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Research Paper

Ensuring LGBT-Affirming Health Care Environments: A Call for Inclusion

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ABSTRACT

Engendering healthcare is a pivotal basic necessity. The Sustainable Development Goals confer the global health community a strategic chance to advance gender equality, human rights, and universal health. Despite grant of rights laid in the Constitution of India, ushering a revolutionary implementation change is fanciful. The ubiquitous asymmetric power dynamics, gender inequities, & other intersecting social issues frequently leaves the minority powerless, disenfranchised, and vulnerable. The paper thus attempts to explore healthcare barriers amongst the most marginalised section of society with regard to gender & sex, who face numerous health inequities viz-a-viz accessibility and quality care. The current study is an attempt to explore the prevailing state of medical education, training and knowledge specifically related to clinical competence for LGBT healthcare in Arunachal Pradesh. Besides, using quantitative scales and secondary sources, various key informants from the health sectors have been interviewed using case studies methods and non-participant observation for data collection. The study reveals that religion and culture play a vital role in acceptance of LGBT community and sensitization. In addition, in order to lessen healthcare disparities within the LGBT population, the clinical competency gap in medical education needs to be closed. Creating LGBT affirmative healthcare while being sensitive to culturally particular requirements, sensitivities, and obstacles that differ globally is another aspect of providing for the health needs of LGBT patients. The suggestive measures for which have also been discussed.

Keywords: *LGBT health, Healthcare Professionals, Healthcare Sector, Equity, Stigma & discrimination, Mental Health*

Health care is a fundamental human good as it affects our opportunity to pursue goals in life, aids in regulating pain and suffering, helps prevent premature loss of life, and provides necessary information to plan for our lives (Baker et al, 1999), as also laid down under the American code of Medical Ethics and Indian Medical Association. Despite the Sustainable Development goals or the grant of rights laid down in the Constitution of India to ameliorate the socio-economic differences, there does exist a gap in equity in terms of access to those enshrined rights ranging from a wide array of disparities from health, personal, social to economic. To curb off the disparities in healthcare, physicians are ethically

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called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics. With decriminalization of 1861 colonial-era law or rather Section 377 being strike down by the five-judge constitutional bench with private, consensual act between two homosexual individuals now no longer being a punishable offense to every Indian citizen today, having the legal right to choose their gender with the liberty to undergo anatomical transformation if their identity is incongruent to their birth gender. Despite such advances and policy changes, a lack of awareness and stigma continues in our society at large wherein healthcare sector amongst others is not an exception. According to research, medical school and residency education for physicians seldom include much knowledge regarding Lesbian, Gay, Bisexual, Trans (LGBT) issues other than Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) (Eliason et al, 2011; Obedin et al., 2011). According to Floyd et al. (2016), among the gender and sexual minority, LGB community is the least studied and understood by Health Care Professionals (HCPs) whilst facing mistreatment by today's health-care system. More supporting studies include a two year study from India which reveals that MSM is a high-risk group with increased prevalence of HIV and other STIs in this group, mandating greater focus, education and counseling (Aggarwal et al, 2015). Similarly, most nurses do not undergo LGBT patient care training (Carabez et al., 2015). In addition, a comprehensive examination of practicing nurses' views towards LGBT patients revealed unfavorable opinions. It is also exigent that in comparison to the cis-gender heterosexual population, LGBT population pose a higher vulnerability to certain health risks. According to Russo et al. (2005), lesbian and bisexual women, have higher susceptibility to develop breast cancer due to the presence of risk factors such as nulliparity (a condition where the woman has never borne a child or given birth) with the former exhibiting higher incidence of cervical cancer due to the presence of risk factors such as a higher BMI and smoking history (Waterman & Voss, 2015), including alcohol use (IOM, 2011).Moreover, homosexual men are more likely than heterosexual males to develop anal cancer as a result of HPV infection due to sexual activities such as receptive anal intercourse (Machalek et al., 2012).

Besides these conditions making LGBT patients a more vulnerable group, majority of HCPs as a point of fact, go on to believe that their practice is inclusive and provides equity of care. However, in reality, majority of HCPs continue to adopt an automatic pilot, which is the standard hetero-normative perspective conforming to cis-normative assumptions. From medical forms failing to reflect the continuum of sexual orientation, sexual and gender identity; to neglect of HCPs in asking about pronoun preferences and rather jumping to conclusions solely based on judgment via patient's behaviour, outwardly gestures or way of dressing; to overlooking specific health & social concerns corresponding from a physical or mental chief concerns. According to the findings by Wilson et al (2014), personal factors like degree of religiosity and self-proclaimed knowledge of several religious perspectives on sex amongst others might be a plausible reason which needs to be addressed in inter-professional curriculum related to LGBT patient care. One has to be cognizant that members of the lesbian, gay, bisexual and trans (LGBT) population is not a homogeneous group, but rather a heterogeneous mix, with varied demographics, sexual orientations, gender identities and behaviours. Numerous accounts are evident of the lived reality of the LGBT community being subject to discrimination, violence and other human rights violations (UNAIDS, 2016) which also calls for full and complete access to quality healthcare including mental health. It cannot be ruled out that LGBT individuals pose heightened vulnerabilities to sexually transmitted infections and HIV infection. Universal reasons across the globe include physiological factors, discrimination & poor understanding of one's sexual health needs (Campbell, 2013). In addition, with regard to accessing healthcare, LGBT patients (including

