needs of the community.

### Call to action:

Therefore, IFMSA calls on:

#### Governments and policy-makers to:

- Implement national policies that assure equity and non-discrimination for all LGBTQIA+ individuals, taking into account diverse social issues they face.
- Encourage public participation and activism in order to end stigma and discrimination against LGBTQIA+ people seeking medical treatment.
- Establish, improve data collection data on various aspects of LGBTQIA+ individuals' lives, such as their experiences with discrimination, access to services, and make it publicly available.
- Ensure that LGBTQIA+ persons have safe and nondiscriminatory access to health care, including mental health treatments, and that they are protected from all forms of violence and discrimination.
- Criminalize LGBTQIA+phobia with harsher penalties in order to protect the LGBTQIA+ population against mental and physical health injuries.
- Ensure universal and free access to gender-transition treatments such as hormonal therapy and gender affirmation surgery.
- Recognize the importance of the social name of transgender and non-binary people and allow them to change their birth name in governmental documents.
- Enact laws to protect intersex children from non-medically necessary sex-assignment surgery.
- Recognize same-sex relationships intending to guarantee health insurance via civil marriage and also health decision-making.

#### Civil society to:

- Unite efforts and manage activities with an inclusive and intersectional perspective, which ensures proper coverage of health care for the LGBTQIA+ population.
- Advocate for laws and policies that ensure equity for LGBTQIA+ individuals.

- Foster positive attitudes towards the LGBTQIA+ community through allyship, continuous improvement on inclusive and respectful behaviors, and condemning discrimination in public and private settings.
- Address gaps in health and social services for LGBTQIA+ people including information on safe and inclusive healthcare providers.
- Provide support to LGBTQIA+ people facing discrimination and harassment.

**Health professionals and health institutions to:**

- Reflect upon personal attitudes and/or biases that might prevent them from providing equitable healthcare regardless of the patient's gender and/or orientation.
- Take personal responsibility to engage in continued professional development and regularly enhance their clinical skills in LGBTQIA+ health in order to meet patients' physical and mental health needs while keeping in mind an intersectional approach.
- Counteract stigma and violence and take disciplinary action against health personnel found guilty of harassment/discrimination towards LGBTQIA+ individuals.
- Collect comprehensive data and conduct and support evidence-based research in the field of LGBTQIA+ physical and mental health.
- Recognize LGBTQIA+ individuals as a population with distinct health issues outside a framework of sexual deviance or sexually transmitted infections and avoid over-medicalization of the community.
- Abstain from any non-medically necessary procedures for intersex individuals without their full consent, especially gender-conforming procedures for children and infants;
- Provide a safe and welcoming environment for all patients, regardless of their sexual orientation and gender identity;
- Incorporate inclusive language and correct terminology in all official documents and research instruments reflecting gender and sexual diversity and allow patients and personnel to change the documentation if they choose.
- Adopt written policies and guidelines to ensure non-discrimination and cultural competency throughout every aspect of their operations.
- Ensure equitable treatment and inclusion for LGBTQIA+ employees and protect staff from discrimination that is based on their sexual or gender identities.

**Medical schools to:**

- Revise and develop a medical education framework that outlines LGBTQIA+ health needs, fosters a non-judgemental approach and teaches soft skills in health care provision, such as communication and building safe spaces.
- Improve knowledge-sharing ensuring that content on LGBTQIA+ individuals does not solidify harmful stereotypes and attitudes.
- Ensure that educational staff is well-trained on LGBTQIA+ matters that relate to health care provision.
- Ensure a safe teaching environment through adopting anti-discriminatory policies abided by students and university staff and establishing effective reporting systems.
- Ensure that the official student documentation contains diverse gender identification with the possibility of changing the documentation at the person's own will.
- Work with affiliated hospitals and other clinical placement providers to ensure that curriculum and culture around LGBTQIA+ health are consistent across all sites.

**IFMSA National Member Organizations to:**

- Implement internal policies and strategies to create an inclusive and empowering environment for LGBTQIA+ members.
- Advocate to their decision-makers for inclusive policies together with civil society organizations and form sustainable partnerships strengthening their anti-discriminatory activities.
- Empower medical students to combat stigma and discrimination within health care and education by developing skills to advocate for the implementation of LGBTQIA+ health in the medical curriculum.
- Conduct activities that aim to reduce discrimination towards LGBTQIA+ individuals among the general population and that provide health information to LGBTQIA+ community members.
- Promote internal structural changes in order to guarantee that the LGBTQIA+ population does not face related barriers to occupying representative/ leadership positions inside the NMO.

## POSITION PAPER

### Background

LGBTQIA+ individuals face health disparities linked to stigma, discrimination, marginalization and denial of their civil and human rights. Although LGBTQIA+ individuals face similar health conditions as the general population, certain physical and mental health disparities are reported at a higher rate among the LGBTQIA+ community. The medical approach to transgender and gender-nonconforming people is specific, as it includes various objectives regarding gender-affirming procedures and specific health challenges of the transgender population, such as certain medical conditions, including pregnancy. LGBTQIA+ community is also exposed to high rates of different forms of violence, especially hate crimes and intimate partner violence. In addition, many people do not have adequate access to health care, since there is a lack of healthcare services according to their needs, and thus suffer worse health outcomes. Health disparities may be also caused by a lack of specific education and training of healthcare providers and a lack of clinical research on LGBTQIA+ health-related issues [1–3].

Due to limited data on intersectional approaches and barriers experienced by LGBTQIA+ individuals, many conclusions are formed through data from Global North, mainly from the USA. Therefore, it was not possible to sufficiently outline regional and cultural differences as well as reflect lived realities of LGBTQIA+ individuals in the Global South.

#### *Terminology*

For the purpose of this document, the abbreviation LGBTQIA+ refers to Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, 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 these 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.

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

**“Cisgender”** is an adjective that is used to describe an individual, whose “gender identity and gender expression aligns with sex assigned at birth”

**“Cisheteronormativity”** refers to the assumption that heterosexuality is the standard for defining sexual expression and sexuality and that insists on the binary gender/sex division where the gender roles and identity are rigid and respond to sex assigned at birth [4–8].

**“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.

**“Gender identity”** refers to an individual's innermost concept of self as a woman, man, a blend of both, gender in the spectrum in between these two, or neither. The term expresses how individuals perceive themselves and what they call themselves.

**“Intersex”** describes a person with a classically non-binary combination of hormones, chromosomes, and anatomy that is used to assign sex at birth.

“**Sex**” refers to a person’s biological status at birth and is typically categorized as male, female, or intersex. Indicators used to define sex include sex chromosomes, gonads, hormones, internal reproductive organs, and external genitalia.

“**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.

“**Transgender**” is an adjective, which represents an umbrella term for a full range of people whose gender identity differs from what is typically associated with 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.