intersex) more specifically those affected by HIV are more vulnerable sections wherein the case is amplified by factors of marginalisation & stigma. According to Meyer's model (1995), (2003), multiple contextual factors ought to be delved in to meticulously analyze the health disparities among minority groups. Plausible reasons to which being socially patterned and determined by circumstances in the environment and the complex interplay between individual factors and the socio-cultural context within which individuals reside. Excess stress analogous to stigma and discrimination contribute to higher rates of mental health disorders as supported by empirical evidences on sexual minority population groups. An ever-growing body of research points to numerous additional health disparities among LGBT population, particularly in the realm of mental health (Bostwick et al. 2010; King et al. 2008; McCabe et al. 2009; Meyer, 2003). Some authors posit that these disparities of heightened mental health issues are the result of the stress that prejudice and perceived discrimination can cause. Several factors contribute to LGBT communities' underutilization of health-care services, including fear of being stigmatized because of one's sexual orientation or gender identity (Bradford et. al, 2013; Facione & Facione, 2007; Whitehead et al, 2016), the high expense of health care, lack of access to health insurance coverage, as well as the scarcity of HCPs knowledge in LGBT health (IOM, 2011; Qureshiet al., 2017; Snowden, 2013) leading to lack of trust in the HCPs due to their unfamiliarity with the health-care requirements of LGBT people which redirects them to hold unfavorable views against community patients (Westerståhl et al., 2002). Further, the case is all the more daunting for the geriatric population of this growing community who has additional barriers to having a fulfilling social life in terms of marriage, adoption rights, child rearing etc.

Anthropology and Gender Studies

A key area of anthropology known as "Queer Anthropology" or "Lesbian and Gay Anthropology" includes the study of sexuality and gender. The former frequently investigates sexual expressions that deviate from common Euro-American conceptions of homosexuality and biological sex or that is susceptible to diverse societal stigmas (Kennedy & Davis, 1993). Additionally, it examines the various ways that sexuality and gender are expressed as well as how societies see these distinctions. In addressing the unfair criticism of sex or gender variations and empathetically supporting the LGBT population, it adopts an anti-homophobic stance. At first, anthropologists thought of sexuality as being essentialist in nature; they thought it was the unchanging, static, and inborn essence of people, unaffected by time and space. The change in anthropological thinking happened in the 1970s, when feminist scholars started to look at historical and cultural influences as influencing elements in forming sexuality. Social constructionist models took the place of essentialist methods. Also, it established the theoretical underpinnings of social constructions and gay and lesbian anthropology as we know it today.

One needs to be cognizant of the fact that heterosexism permeates every aspect of therapeutic encounter for LGBT people. It is defined as "the ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationship, or community," is ingrained even into the health care system through mission statements and intake forms, gender-specific restrooms and displays of posters and pamphlets, and all of a patient's interactions during a visit, including those with receptionists, other patients and other HCPs. Today, Medical Anthropology is a sub field of Anthropology which tries to better understand the factors that affect health and well-being, the experience and distribution of illness, the prevention and treatment of illness, healing processes, the social relations of therapy management, and the cultural significance and utilization of pluralistic medical systems.

Despite the deletion of homosexuality as a mental illness in the Diagnostic and Statistical Manual (DSM), 1973, negative sentiments towards LGBT, stemming from societal and cultural conventions are still present (Johnson & Johnson, 2013). SGM are subjected to prejudice, stigma, and negative views, including threats, economic exploitation, assault, and verbal and physical abuse (Moleiro & Pinto, 2015). Additionally, individuals can encounter prejudice in a variety of spheres of their existence, including health care, work, education, hate speech, and military duty (Herdt & Van de Meer, 2003). It has been found that SGM people feel unsatisfied in medical settings, are less likely to seek medical attention than heterosexuals, gain less from medical attention, and have a poor relationship with medical staff (Diamant et. al., 2000). SGM individuals are also not given the basic medical treatment they require since health care professionals failed to recognize the requirements of SGM people, resulting in their illness and a lack of access to health care services. (Neville & Henrickson, 2006, McClain et al., 2016)

Cultural competence training is designed to increase cultural sensitivity in general and to provide a deeper understanding of specific cultural groups and their beliefs, norms, social practices and health practices. It is meant to help prepare health professionals for working with culturally diverse and minority patient populations. It is a clear admission that the prevalent "one-size-fits-all" approach to health care is unable to appropriately address needs that may differ based on colour, ethnicity, gender, sexual orientation, or language proficiency, preventing problems that could otherwise occur (Baker & Beagan, 2014). Nonetheless, despite the best efforts, the medical community still has gaps in its knowledge of how to define and provide LGBTQ patients with culturally appropriate health care. LGBTQ individuals are a largely invisible patient population with specific healthcare needs and dangers that are still not fully recognized by both patients and HCPs (Beagan and Kumas-Tan 2009; Turner 2005, Harbin et al. 2012, Carpenter-Song et al., 2007).

Furthermore, a significant issue with the idea and practice of cultural competency is the way it defines and approaches culture, which is very different from how it is now applied in anthropology, where it has its roots (Kleinman and Benson, 2006). Undoubtedly, the idea of culture can be crucial to medical education and clinical practice; simply acknowledging how cultural differences are always present in patient-physician interactions serves as a crucial reminder that "obvious" or "common" knowledge will not always be shared by the two parties (Turner, 2005). Wilkerson et. al., (2011) believed that patients are more likely to share their sexual or gender identity and any associated problems when they feel safer, which in turn develops more trust between patients and HCPs.