## Discussion

### Specific health needs and health disparities

#### **Mental health**

Several studies have proven that LGBTQIA+ people have poorer mental health compared to heterosexual and cisgender people: LGBTQIA+ youths are more likely to experience suicidal ideation, suicidal attempt, and depression; whereas LGBTQIA+ adults seem to have more depressive disorders, suicidal ideations, and anxiety disorders than heterosexual adults. Depression rates are 5 times higher in transgender people and 3.5 times higher in LGB people; [9] suicidal attempts are reported up to 14 times more often among LGBTI individuals. Some populations are even more affected, because of their age or ethnicity: LGBT youth face bullying and discrimination in schools, and 1/3 of older LGBT people experience mental issues thorough their lives, after suffering overt harassment, discrimination, and fear of discovery of their identity. LGBT+ people from ethnic/racial minorities are also usually subject to worse mental health due to experiencing intersecting discrimination on the basis of their sexuality and their ethnicity [10].

It is important to outline that a hostile environment due to cisheteronormativity, heterosexism, transphobia and homophobia persisting in the society are the reason for the impeded mental health of LGBTQIA+ individuals, not one’s sexual orientation or gender identity. As a result, stigmatization of a certain group leads to minority stress. In this model, internal distress is caused by two factors; distal/external factors, such as harassment and discrimination, and proximal/internal factors, which consist in the resulting fear of those events happening [9]. Leading to this minority stress are notably discrimination, including from medical staff, but also bullying or hate crimes. Discriminations can lead to economic instability and vulnerability to health and mental health issues [9]. Concerning bullying, the percentage of non-heterosexual people being bullied is much higher than their heterosexual peers, and that bullying is also more aggressive and results in more mental health issues [11]. A consequence of minority stress (especially conversion therapies) is that LGBTQIA+ people themselves can have homophobic/transphobic social attitudes, defined by the concept of “internalized homophobia”. It results in self-deprecation and denial [10].

One specific act that has been proven very deleterious to mental health is conversion therapies, where families of LGBTQIA+ kids send them to a “therapist”/religious leader in the attempt to psychologically and/or physically “change” the kid’s sexual orientation to heterosexual. There is no evidence that they have intended outcomes but multiple research has shown the devastating effect conversion therapies have on individuals’ mental health, leading to depression, regression of one’s identity, suicidal thoughts and attempts [12]. They’ve been banned in more than 20 countries (of which 13 in the last 3 years), [13] and are condemned by American Psychological Association as well as other psychology-associated organizations [14].

A consequence of these gender/sexuality-based discriminations is that the LGBTQIA+ population doesn’t feel safe within society. They are therefore scared to seek support, including reaching out to mental health

facilities and professionals as they anticipate discrimination from healthcare providers as well. Out of fear, they may not be completely honest, compromising the patient-provider relationship. They might also experience the feeling that they don't deserve the same respect and access to healthcare as heterosexual people. As LGBTQIA+ patients have different mental health needs than heterosexual individuals, omission of this by healthcare providers might lead to the feeling of invisibility by healthcare systems.[9] The most efficient way to ensure the LGBTQIA+ population's mental health is to offer support, and psychosocial education and ensure safe spaces through anti-discrimination policies and workforce education. Specific sensibilization and training programs, as well as more innovative methods like self-reflection to address the healthcare providers' attitudes, are possible ways of guaranteeing that [9]. Family acceptance has also been proven to be the better protecting factor for LGBTQIA+ persons [10].

### **Physical health**

When the most common LGBTQIA+ health issues are analyzed, 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]. Also, there is a significant rate of drug and tobacco abuse, which has been related to marginalization and also contributes to an increased risk of cardiovascular problems. Gay men have a 72% higher risk to develop hypertension compared to straight men. Among women, no difference was observed between lesbian and heterosexual ones[15] [33] [43][44][45][46]. Besides, a systematic review has shown that both lesbian women and gay men had a greater risk of cardiovascular diseases (CVD) and also more elevated biomarkers for CVD in blood samples, which is may be explained by stressful events in life they experience in contrast to the straight population[16].

Due to hesitancy to attend health care out of fear of discrimination, they are more prone to be lately diagnosed with life-threatening diseases, such as cancer. The risk of prostate cancer in trans women and of gynecological cancers in trans men who don't undergo a hysterectomy is commonly forgotten and it must be taken into consideration [40]. The increased usage of transgender hormone therapy has been raising dilemmas regarding the risk of some cancers. The nationwide cohort study in the Dutch population showed that transgender, who were assigned males at birth, had a higher risk for breast cancer compared to cisgender males, but the risk was still significantly lower than in Dutch cisgender women [17]. The other study on the Dutch population in 2020 showed that people, assigned males at birth and receiving androgen deprivation therapy and estrogens, have a substantially lower risk for prostate cancer in comparison with the general assigned males at the birth population, and the deprivation therapy has shown to have a preventive effect on the initiation and development of prostate cancer [18]. 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.

### **Violence against LGBTQIA+ individuals**

Most times it is forgotten as a matter of health, violence plays a huge role as a public health issue for the LGBTQIA+ population. In the US in 2020, out of a total of 8,052 single motivation bias incidents, 1,110 incidents were sexual orientation hate crimes, 266 hate crimes on the basis of sexual orientation, and 75 gender identity-related hate crimes [19]. In comparison, the UK Government statistics from March 2020 to March 2021 report 114,958 hate crime offenses, 17,135 reports regarding sexual orientation hate crimes and 2,630 transgender hate crimes [20][21]. A study delves deeper into the hate crimes against LGBT individuals in Brazil, a country that has the highest rates of deaths due to hate crimes followed by Mexico and the USA. The perpetrators often being partners and the most common being the victim's house. In Europe, Italy has the second highest rate of murders of transgender persons resulting in death, after Turkey. When we further disaggregate the data on deaths of transgender people, according to Transgender Europe (TGEU), between 2008 and 2017, there were a total of 2609 murders, Brazil accounting for the largest [22–24]. The highest risk LGBTQ groups are people of color, transgender and gender non-conforming people, immigrants and gay men

[10]. 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. Fear of discrimination from medical providers also plays a role in the decision not to seek medical care. [15]

Among LGBT individuals, the risk of intimate partner violence (IPV) has been shown to be as high as the general population [25][26]. A systematic review of the literature (2019) found that transgender individuals are 2.2 times more likely to experience physical abuse and 2.9 times more likely to experience sexual abuse than cisgender individuals. IPV is generally under-reported, understudied, and lacks an adequate and specific public support system. In the LGBTQIA+ community, IPV can take very specific forms, such as forcing a partner to public disclosure of their sexual orientation against their will. The rates of rape, assault and stalking are elevated in WSW, who are in same-sex relationships [10].

The experiences of violence have negative outcomes on their mental health. Studies from Sweden and Kenya show that LGBTQIA+ people who experienced violence have higher rates of depressive symptoms, anxiety and post-traumatic stress symptoms [27,28].

### **Sexual and reproductive health**

Studies related to the overall sexual and reproductive health and rights of LGBTQIA+ are lacking, with the exception of sexually transmitted infections [29]. In the clinical context, it is important to be aware of the distinct health challenges of LGBTQIA+ individuals, that lay outside a framework of sexually transmitted infections. The LGBTQIA+ health challenges, that are insufficiently researched, include reproductive organs cancers, infertility and pregnancy.

#### *Sexually Transmitted Infections (STI)*

Gay, bisexual, and other men who have sex with men (MSM) have higher rates of HPV infections. CDC reports that gay, bisexual, and other MSM are 17-times more likely to get anal cancer than heterosexual males. MSM living with HIV have a high incidence of anal cancer, exceeding that of cervical cancer in the general female population. Further research is needed to determine the incidence of HPV among women who have sex with women (WSW), and since WSW are less likely to undergo regular cervical screening they are, thus, at higher risk for cervical cancer. Research has shown that transgender men seek "Cervical Cancer Screening" way less than cisgender women, mainly due to unwelcoming Healthcare environments. Regular screening programs are addressing all women, but the compliance in these programs is lower in WSW in comparison with heterosexual women. Thus, screening programs should take various sexual behaviors into account in promoting participation among non-attending women [30][10] [30] [31]. LGBT individuals also often get other STIs, including chlamydia and gonorrhea infections. MSM account for approximately 20% of new cases of HBV infection, thus it is strongly recommended for MSM to receive an HBV vaccine. CDC estimates MSM account for approximately 3/4 of syphilis cases, many of which are often associated with HIV coinfection [31]. Among people who have receptive anal sex compared with the general population, proctitis is particularly common. It has been shown that recent genital-on-genital contact between people with external female reproductive organs is associated with a higher rate of bacterial vaginosis [10].

MSM and transgender individuals remain the group with the highest incidence and prevalence of HIV infection. Overall, HIV infection risk is 27 times higher among MSM and 49 times higher among transgender individuals than in the general population[32]. From 2009 to 2014, 2351 transgender people were diagnosed with HIV in the United States, of which the majority (84 %) represented transgender women [10]. A study from 2017, on the other hand, estimated HIV prevalence among trans and gender-diverse people at 0.46–4.78/1000, compared with 1.7/1000 in the British general population. Lower prevalence may be connected to the greater access to free health promotion and HIV testing in the UK, as well as high rates of

viral suppression, and thus lower risk of transmission [33]. Transgender women are especially exposed to high rates of psychosocial stigma, marginalization and discrimination, which can affect the mental health of these individuals, and also their economic opportunities, and thus may place members of this population at an increased risk for HIV infection. Mental health conditions, including substance use disorders, are associated with an increased risk of HIV infection, and conversely, some mental disorders occur as a direct outcome of HIV infection. Prevalence rates in mentally ill patients have been reported to be 5% - 23%, compared with a range of 0.3% - 0.4% in the general population in the USA over comparable time periods [34]. High-risk behaviors, such as injection drug use, may play a role in HIV risk in the population of WSW [10]. Men living with HIV are even more likely than those who do not have HIV to get anal cancer [35] [30]. HIV status has been linked to higher cancer prevalence and mortality rates in some cancers, including colorectal, pancreatic, lung, and melanoma cancers [30] [36].

#### *Parenthood and pregnancy*

Lesbian and bisexual women also experience a lack of support during pregnancy. In the cultural context, pregnancy is often treated as an exclusively female experience. Pregnancy and parenthood services are often based solely on traditional mother-father dynamics [37] [38]. Stigma, discrimination and inadequate medical support, which is coming from the lack of appropriate knowledge and/or training from healthcare professionals are factors that can contribute to unequal prenatal and postnatal care in transgender men, in the addition to substantial obstacles to achieving pregnancy and unique medical implications and physical challenges during pregnancy and birth. Cisnormative assumptions about pregnancy status and experiences often exclude trans men and non-binary people with masculine gender expressions [39].

#### **Gender-affirmation procedures**

Gender nonconforming and transgender people can pursue many different gender-affirming procedures to ease or treat their gender dysphoria. These procedures can be surgical, hormonal, and non-medical and they have been shown to ease gender dysphoric individuals and help attain a greater level of comfort in the gender expression of transgender and gender-nonconforming people. Transitioning is an extremely personal process that usually takes years. Different people will choose to have different procedures depending on their needs and desires so the treatment must be tailored specifically to each patient [10] [40].

Hormonal therapy is a component of transitioning and consists of blocking the endogenous sexual hormones and can also replace them with the hormones of the identified gender. This type of therapy is mostly used to reduce the secondary sex characteristics of the assigned sex [10]. Hormone therapy has been shown to improve quality of life, specifically improving self-esteem and decreasing the severity of depression. Requirements to start hormone therapy vary among countries but we still observe a majority of nations that require documented "proof" of gender dysphoria for a certain period of time by a healthcare professional. Hormonal therapy does come with some adverse effects that patients will be made aware of before starting, to assess the benefits and risks but also to plan for possible future fertility problems. Hormonal therapy has shown to greatly alter reproductive capabilities and therefore requires planning for those who want to reproduce. Among other adverse effects, we have to highlight the cardiovascular effects that the medication can have, making it less accessible to people with comorbidities [41].

Surgical options can be divided into genital and non-genital surgeries, both of them being components in managing gender dysphoria, and therefore improving quality of life. There are a great number of surgical options available, and in most countries where these procedures are done, documented "proof" of gender dysphoria is required to even consider starting the process. We observe that genital surgeries are the ones that require the most documentation and are therefore less accessible. Several studies have found that surgical procedures are some of the most effective ways to improve the mental health of gender dysphoric individuals, leading to a decrease in toxic practices such as smoking, excess drinking, and drug consumption as well as a decrease in suicidal ideation. Access to these procedures can therefore be lifesaving and greatly

improve the quality of life of transgender and gender-nonconforming individuals. Being able to undergo all the desired procedures has shown the most improvement in mental health and healthy lifestyle choices [41].

### **Specific health needs of intersex individuals**

A number of international medical classifications of diseases, such as the ICD-11, are still classifying Intersex Variations as “Disorder of Sex Development” [42]. This is why certain medical procedures are still introduced as medically therapeutic. This has proven to increase the prevalence of unnecessary bodily modifications that may result in future mental issues.

The intersex community, over the years, has not been well-represented in the LGBTQAI+ community. Research, especially medical research, is still lacking for most intersex-related health issues and disparities this community may be facing.

Very few studies have been conducted on the mental and physical health of Intersex individuals. However, these same studies have shown a higher rate of mental health issues among the intersex community. Depressive disorders, Anxiety disorders, and PTSD have been the most common mental health diagnoses among intersex individuals. A study showcased that around a third of its participants attempted suicide at least once in their lifetime, noting that the responses to this question were indifferent to the age of the person.

According to a recent study conducted on 198 adult intersex individuals in the United States, over 43% of these participants rated their physical health as poor/fair. Additionally, around 53% of the participants rated their mental health as poor/fair. More than a third of the population reported difficulty in their day-to-day tasks and over a half reported difficulties with cognitive tasks during the day. These results clearly translate the health disparities experienced by this population of the LGBTQAI+ community. The most prevalent non-communicable diseases (NCDs) found among the community members included arthritis, anxiety, depression, as well as hypertension. These NCDs are greatly dependent on the patients' age, showing significant age differences in their prevalence. [43] On another hand, a higher risk of germ cell malignancies among intersex children has been found. However, no studies have been conducted to find if the risk is also higher among intersex individuals of other age groups.