Therefore, it is very much important for the researchers to delve into the work through Anthropological lens as well, for most of the sources of problems lies in the cultural aspects of the society. Logical conclusions can be given through better understanding the ways of lives of the society. In addition, it is quintessential to analyze the loopholes and lessen healthcare disparities within the LGBT population. It is hitherto evident that LGBT patients undergo a multiplicity of issues ranging from poor mental, physical, sexual and overall health impeded by a range of socio-economic and other intersectional factors with absence of any recognized Government body or NGO working specifically for the welfare of the community members. With these prevailing issues, it is pivotal that HCPs be competent enough to be aware of the topic in order to professionally address these complex sensitive issues for the best treatment outcome considering the patients feel comfortable enough to openly express themselves and their chief complaints whenever they approach them. Additionally, study of the elements that contribute to fostering health equity, reducing discrimination, and

enhancing competent service delivery is required as this group expands. Further, the clinical competency gap in medical and nursing education needs to be closed in order to raise public health concerns for the LGBT community & a wider population. Hence, the current study becomes quintessential to investigate the state specific healthcare system, attitude and knowledge of HCPs towards the LGBT patients which is an unexplored research area till date.

Rational of the study

The increased incidence of these conditions faced by the LGBT population reinforces the need for good access to healthcare services. This is further heightened by presence of systemic barriers which include lack of specialized services such as gender identity clinics, combination of insensitivity, ignorance and discrimination, cost-related hurdles including poor treatment from HCPs. There is a lack of data on the health needs of the LGBT community in the state and elsewhere resulting in a dearth of knowledge, particularly with respect to STIs, STDs, mental health and other associated factors impacting overall health of this high-risk group. As societal views of sexual orientation and gender minorities vary significantly among cultures and populations, it is important to assess whether these disparities are present in the Indian medical education & healthcare system, with specific regard to the state of Arunachal Pradesh.

Objectives

1) To assess knowledge, attitude & practice behaviours of HCPs regarding LGBT health.
2) To explore & understand the barriers to accessible healthcare needs for community patients.
3) Identify areas in which healthcare experiences can be improved through enhancements in HCPs' education, consciousness-raising, skill development, and healthcare system.

MATERIALS & METHOD

The current study is a mixed method study of both qualitative and quantitative, which includes primary sources extending from interviews, schedules, case studies, observation as well as secondary sources involving books, articles, reports, journals, which were used as investigative tool to generate data. In addition, various key-informants from health sector were also interviewed. Duly filled consent form was taken post rapport formation along with following all other ethical code of conduct. Audio-visual tools were also used to record the interview. Non-probability purposive sampling technique was used to deploy the sample. Data was collected from a varied pool of HCPs (n=30) with age ranging from 26 to 55, comprising of 24 working medical practitioners from 5 esteemed hospitals of Itanagar Capital Region (ICR)namely Tomo Riba Institute of Health and Medical Sciences (TRIHMS), Rama Krishna Mission, Hemma, Niba and Hormin, and 5 Healthcare sector administrators from Arunachal Pradesh State Aids Control Society (APSACS) and Project Manager from an NGO named Turbu Daleh Multipurpose Cooperative Society (TDMPCS) functioning under the banner of National Aids Control Organization (NACO).Designated Counselors working at Integrated Counseling & Testing Centre (ICTC), Gynecology and Dermatology departments were also interviewed. Transcription of recorded data & observing similar patterns was used to thematically structure the analysis.

RESULTS & DISCUSSIONS

Table 1: showing demographic details.

Variables	Categories				
Age	**26-35** 10	**36-45** 10		**46-55** 10	
Gender	**Male** 18	**Female** 12			
Gender congruent as assigned at birth	**Yes** 30		**No** 0		
Religious Affiliation	**Indigenous Faith** 14	**Christian** 12	**Hindu** 2		**Atheist** 2
Department	**Dermatology** 13 Counselor: 1 Physicians & other HCPs: 12	**Gynecology** 13 Counselor: 1 Physicians & other HCPs: 12	**ICTC** Counselor: 1	**APSACS** 2	**NGO (TDMPCS)** 1
Work Experience (In years)	**1-10** 6	**11-20** 15	**21-30** 9		
Have LGBT member as family/friend/ colleague/ acquaintance	**Yes** 9		**No** 21		
Provided primary care to LGBT patients	**Yes** 10		**No** 20		
Received Focused training regarding LGBT care	**Yes** **During Specialization:** 24		**No** 6		