Note that there are insufficient studies and data on other NCDs from the ones discussed above, as well as a lack of developed data on intersex adults.

### **Asexuality**

Throughout history, asexuality has often been overlooked as sexuality. People with minority sexual and gender identities have been undergoing pathologization by physicians, and asexuality has been medicalized in contexts of sexual desire disorders, hypothyreosis, depression, negative body image, or even considered a “transient state”, especially for the younger population [44] [45]. Different population-based surveys display the prevalence of self-defined asexuality to be 0.3 - 1 % [46] [47] [48] [49]. The literature presents asexuality as a sexual orientation and states that the self-identification of asexual people is not a pathological condition nor a mental disorder [50] [51]. Asexuality does not necessarily mean the absolute lack of sexual encounters, since some asexual individuals may still experience sexual desire/arousal and or activity to some degree and they may even derive pleasure from it. However asexual people tend to just not direct or connect the desire/arousal/activity toward it with anyone or anything [52] [53]. The important difference between asexuality and hypoactive sexual desire disorder (HSDD) is that asexual persons do not experience distress due to the lack of sexual attraction and/or desire [51] [54]. Patients with HSDD often experience marked distress/interpersonal difficulty, whereas asexual individuals seem contented and/or function adequately interpersonally. Nevertheless, asexuality is likely to be present in HSDD and related disorders, which can present a risk of misdiagnosis [55] [56] [57] [58].

Asexual people may suffer stigma and marginalization on the behalf of the sex-normative-oriented society. This is associated with an increased risk for depression and anxiety, poor mental health, and worsened general well-being [44] [45] [55] [59].

Research shows that autistic people are more likely than people without autism spectrum disorder to self-identify as asexual. Studies have shown a significant percentage of young women and gender-diverse autistic people self-identifying as asexual, and among people on the autism spectrum, asexuality is more frequently documented in comparison to the general population [47] [60] [61] [62]. Despite the increase in the body of literature on asexuality, the gap concerning asexuality and the health of asexual people still remains. Further research is needed in order to spread awareness and understanding and address the pathologization of asexuality amongst healthcare practitioners. Continuing research on health disparities experienced by this population is needed, especially on the account of pathologization amongst healthcare practitioners. Even though asexuality is a sexual orientation, the importance of maintaining a clinical focus for some related conditions still remains [63].

#### Intersectionality within the LGBTQIA+ community

LGBTQIA+ individuals are marginalized members of society by virtue of being sexual and gender minorities, resulting in various social, health, and political outcomes as outlined in the position paper. Very often these individuals face the stress from multiple minority identities such as race, ethnicity, ability, caste, citizenship and migration status to name a few. These identities are often complex and layered, adding to the lived experiences of these individuals. These identities and the systems of oppression that follow, intersect and interact uniquely to affect their health and other social determinants of health adversely. Some have termed this as “Multiple Minority Stress”. These stressors affect health in various ways such as chronic biological stress mechanisms demonstrated by the higher levels of E-selectin circulating in African American men, poor mental health as a result of psychological distress, affect health behaviors such as smoking and/or even use of health services [64–66].

There is a dearth of research and literature that documents the health needs of these individuals including their lived experiences. Julie Fish highlights in their article “Navigating Queer Street: Researching the Intersections of Lesbian, Gay, Bisexual and Trans (LGBT) Identities in Health Research”, that in the UK most research includes only gay men and lesbian women that are white, young, middle-class and without disability [67].

When we compare health-related metrics of LGBTQIA+ individuals from Ethnic or Racial minorities, a study in the USA revealed that among adults, African American and Hispanic LGBT adults had a lower physical Health-Related Quality of Life (HRQOL) and almost equivalent psychological HRQOL, as non-Hispanic White LGBT adults. The study highlighted that these were attributed to lower income, educational attainment, identity affirmation and social support. The same study also noted that African Americans faced a higher lifetime LGBT-related discrimination [68]. This can be attributed to the fact that they face both heterosexism and racism within and outside of the LGBTQIA+ community. A study of the health of gay and bisexual Latino men tells a similar story, with them reporting experiences of racism within the gay community [69]. A commentary from the UK notes that very often Black and Minority Ethnic LGBT adults hesitate to describe themselves as gay or lesbian, as it may be seen as a denial of their ethnicity and thus get excluded from many kinds of research. These communities coming out have different connotations, and implications for them [67]. Another study from the USA notes similar trends not just in African American and Latino men, but also in Asian American LGBT adults. In Asian American cultures, studies note that LGBT adults are less likely to self-identify as LGBT because of strict checks on sexuality and the strong importance of traditional gender roles, which contribute to ideas of being lesbian as foreign to their culture or rather Western. Those who defy these cultural norms, bear the burden of shame in their community [70]. This kind of stigmatization hampers the identity development of those with multiple minority identities, especially when they experience discrimination within their own social circles [71]. Researchers suggest that to overcome this issue of

self-identification to make sure research participants are diverse, to expand the definition of sexuality to include desire, behavior and identity [72].

Some other evidence on the compounded effects of health disparities due to multiple minority identities is three studies, one that documents that both African American and White same-sex attracted youth exhibited higher levels of depression than heterosexual participants of that study, while the other two report that, African American LGB adults have a higher risk of suicidality and depression compared to heterosexual people of color and higher risk of suicidality than White LGB individuals [73–75].

When individuals of sexual and gender minority and racial/ethnic minority face microaggressions, especially in clinical settings they influence their health-related behaviors, service utilization, and both mental and physical health.[71,76].

For persons living with disability, sexual and gender-related needs are often overlooked, this was especially highlighted by a study on autism spectrum disorder. The qualitative study which investigates the experience of gender dysphoria for autistic adults, that both gender dysphoria and autism spectrum disorder carry an increased risk of suicide and mental health disorders, most commonly anxiety and depression [77]. Minority stress, stigma, prejudice and discrimination due to being a social minority are contributors to increased risk of suicide and mental health disorders [78].

Individuals with developmental disorders have communicated difficulties in accessing LGBTQIA+ spaces due to various physical, communication or sensory difficulties and being accepted among non-disabled members. Another research notes that neuroatypical transgender individuals also not only have difficulty in accessing public services and employment along with transphobic aggression but also discrimination within LGBTQIA+ spaces, thus facing “double discrimination” and “layered stigma” [79]. Thus services should address these needs sooner, especially through social support [77].

#### Barriers to accessing healthcare

An adequate set of research studies have been carried out across the United States on the active and significant barriers that individuals within the LGBTQIA+ community have to encounter while trying to access health care. It was reported by various LGBTQIA+ individuals that they find extreme difficulty in finding suitable providers that are able to accommodate and understand their needs. Furthermore, these reports have indicated high levels of discrimination from insurers or providers. With the severe lack of federal legislation that is able to prevent and stand up to healthcare discrimination issues that are rooted in the sexual orientation and gender identity of individuals.