Table 1 shows an equal representation of the varying age groups of working professionals to control the aspect of generational gap. A brief pilot interview taken prior to the current investigation with practicing Senior Residents (SRs) particularly revealed that official data on the records of LGBT community can be tapped by interview with specialists from Dermatology and Gynecology departments due to an increased rate of community members suffering from Genital warts, VDRL, TPHA positive, genital herpes, genital molluscum contagiosum, gonorrhea to name a few, hence the inclusion of the chosen departments. Professionals at APSACS became a direct point of contact to cover core component, subject specific queries related to sexual health, with TDMPCS being the only operative NGO in ICR comprising of Men Who Have Sex Men (MSM) & Transgender (TG) as its core constituents. With regard to awareness & knowledge revolving around LGBT community in general, the corresponding answers during the interview revealed that having someone known has in a way been instrumental in getting acquainted with the topic. The data reveals that 10 HCPs have provided primary care to LGBT patients. However, the initially reported figures dropped down on uncovering that many were not fully confident of their encounter due to absence of self-confirmation of one's identity by the patients showcasing a mismatch between HCPs knowledge, beliefs and communication behaviour. Further interviews with designated counselors & Programme Manager at ICTC, Dermatology, Gynecology, APSACS and TDMCPS respectively, disclosed that there is a procedural lapse wherein many a times the specialists on finding out that the patients are infected, omit out on sending the patients to them either due to neglect, ignorance, rush hours and hence non availability of time management in patient care due to healthcare disparity of doctor to patient ratio. This thus, further alienates the information on affected LGBT patients for an accurate data base for

future follow-ups & care. The interview also revealed that 'gender & sex specific course' is a minor portion of the syllabus only post specialization as reported by HCPs pertaining to Gynecology & Dermatology departments which literally needs to be mandated for the general UG course.

Table 2: Showing distribution of total HCPs Interviewed.

HCPs	Hospitals Covered	Administrations	NGO (TDMPCS)
Physicians & other HCPs: 24 Counselors ICTC: 1 Gynecology: 1 Dermatology: 1	TRIHMS RKM Hospital Hemma Hospital Niba Hospital Hormin Hospital	APSACS: 2	Programme Manager: 1

The above table shows the distribution of sample based on the nature of their job profile and institutional affiliation.

Table 3: Showing attitudes of HCPs towards LGBT patients.

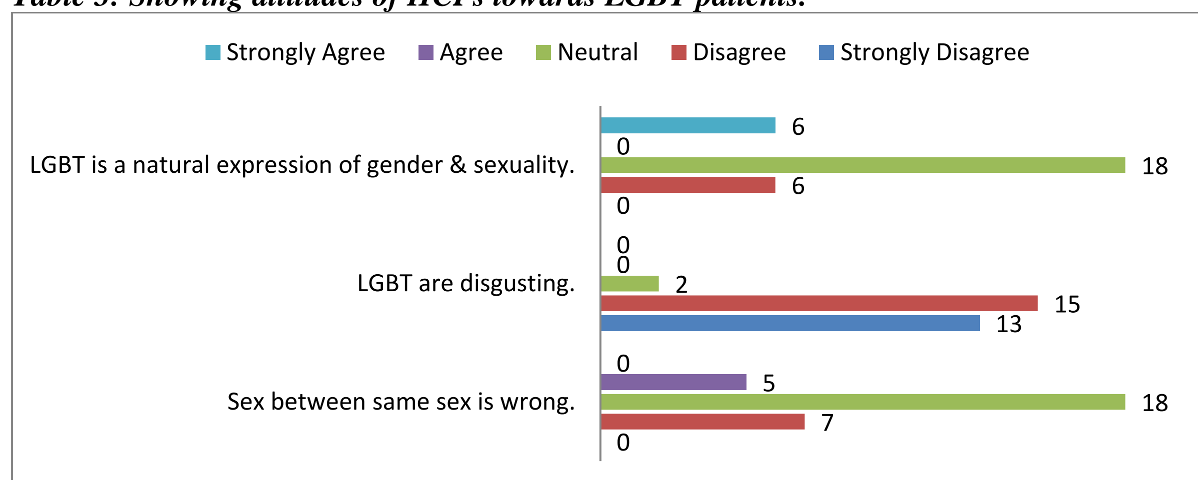


Table 3 shows the extent of attitudes held against the LGBT patients by the HCPs. Majority (93%) of HCPs strongly voiced on not being appalled by the community patients. However, surprisingly, majority (60%) of the sample chose to remain neutral in accepting if LGBT was a natural expression with few (20%) perceiving it to be 'unnatural'. Lack of knowledge could be a plausible explanation as to why majority of physicians repeatedly chose to remain neutral. Further, it was alarming to observe that many (60%) yet again chose to remain innocuous while some (17%) firmly maintained the belief that same sex is wrong which is quite alarming and contradictory of a thought to emerge from a HCP. This is because on completion of their graduation marking entry into the medical profession, physicians, nurses and other HCPs take an oath of ethics be it Hippocratic oath, Florence Nightingale pledge to name a few serving as a guide to ideal conduct. Here, they solemnly pledge to practice their profession faithfully, maintain utmost respect for human life from time of conception, without permitting any considerations to come in-between one's duty & one's patient and to practice one's profession with conscience and dignity and to behave in an altruistic manner towards all patients. This however, in practicality is found to be breached in the case of community patients who report negative experiences including encountering homophobia, and unsatisfactory or unequal healthcare treatment (Hollenbach et al, 2014; Office of Disease

Prevention and Health Promotion, 2000) to experiencing discriminatory care (Daniel et al, 2015). This has also been found to be compounded by self-identified homosexual physicians who underwent heterosexism, homophobia & hostility in workplace as per previous findings by AAN (2012) and Chapman et al (2012). This is supported by many research findings wherein various degrees of homophobia and discrimination continue to be noted by both physicians and trainees. Further, significant portion of medical students describe the climate at their institution as 'non-inclusive' (Lapinski & Sexton, 2014; Sitkin & Pachankis, 2016). This therefore, necessitates a call for action by Institutional Heads, Board members and other Administrative Heads to bring in transformational shift for inclusionary practice behaviours of HCPs.

Table 4: Showing feelings on providing healthcare to LGBT patients.

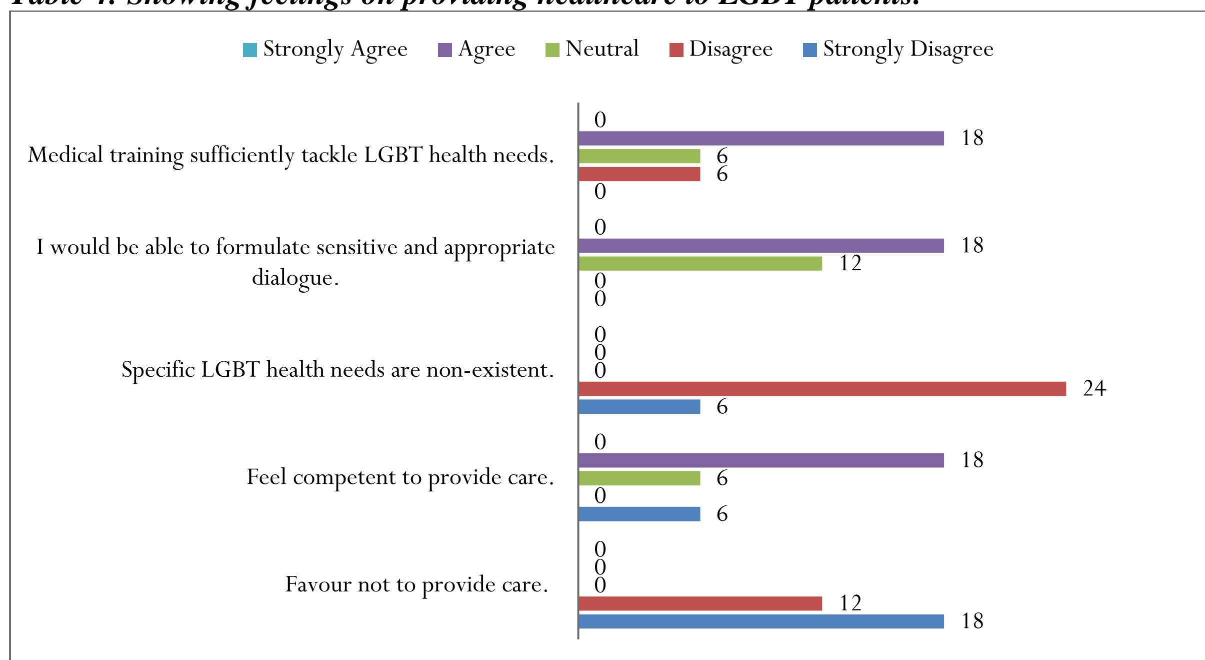
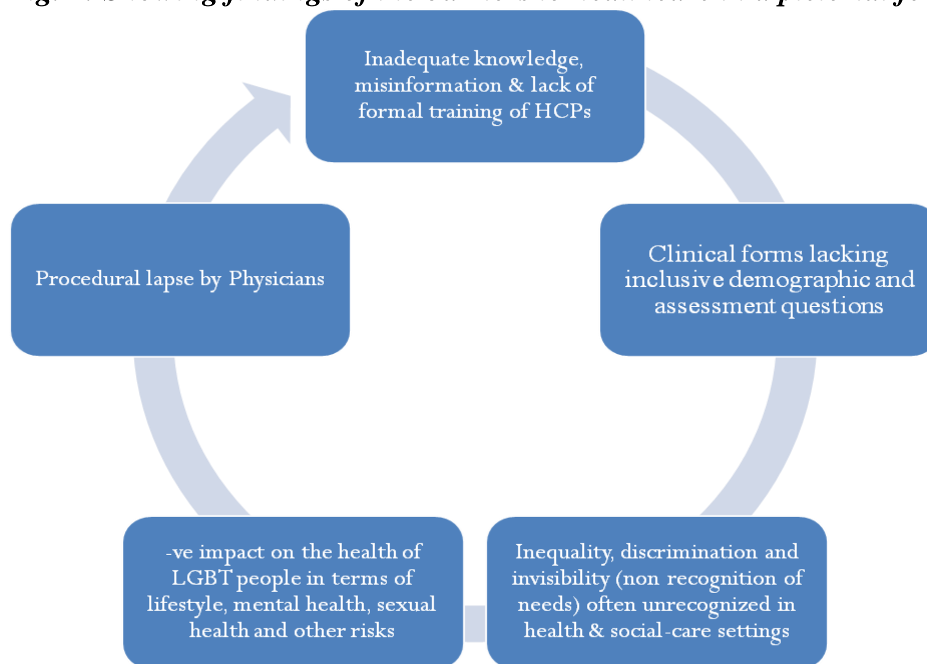