Preventive medicine and services targeting the LGBTQAI+ community focus on HIV and other STIs, therefore missing other major health concerns. At times, these services do not focus on the diversity of the LGBTQAI+ community and also fail to target community-specific health needs within the community itself. Lack of awareness of knowledge within the medical community, especially among the primary care workforce, has shown negligence of the specific health needs of LGBTQAI+ individuals by ignoring the obstacles they face throughout their lives [80].

LGBTQ+ people have a lower income on a worldwide level as well as higher poverty rates, compared to cisgender heterosexual individuals. This has shown significantly worse health outcomes and less access to healthcare services. On another hand, people of color from the LGBTQ+ community are twice more likely to face discrimination in their jobs compared to white LGBTQ+ individuals, further translating lower access to proper healthcare services. During the COVID-19 outbreak, the LGBTQ+ community has shown significantly higher rates of job loss, homelessness (including teenagers and young adults), health coverage loss (if initially present), and psychological and physical consequences. These results, which have also been flagrant

during & after the HIV&AIDS pandemic, clearly show the direct effects of all socio-demographic barriers that the community face and their direct impact on their access to proper healthcare [81].

Recently, the department of health and human services in the United States has proposed regulations that would lead and allow the providers of health care to not only discriminate but also refuse to provide LGBTQIA+ people, women, and others with the key services that they require; this was done through the assertion of both moral and religious objection. These recent developments and changes will only aggravate the barriers that LGBTQIA+ individuals struggle against in order for them to receive health care. Furthermore, it provides the insurers and providers latitude to discriminate based on gender identity, as well as sexual orientation.

### **Discrimination by Healthcare Providers**

Barriers to health care are heavily found when it comes to the needs and proper care required by LGBTQIA+ individuals. It has been reported that LGBT people are twice as likely to be uninsured when compared to their non-LGBT counterparts. To further worsen the matter, finding providers that will treat them without passing judgment or being discriminatory against them due to their sexual orientation or gender identity is nearly scarce to very limited, specifically in areas that are more rural.

A survey conducted by the center of American progress in 2017 found that 8% of lesbian, gay, and bisexual participants of the survey and an additional 29% of transgender participants; reported at least one incident in which a healthcare provider refused to provide them with healthcare, or even see them due to their sexual orientation or gender identity all within the one year prior to the study. Within the same study and over the same period of time, the same population of respondents reported that 9% of LGB participants and 21% of transgender participants experienced an encounter with a provider that used harsh or even abusive language. Moreover, many LGBTQIA+ persons are discouraged from obtaining treatment because of discrimination. According to the Center for American Progress survey, 8% of LGBT respondents delayed or avoided medical care due to fears of discrimination in healthcare settings, with those who had already experienced prejudice being especially inclined to postpone getting care.

### **Limited Antidiscrimination Protections**

When LGBTQIA+ community members experience discrimination in health care facilities, the options they can turn to for recourse are extremely limited. As in the United States, 37 states do not prohibit or stand against discrimination by health care providers and insurers, and only 19 states prohibit such discriminatory acts and prohibit the exclusion of medical services for transgender people in insurance plans.

### **Lack of Accessible Services**

LGBTQIA+ persons may have trouble locating the exact services they require even before contacting healthcare professionals. They may not have access to other providers if they are discriminated against. According to the Center for American Progress, 18% of LGBT persons feel it would be "extremely difficult" or "impossible" to locate an alternate provider if they were refused care at a hospital. Outside of big cities, the percentage increased to 41%. If they were turned away from a hospital, community health center, or pharmacy in their neighborhood, transgender persons were most likely to report that other options would be unavailable or inaccessible. This is partly due to the fact that there may be a scarcity of LGBTQIA+-friendly suppliers.

This is partly due to the fact that, especially in more remote regions, there may be few clinicians who are known to give care to LGBTQIA+ people without passing judgment on their sexual orientation or gender identity, or who are trained to provide specific sorts of treatment. Only 16% of respondent institutions offered extensive LGBT-competency training, while 52% had no LGBT-competency training at all, according to a survey of US medical schools performed in 2012. Training on LGBTQIA+ community health matters may be

optional or merely a minor part of a broader course on servicing varied or ethnic communities if it is given. Even in cases in which multiple providers are found located within an area, there are other barriers that partake in this situation. As material and logistical barriers may prevent LGBTQIA+ people from accessing these providers.

### **Social barriers to Access**

According to a survey, 15% of transgender respondents were jobless, and 29% lived in poverty. Individuals without jobs may have a harder difficulty keeping their insurance and purchasing health care. In early 2017, it was projected that 25% of transgender people were uninsured. A third of transgender respondents in the 2015 U.S. Transgender Survey said they had skipped medical treatment they required in the previous year due to financial concerns. Another unexpected barrier that affects LGBTQIA+ people and their ability to access health care is unemployment and poverty. These factors combine together with the other previously mentioned barriers which further makes the ability to obtain any type of care nearly unattainable. In a study that examined the data collected from 2010 to 2014, it was found that the rates of poverty and unemployment were severely higher in U.S. same-sex households than in their heterosexual counterparts.

Moreover, this issue of barriers to accessing health care as a member of the LGBTQIA+ community is not restricted to the United States, this issue is a global issue and traverses cultures, ethnicities, and geographical territories. A Canadian study done on lesbians who have cancer showed that although a small number of patients were denied medical care, most of them felt caregiver discomfort while treating them and these negative experiences lead to the lesbian patients not wanting to even seek medical help. As an American study done on lesbians showed that, the medical care and frequency of seeking it, and communication with the care provider were all influenced by if the care provider showed homophobic actions. Some lesbian patients would choose not to disclose their sexuality when seeking medical care, fearing discrimination or bias in the treatment.

An important note to make is that all the studies mentioned were done in the Global North countries, applying the knowledge to the Global South country can be challenging. As they may face many more barriers when it comes to seeking medical care, and most of the literature on this topic comes from secondary sources. So more effort must be done to study these barriers. Lastly, a majority of the studies are done on lesbians with a fewer number of studies done on bisexual and homosexual people [82–85].

### Discrimination in healthcare settings

#### **Homophobia and biphobia**

In healthcare settings, studies have shown implicit preferences for heterosexual patients during treatments instead of Lesbian or Gay patients. These preferences were mostly expressed by heterosexual healthcare providers, especially heterosexual nurses [86]. Despite the oaths taken by health & social care providers to treat all patients equally and fairly, homophobic attitudes during services are still widespread. In a five-year span, 24% of health & social care providers in the United Kingdom have heard their colleagues make negative comments about LGBTQIA+ individuals. Moreover, more than ¼ of LGBTQ+ staff reported experiencing bullying from their heterosexual colleagues. A worldwide “one-size-fits-all” approach is found to predominate in public healthcare provisions, encapsulating care given to all patients. This approach has created huge gaps in the ways LGBTQAI+ patients are cared for and the LGBTQAI+ staff is treated [87]. A study conducted in Turkey has shown an above-the-average homophobic attitude of health professionals and showed a lack of training programs & initiatives to improve the health professionals’ attitudes towards the LGBTQ+ community [88].