Table 4 shows that majority of HCPs (80%) strongly agreed that medical training adequately address healthcare needs of LGBT population. Furthermore, the same percentage accepted of being equipped to handle LGBT patients with sensitivity and ethical care. However, when asked via interview schedule, all the HCPs revealed receiving no special course or formal training for the same with the contrasting verbatim they gave stating "I/We treat all patients with equal dignity and care" to even claiming" No special training is required as such because we do treat all as the same". An interesting observation reveals with regard to non-alignment in receiving exposure yet showing competency & readiness in patient management of LGBT population displayed by all HCPs while a significant majority (73.33%) agree that queer patients do have specific health concerns proving the growing necessity of updating Continuous Medical Education (CME) and even bachelors' degree curriculum. Both pilot interview and systematic investigation revealed that HCPs are only acquainted with the aspect of gender and sexuality during specialized course wherein necessity of the formality comes into the picture which is quite alarming when every HCP needs to be familiarized to deal with every individual patient as per the care required. This further necessitates diseases, disorders and other correlated factors to be thoroughly investigated and included under study during CMEs. Transgender healthcare appeared to be an especially neglected area. This finding is supported by previous evidences which report that transgender patients have the greatest incidence of underutilization of health-care services, reporting far greater instances

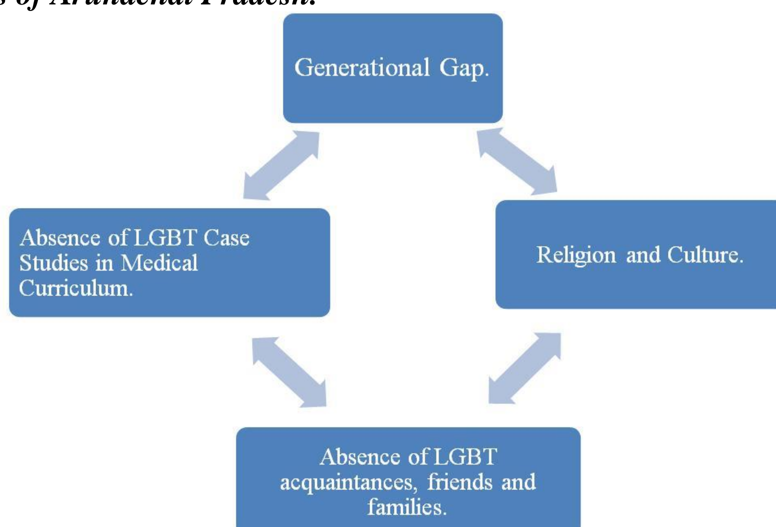
of mistreatment in health-care sector, including denial of care. (James et al., 2016; Kosenko et. al, 2013). However, the overall interview unveiled a positive inclination from all HCPs towards a holistic, gender fluid healthcare system for all.

Fig. 1: Showing findings of the barriers to healthcare in a pictorial format.



The above figure displays the main research findings of the current study wherein barriers to accessible healthcare are highlighted which eventuate as hindrances for the community patients. The current study demands an immediate call for attention whereby the issues need to be timely addressed for the betterment of the healthcare sector and to truly progress towards an egalitarian society.

Fig. 2: Showing major hindrances to LGBT Affirmative healthcare behaviour amongst HCPs of Arunachal Pradesh.



The above figure shows the generational gap between majority of SRs and other HCPs and the young patients who are aware and self-identify with their gender and sexual identity with the former having a lack of familiarity of the topic which widens the healthcare gap. Another

contributing factor being absence of LGBT acquaintances, friends and family, the plausible reasons for which include, community members hiding under the closet and not being out with their identity due to prevailing societal taboo, associated stigma and discrimination. This, along with other prevailing issues like absence of the mentioning of LGBT and related terminology in the lingua and cultural history of the state with the subject of sex being hushed in the households; existence of orthodox beliefs and practices in the name of religion which view LGBT individuals as 'sinners' and 'abnormal' who require to be punished or changed as per the verbatim of interviewees. Other barriers include absence of medical case studies pertaining to LGBT patient population which if carried out in theory in addition to live clinical presentations of an out and proud community patient would immensely prove beneficial in HCPs' sensitization training and build their patient-handling competency skills.

Interview with Junior Residents (JRs), Senior residents (SRs) and Administrators of Health Department

When we interviewed some JRs & SRs of TRIHMS and Administrators of APSACS about LGBT including other HCPs, they had several opinions which came to light.

On the question, regarding their understanding and perspectives on LGBT community,

JR 1:

> *"I only know the abbreviation of the acronym LGBT but I do not have the clear or deep knowledge about their lives, what are their thoughts, the way they live and what are they. However, I do feel that they are also normal people like us, they are also human with different preferences and choices in life."*

SR 1:

> "*I do feel that they are born that way which is very much natural but I also feel that some of them are influenced by others, for instance if a boy grow up playing among girls for a very long time he may be influenced into becoming one"*

SR 2:

> "*Earlier, I used to think it as it was a very rare case and was not that aware about it, but now since I have friends from the community, and because of my profession I also did encounter/dealt with many patients from the community. So now, as compared to the past, I'm much more aware about their lives and existence"*

Administrator 1:

> *"They are normal people with different sexual choice and behavior but they are also normal like the heterosexual people"*

Conclusion: Most of the HCPs are not very well aware and sensitized about the LGBT community. Those who are aware are mostly due to experiences they have with their LGBT friends and acquaintances or patients.

On the question, what is your religion and do you have the mentions of LGBT in your culture? To which they responded,

JR 1:

> *"I believe in Indigenous faith and we do not have the concept or citations of LGBT in our culture or religion as far as I know".*

SR 1:

> *"No trace of anecdotes or mentions of LGBT can be found in our tribal folktales stories and traditional religion"*

SR2:

> *"I'm not aware about most of the things related to tradition, folklores and culture, I may be wrong but as far as I know there is no mention of LGBT concept in our culture"*

Conclusion: It is observed that there is no citation or mentions of LGBT concepts in religion or culture of the local population or there was a lack of awareness of one's own culture and religion, hence, they could not comment on the question. This poses as a barrier for the people of the state to better understand the LGBT community as it is a new concept for them, further leading to homophobic mentality, questioning on the existence of LGBT community.

On the question, whether they had ever treated or dealt with LGBT patients? To which they responded,

JR 1:

> *"Yes, I have dealt with only two LGBT Patients; they came for illness such as hypertension and dehydration. I did not feel the difference in treating them, It was as normal as I treat other heterosexual patients. We do not see them differently; we see them as any other patients that need treatment".*

SR 1:

> *"Yes I have dealt with some of them; most of them came for sexually transmitted diseases. I treated them equally, just as I treat other patients who come to us for the help."*

SR 2:

> *"Major health problems faced by the community are syphilis, HIVs, Hepatitis and other STDs. In order to maintain or keep their gender or sexual identity as a secret, they usually come alone for diagnosis and treatment. One of the challenges to deal with them is that we cannot inform or contact their parents or guardians so as to maintain their privacy. Since they are all alone, we doctors are the only primary care takers of patients who are from the LGBT community. There was one guy in his mid-40s, has 3 children from the marriage. He informed me that he is from the LGBT community and has come for diagnosis related to STDs. Since he has not revealed his identity to his family and the society, it is quite challenging for us to treat such patients because at times there may be complications or danger while treating but we are not able to inform the parents or family just because we have to maintain or respect their privacy concerns. This is one of the challenges for me I guess".*

Conclusion: Most of the doctors had in a way encountered or treated LGBT patients but they treated them similar to their heterosexual counterparts. However, some doctors have raised the issue of not being able to contact the parents or guardians in case of treating some minors or complicated diseases, in which they might need parents' consent to do so. Since HCPs of the state do not have an expertise in handling LGBT patients there might be procedural issues which become an issue of concern.

On the question, whether there was any special course on treatment of LGBT patients while pursuing MBBS course? To which they responded,

JR 1:

"I did my MBBS course from Regional institute of Medical Science (RIMS), Manipur, there was no specific course on LGBT patients. But however, I'm aware of the fact that there are gender reaffirming surgeries, hormonal therapies and other medical procedures available for LGBT people. But I'm not technically sound or have gone through any training regarding it. I did not attend any workshops and seminars regarding LGBT healthcare needs too. For me, I just treat them as any other patients"

SR 1:

"During my MBBS course, there was no separate course on handling LGBT patients. But in Dermatology, especially in Venereology part, we were taught to handle STD affected patients in which LGBT people were part of it too due to the prevalence of the STDs diseases in this population"

SR 2:

"In my MBBS course there was no training with regard to LGBT population, but during PG, we were taught to handle STI cases. It was under strict provisions that every 3 months, we used to review the cases of STIs patients, maintain the statistics, and type of patients, be it from heterosexuals, housewives or LGBT populations. Proper academics were taught to us regarding the handlings of STIs patients. After assessing the prevalence of diseases in certain populations, we seek help from the higher authorities to take preventives changes"

Conclusion: No special course on handling of LGBT patients or Gender and sexuality courses were taught during their academic curriculum. Only dermatologists were taught some courses during their post graduate education. Others suggested that there should be special course on LGBT patients or gender and sexuality. Additionally, they also suggested that workshop and sensitization programs should be regularly conducted for the HCPs to make them aware about the issues and concerns of LGBT community. Whereas, some others opined that it is not necessary since LGBT people's issues similar to heterosexual issues, which can easily be dealt by the HCPs.

On the question, whether HCPs document the gender identity and sexual orientation of the patients they deal with? To which they responded,

JR 1:

"No, usually we do not document such things but then again that depends on the nature of the case, for instance I have dealt with few patients with STDs. In such cases, we do seek details about the sexual habits, preferences, partners and other relevant details. So while examining such cases, we assume that the patients belong to LGBT community but otherwise we cannot comment."

SR 1:

"Regarding the relevance of noting down the gender identity or sexual orientation, we do not record it as by default there is male and female section in the sheet. Other than that I cannot comment on it since I have not dealt with many patients from the LGBT community"

SR 2:

"We refrain from noting down the gender and sexual identity mainly due to the privacy concern as some patients from the community may not be comfortable enough to share about their details. At times they come with their parents and friends, so in front of them they may not prefer to share about their identity. But we do separately maintain records through counselors for STIs patients. In Derma department there is

one counselor assigned who is responsible for giving counseling and maintaining the records of the patients"

Conclusion: Most of the doctors do not ask for the gender identity confirmation as it is by default listed in the slip as male and female. Whereas others do not do it due to privacy concerns of the individuals about their gender identity. On the other hand, most of the LGBT community members do not reveal their identity due to fear of the prevailing societal stigma.
On the question, whether your hospital is equipped with enough facilities and infrastructures to treat LGBT patients? To which they responded,

JR 1:

"Yes, I do feel that we have enough facilities to cater the needs of LGBT people, it is so because I feel they are also human like any other patients. They also suffer the same illness and diseases like other people do. Therefore I don't think there is need for any special medical treatment, facility or institution. But for gender reaffirming surgeries they will have to seek for special institute equipped with such facilities"