#### *SOGIECE*

The term conversion therapy is a term that most people these days are familiar with. It is an expression meant to refer to efforts to modify a person’s sexual orientation, gender identity or gender expression. These efforts

emerged primarily during the twentieth century as at the time it was considered a pathology. Conversion therapies within that time frame were classified as therapeutic, by the Mental Health field. This led to the presumption of heterosexual orientation and gender identity matching to sex assigned at birth (cisgender) as the biological norm while any deviation from that was considered to be a mental illness that needed to be treated. Later on, these categorizations were depathologized. Moreover, the use of the term therapy is problematic due to the fact that therapies are based on solid medical backgrounds as well as heavily extensive research. However, an extensive list of medical and mental health professional associations have repudiated these practices due to the lack of any scientific or research support. Furthermore, the term conversion is stating that people can be changed and converted. Although the newest term to replace the expression “conversion therapy” is not the most definitive way of conceptualizing such practices it is somewhat of a more accurate reflection of these practices. The term is sexual orientation, gender identity or gender expression change efforts (SOGIECE).

SOGIECE can take on many different forms, this includes:

- Pathologisation of sexual and gender diversity
- Early attempts: bicycle riding, lobotomy and castration
- Hormone intake
- Masturbatory reconditioning
- Hypnosis
- Internment in clinics or camps
- Violent psychotherapy and counseling, including Abusive or otherwise questionable methods such as Nudity and “Touch Therapy”
- Religious counseling
- Exorcism and spiritual/miracle cures

Some of the most debated issues within the community of SOGIECE survivors, as well as scholars and activists, is the enacting laws that ban “Conversion therapies”. The current laws are vastly varied within their approach thus demonstrating that there is more than one method of banning or legally restricting “Conversion therapies.” In 2019, a bill that focused on the banning of conversion therapies aimed at minors was classified as unnecessary by the Swiss Federal council. The arguments presented for this classification explained that the applied criminal laws already sufficiently protect children from any form of abuse and the parents can be brought to justice if they don't oblige to their duties of educating their children. Furthermore, the Council observed that different professional regulating bodies' codes of ethics compel its members to "conduct their activity with care and professional conscience, respecting the boundaries of their competence and the rights of their customers." This issue was expressed by Christian organizations at a public consultation held by the Queensland Parliament (Australia) in 2019 as part of the legislative participatory process to explore a legal prohibition on "conversion therapy." In principle, if a victim can articulate their case and offer compelling evidence to indicate the harm—either mental or physical—suffered as a result of "conversion therapy.” This may be possible if the provider's tactics included the use of severe force, physical assault, or any type of criminal behavior. Torture, physical abuse, wrongful imprisonment, and cruel treatment all come under current criminal law laws and can be punished appropriately, regardless of the perpetrator's intent. Nevertheless, bringing a claim against a provider of SOGIECE within the currently existing laws without any evidence of physical violence could be impossible within the practice areas for several reasons. Providing such proof can be difficult in and of itself since many treatment settings are one-on-one settings with no witnesses or other kinds of recording (in this regard, undercover investigations have proved to be one of the few ways of exposing SOGIECE providers). six Furthermore, assembling all of the essential factual and legal reasons to persuade a court that there is a case to be heard necessitates SOGIECE survivors relying on legal aid services, which are not always available or financially accessible, or are not versed in legal SOGIECE problems. These enlisted barriers among many others can dramatically reduce the possibilities of survivors being able to bring up claims as there is little to no chance of success. Criminal laws will very definitely

provide the legal foundation for prosecution when criminal behavior occurs in the framework of SOGIECE. Legislation that expressly prohibits the supply of SOGIECE (criminal or otherwise) permits survivors to rely on legislative provisions that provide a firmer legal foundation in their quest for justice and reparation.

In order to outlaw the “conversion therapies”, the explicit inclusion of SOGIECE under it is defined as an act of discrimination against people within the LGBTQIA+ community might help act as a legal tool for this purpose. A prominent example of this is the bill introduced in May of 2019 as the chamber of deputies in Chile amend the anti-discrimination law among other things. As any act done by the parents against their children in order to change their sexual orientation or gender identity has been listed as an “act of arbitrary discrimination.” Any person would be able to file a complaint in favor of the child that is the subject of such discriminatory acts. A study carried out in Canada in regard to the prevalence of SOGIECE acts managed to find that exposure to such acts was prevalent even in provinces with robust legal protections for sexual as well as gender minorities. This could suggest that such acts of legal protection do not mention “conversion therapies” explicitly and have not had the effect of offering protection against SOGIECE.

Establishing measures for the protection of children can be done through child protection law legislation, this should be taken into account when considering measures to restrict SOGICE. A federal bill that is still in process in Mexico would help establish the possibility of parents losing their rights of guardianship if there is proof of any acts of force against underage children to pressure them into SOGIECE. Moreover, in 2019 a bill was introduced in Chile that constitutes acts aimed at changing a child’s sexual orientation or gender identity are considered intrafamilial violence and could be classified as “imminent risk” for the child.

The following countries have banned SOGIECE so far: Brazil, Samoa, Argentina, Uruguay, Taiwan, Fiji, Germany, Ecuador, Malta, Ireland, Israel, Denmark, Norway, Finland, Chile, Canada, France, and New Zealand. In Spain, the provinces of Murcia, Valencia, Andalusia, Madrid and Argon. In Australia, Queensland state has banned it [13].

### *Education*

Countries have to make sure that workers in the mental health field are well trained and have access to both scientific and unbiased information about sexual and gender diversity. In an attempt to meet the obligations that they have, about stopping any kind of discrimination or pathologization of sexual identities. The UN Committee against Torture recommended that all public officials and health professionals receive training and education that eliminates discrimination against the pathologization of the LGBTQIA+ community. This came after the discrimination against the LGBTQIA+ community that is implied in Chinese mental health education. In 2014, researchers from the Guangzhou branch evaluated 90 college textbooks and found that about 40% of them thought homosexuality was a disease, and more than half of them said homosexual people should undergo “conversion therapy” to “become heterosexual” [89].

### **Transphobia (Including Transmedicalism)**

Transgender individuals have always been faced with more barriers, especially in healthcare, compared to other members of the LGBTQIA+ community. Throughout the years, Primary Health Providers have shown higher rates of discrimination (whether physically, verbally, or sexually) towards transgender patients, which has shown to adversely affect these patients’ health during their whole lives.

Transphobia in healthcare settings was strongly associated with less sharing from patients of their gender identities, gender-identity-related health issues, transphobic situations in their lives, and gender-based violence. Studies have shown that by increasing primary health providers’ on trans-related health issues, both quality and access to healthcare services are said to improve for transgender patients.

Hiding the patient's own transgender identity from healthcare providers, especially physicians, can negatively affect the health services they receive. On another hand, research has not been inclusive of the Transgender community, therefore increasing the Healthcare gap for Transgender individuals worldwide and reducing the standards of care they receive. Hetero normative, cisnormative environments in Healthcare settings have been shown to decrease the access to proper Healthcare for the Transgender community: Transgender individuals seek health care less, in fear of being mistreated, harassed, abused, or treated as the "Other". Multiple healthcare facilities have shown a lack of knowledge, awareness, and experience regarding gender minorities. This has been recorded both on the administrative and healthcare levels.

Transgender men are twice as likely as transgender women to keep postponing seeking healthcare needs, even when urgent, due to their fear of discrimination. Transgender people of color have been noted to experience higher levels of transphobia in healthcare settings compared to their white counterparts. Noting that transgender individuals also face higher levels of poverty and unemployment, this renders their access to health services even more challenging at times. This shows the importance of the adoption of an intersectional healthcare approach in our services [90] [91] [92].

### **Acephobia**

Asexuality is often an object of microaggressions, which are similar to those experienced by other non-heteronormative orientations[93]. In the social context, asexual individuals often face the issues such as marginalization, bias and lack of understanding, which are also often present in healthcare. Healthcare providers often express denial, resistance, rejection [94] and pathologization of asexuality due to incompatibility with heteronormative expectations. Stereotypes regarding asexuality can create barriers to physical and mental health care.[94] Research shows asexual individuals often assume health practitioners would be biased toward them.[95] In addition to this, the experiences of disclosure to health care practitioners are reported as being particularly stressful, as the majority of participants in the 2014 study did not feel comfortable disclosing their identity to providers nor discuss sexuality status with them. On the contrary, asexual individuals seem more likely to disclose their sexual orientation to mental health providers, since they consider it more relevant for the therapy process[95]. Research on the topics is limited, but the existing studies show that a majority of health professionals are not aware and educated on asexuality. The lack of understanding and education on asexuality by healthcare providers can lead to attempts of providing unwanted treatments to the patients, instead of delivering the treatments needed by the patients upon their admission. [96]

### **Intersex mutilation**

When a baby is born with "ambiguous genitalia", meaning we can't attribute them to being male or female, they might be subjected to undergoing "corrective surgery", trying to conform them to a gender decided by parents or doctors. But for several decades now, intersex patients' associations have been warning about the deleterious effect of those surgeries. They can notably cause scarring, chronic pain, chronic incontinence, loss of sexual sensation, infertility, inaccurate gender assignment, and trauma.[97] Additionally, even though there is no medical evidence supporting that surgery can help an intersex baby, some parents feel pressured into choosing medical procedures. They often report that they regret their choice as it did not benefit their child, harmed them, and created difficulties in the parent-child relationship [98].

Even though some of the surgeries might be necessary for the child to be healthy, most of them are unnecessary and purely for aesthetic purposes and due to the social pressure of binary society. Additionally to the physical and mental issues they may cause, they're also a problem in ethics, as the child is not able to deliver informed consent. For that reason, after Malta in 2015, Germany recently decided to ban non-necessary surgeries on intersex babies. More than 50 countries have signed a statement calling on the United Nations Human Rights Council (UNHRC) to adopt "concrete measures to combat harmful practices, violence and discrimination based on sex characteristics.", including intersex people [99][100][101].

But coercive surgeries at birth are not the only discrimination toward intersex people. The UN also warns about infanticide, forced and coercive medical interventions, discrimination (in education, sport, employment, and other services), and lack of access to justice and remedies.[102] Their right to health is threatened by stigma and bias, lack of clinical training, and unnecessarily pathologizing clinical practices and classifications. It can be difficult to obtain legal identification documents as their legal status is not established or recognized. Society as a whole is also struggling to classify the diverse legal and social status of intersex people, as they do not fit the usual sex or gender categories [103].

The Intersex Society of North America is demanding that “Children with intersex, parents of those children, and adults with intersex should be treated in an open, shame-free, supportive, and honest way. They should consistently be told the truth (this includes providers being honest about uncertainty), and should be given copies of medical records as soon and as often as they ask for them.” [104]

#### Gaps in medical education and research

Regarding medical education, it's seen that there is a great lack of LGBTQIA+ subjects inside the standard curriculum of most universities. The health professionals do not feel enough capacitated to tend to these patients, especially the transgender population, since their body physiology, such as menstruation in a man, is completely forgotten and supplanted by the cisgender models.[105] This scenario leads the LGBTQIA+ people to avoid looking for healthcare since their needs will not be understood and their physical and mental health will be at risk due to the lack of knowledge of the physicians.

Thorough teaching is needed to best support LGBTQIA+ patients. As outlined by guidelines including those published by the Association of American Medical Colleges, the 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 [106,107].

To counter this educational gap, some students and advocate health professionals create initiatives, like co-curricular programs, to supplement the lack of institutional interest in implementing the LGBTQIA+ discussion inside the curriculum. Some of it is designed to educate not only graduating health professionals but even the already graduated ones. In this way, the students and LGBTQIA+ organizations sometimes have been the only and main characters to fill the educational gap that should be the duty of both universities and governments.

Another obstacle in the development of well-established LGBTQIA+ teaching programs in the curricula is the lack of materials and evidence-based studies to give the basis for the elaboration of the educational strategy. The limited number of researches is explained by technical difficulty to cover the array of definitions for LGBTQIA+ people to describe themselves in non-qualitative research. For example, if a queer pansexual person is asked about their sexuality and some limited definitions are given such as heterosexual, gay or bisexual in a study, maybe they will answer bisexual, but if they are asked in another research that allows them to describe themselves freely, they certainly answer how they truly understand their inner self. [108] Besides that, sexuality and gender identification may be changed in the course of one's personal life and they must be understood as fluid. Such issues become statistical problems in the end.

Also, the diminished number of researches concerning LGBTQIA+ health problems, such as risk factors for diseases plays a big role in the studies gap. This is partially explained by the difficulty of physicians in properly asking the patients about their sexuality and gender identity which can be even worse if respectful

and inclusive language is not used during the clinical consultations, leading the patient to feel uncomfortable and omitting such pieces of information [108].

### LGBTQIA+-friendly services and strategies to improve the health of LGBTQIA+ individuals

LGBTQIA+ people share remarkably similar experiences related to stigma, discrimination, rejection, and violence across cultures and locals. Sodomy laws, which brand gays and lesbians as criminals, are often the basis for harassment and discrimination. Social conditions that are characterized by rejection and discrimination distinguish the public health of LGBTQIA+ populations because they affect a wide range of issues, including the selection of research priorities, the design of public health prevention and intervention programs, as well as the development of standards, access to services, and the provision of culturally sensitive care. Stigma and discrimination affect the health of LGBTQIA+ people in many ways.[10] Indirect routes are invisible but more pervasive: they include inadequate attention to health concerns of LGBTQIA+ people because of stereotypic thinking, lack of attention to LGBTQIA+ health issues because they affect only a relatively small number of people, and lack of knowledge and insensitivity regarding the cultural concerns of LGBTQIA+ people.