JR 2:

"There is already shortage of men power and infrastructure for the general population; I do not think that the creation of a separate section for the LGBT people exclusively is possible at this hour. If it happens then it is good for them. But I personally feel that it will create unnecessary division, instead all patients should be treated as one irrespective of their gender and sexuality"

SR 1:

"I do feel that everyone is equal in our eyes, we treat all those who come to seek, without any discrimination. Since they are also our patients, so yes we do have sufficient men power and infrastructure to deal with them"

SR 2:

"We are responsible to deal with STD patients, since many people from the LGBT community also come to us for treatment, so I do treat them the same way as I treat others. But regarding the other complicated surgeries, treatment regarding their gender reaffirming surgeries and treatment we do not have expertise in it. For that, they need to go to specific hospital where such facilities are available. But for common problem, we do and can cater their needs too"

Conclusion: Many doctors feel that the health issues of LGBT can be looked after by the available man power and infrastructure in the hospital. They feel so because they assume that LGBT health issues are same as health issues of the heterosexual people. However, few HCPs also confessed that special or complicated health issues cannot be dealt by their hospital due to the lack of expertise and proper infrastructure. On the contrary, some HCPs also reported about hospitals lacking basic facilities, lab testing diagnostics and infrastructures to cater the needs of people which ought to be provided by the government.

Interview with one of the Administrator of Health Sector in context to LGBT and Health Care:

"We have people from the LGBT community who are beneficiaries of social protection schemes. These programs are for general HIV infected population in which LGBT are also a part, there is no specific schemes for them. We usually target MSM (Men Sex with Men) and transgender people as there is high prevalence of diseases and unsafe sex practices. So, we hire and employ people from the LGBT community to tap the specific population and make them avail the benefits of the schemes. We also provide the required training to some LGBT

individuals; send them to Delhi for capacity building workshops to take care of the affected LGBT community. Many organizations are also connected with us, who also work for the community. By sampling the target population under core composite group of 250 to 350 people from different regions of the state, we sign Memorandum of Understanding with NGOs and then proceed with the implementation process of the programs. Despite the efforts of the Government and NGOs, there is need for mass sensitization programs to create awareness about the concepts of LGBT community in the state. Since the concept of LGBT is very new to many, it is still considered a taboo and abnormal in the society. The viable solution is that the community people should come forward and educate other general populations and the Government about their issues and concerns"

CONCLUSIONS

The current study thus highlights the underlying fact that adequate LGBT sexual health education amidst other physiological and mental health concerns for emerging HCPs is currently lacking in addition to growing health concerns of LGBT community. Besides, fostering LGBT healthcare needs requires forming an affirmative healthcare setting susceptible to cultural specific needs, vulnerabilities and obstacles varying across the globe. Therefore, facilitating increase in self-identified community patients, pioneering better quality of healthcare which is the prime need of the hour. A shift in focus to consciousness raising and capacity building of physicians as well as allied team is very much rudimentary. In-depth reflection of the associated harms of stigma, discrimination & non-inclusiveness is fundamental to better understand high risk groups and its associations with risk taking behavior and appropriately aid in co-morbid disease control.

Future Implications

The LGBT population experience widespread health inequities and hurdles to high-quality care due to a lack of comprehensive LGBT sexual health education among HCPs. Clinical training programs and healthcare organizations are encouraged to start talking about the inequality and affirm LGBT patients in order to foster basic competences in LGBT health care and to establish health care cultures that welcome, include, and protect LGBT individuals. With a health education program, basic LGBT ideas, vocabulary, and openness/acceptance towards LGBT persons may be emphasized. To provide inclusive sexual health care, creative teaching methodologies and paradigms for clinical application may inculcate essential concepts, language, and positive attitudes alongside clinical expertise.

The expansion of the nomenclature LGBT broadly encompasses an inclusion of Queer, Intersex, Asexual, Pansexual and + denoting others not falling in the aforementioned terminology (LGBTQIAP+) under its wing today, which however weren't included in the current study due to the latter being an under representative population in the state (as per pilot findings) and the non-familiarity of the HCPs thereof. This however, can be looked into in future studies, especially from the insiders' perspective of the issues faced by the community patients of being medically underserved. The expansion of succeeding research efforts can propel significant attention from legislators, policy makers and community leaders in the quest for equal rights for the members to reduction in gaps in training and education for physicians, nursing professionals and other allied team in the healthcare sector which have long been overlooked. Curriculum structure and content should be duly updated to incorporate an inclusive range of patients for as suggested earlier, lack of awareness, and other related existing health disparities can also prove to be a major barrier of hindrance between establishing a good doctor-patient rapport, delivering ethical standards of delivering high quality patient care or directly impact physician communication behaviours. Little

changes in how doctors treat patients might go a long way towards promoting inclusiveness. For example, on arrival of a patient with STI, the doctor should try to ask the patient whether *one's partner* has the same problem rather than asking if one's husband or wife has the same problem as simple rewording can significantly improve one's ability to be sensitive. Educating doctors to be competent in understanding the issues LGBT persons face and why they face them is critical to deliver a just and equitable service. Further, HCPs should build a network of LGBT-affirmed doctors to make healthcare more accessible and safe for the LGBT population.

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