LGBTQ+ individuals are at higher risks for NCDs & health issues not related to their sexual orientation & gender identity, compared to their heterosexual/cis-gender counterparts. As such, they require special public health attention and unique approaches for investigation, prevention, and treatment. The development of LGBTQIA+ friendly services and strategies is therefore essential to improve the overall wellbeing of our population and has to be approached from many perspectives. The efforts have to start making these services more accessible. A study conducted on LGBT patients showed that healthcare providers with cultural and clinical knowledge of the LGBTQIA+ community received a greater number of visits from their patients, and had an increase in preventive testing and vaccination [108].

Studying effective methods used in LGBTQIA+ services can be divided into two main categories: Communication and Physical Environment.

#### **Communication**

In terms of language, clinicians must know and use the correct terminology that transgender and gender-nonconforming people may use, including gender pronouns (and in some languages gendered grammatical forms) and alternate terminology for their body parts, always avoiding presumptive language and assumptions about the patient's sexuality, identity and sexual behavior, including for people who identify as heterosexual.[109] A survey showed that 9.4% of men who identified as heterosexual had reported engaging in sexual activities with at least one other man in the preceding year. Other recommended practices are the use of gender-neutral language in all forms that include spaces for patients to announce their preferred name (that might be different from the one in legal documents and it should be respected), their pronouns, and gender identity. Safe and unprejudiced environments have been shown to increase ease of disclosure. This is best achieved by training all the staff on the use of appropriate language, LGBTQIA+ health and specific needs, and identifying and dealing with discriminatory beliefs. Having personnel to handle relevant LGBTQIA+ care leads to fewer negative experiences and therefore, greater ease which leads to better communication and ultimately better health [108].

#### **Physical environment**

When it comes to the physical environment, different practices have shown to be very effective. Public displays of support such as prominently displaying LGBTQIA+-friendly symbols and having brochures, newsletters, and magazines tackling LGBTQIA+ specific issues exhibited in the waiting rooms, help create an inviting environment for patients who may scan the environment for cues supporting disclosure of their sexuality, gender identity or sexual behavior. Other methods to create an inclusive physical space include

single-person gender-neutral bathrooms, well-publicized patient nondiscrimination, and confidentiality policies and media containing LGBTQIA+ representations [108].

#### Global perspective

Although the rights of LGBTQIA+ persons are protected under existing international human rights law and internationally, there has been a concerted effort to ensure access to healthcare as a right for all people, there are significant obstacles and barriers exist due to health inequalities and the associated factors including gender, ethnicity, income, employment, and housing [110].

This detailed problem finds its cause in the different legislations in different countries around the world where a direction towards equality is not contemplated, as well as in the various prejudices adopted and spread:

- 69 UN Member States with provisions criminalizing consensual same-sex conduct; at least five UN Member States where certain sources indicate that the death penalty may be imposed.
- At least 42 UN Member States where there are legal barriers to freedom of expression on issues related to sexual and gender diversity.
- 41 UN Member States with known legal barriers to the registration or operation of civil society organizations working on Sexual and Gender Diversity.
- Only 11 UN Member States and 1 non-UN Member State with constitutional provisions that confer protection against discrimination based on sexual orientation
- Only 4 UN Member States and one non-independent jurisdiction (Puerto Rico) ban SOGIECE [13,111–113].

The visibility of LGBTQIA+ communities has grown globally after a breakthrough 2011 UN resolution called for attention to the violence and discrimination perpetrated against people based on their sexual orientation and gender identity. Stigma, discrimination, and violence are among the factors that contribute to LGBTQIA+ health inequalities. Despite the fact that these structural and social determinants of health are recognized, little progress has been achieved in addressing them.

In parliaments, assemblies, courtrooms, and on the streets, lesbians, gays, bisexuals, trans, intersex, and other populations are fighting for the realization of rights that they have like all other individuals. Because just as there are several advances in certain countries, there are also many others where this population is even more repressed, finding LGBTQIA+ people in a continuous confrontation against real discrimination in all areas of life [114].

#### IFMSA Contribution to Health of LGBTQIA+ individuals

IFMSA Programs have vastly advocated for the health of LGBTQIA+ individuals through various programs such as Gender Based Violence (GBV), HIV, AIDS and other STIs (HAS), Ethics and Human Rights in Health (EHRH), Mental Health (MH), Emergencies, Disaster Risk and Humanitarian Action (EDRHA) and most notably the Realizing Sexual and Reproductive Health and Rights (RSRHR) programs. While these program activities target and benefit LGBTQIA+ individuals, the RSRHR Program has an entire focus area dedicated to LGBTQIA+ issues.

From the term 2018-19 to 2020-21, 26 activities have directly targeted LGBTQIA+ individuals to address issues faced by them related to SRHR, Mental Health and GBV. 38 activities have indirectly benefited individuals and the community by addressing their situation of vulnerability in Emergencies, Disasters and Humanitarian Situations, through advocating for their rights, especially in relation to Health, other than the already above-stated areas. More than 11,091 LGBTQIA+ individuals have benefited from IFMSA activities.

Beyond activities conducted by NMOs, IFMSA International Team has worked to advocate for LGBTQIA+ health through the power of social media campaigns, educating and creating awareness on common issues

faced by individuals and the community. Every year since 2018, the PC for RSHR has coordinated efforts with SCORA IT to conduct a campaign on International Day of Homophobia, Biphobia and Transphobia (IDAHOBIT), putting to light the discrimination and violence they face on a day-to-day basis. In 2020, with ILGA International a webinar was conducted as part of the campaign. A campaign on Pride Month was conducted too, during the same term.

In ensuring that LGBTQIA+ individuals and the community are able to access equitable, inclusive and quality healthcare, IFMSA has been building the capacities of medical students worldwide through workshops in SRTs, pre-General Assemblies, pre-Regional Meetings, SCORA X-Changes, sessions in General Assemblies and Regional Meetings. These include topics on the basics of SOGIESC, CSE, LGBTI refugees, The Queer Theory to highlight a new perspective on SOGIESC, Educational Activity on Sexual Orientation and Gender Identity in Exchanges. Toolkits and Policies were also drafted by the IT and released to increase knowledge of medical students on LGBTQIA+ health and advocate for their inclusion in IFMSA exchanges to make it a safe space for them. This includes the policy document adopted in August Meeting 2019 on “Health of LGBTQIA+ individuals”, a toolkit on “Educational Activity Toolkit: Sexual Orientation and Gender Identity in Exchanges”.

Our advocacy was not just limited there but also to external meetings and conferences such as AMEE and FIGO. At AMEE Conference 2021, the abstract “Addressing the LGBTQIA+ Health in medical curricula” was accepted for presentation. At FIGO World Congress 2021 “SRHR of LGBTQIA+ women in medical curricula” was also accepted for presentation. An official press release for Intersex Awareness Day 2018 was spearheaded by the PC for RSRHR that term [115–117].

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