Thangam Debbonaire MP welcomed speakers and guests and explained that this event was one in a series of events organised by the Parliamentary Office of Science and technology for parliamentarians during session. She went on to describe how emerging evidence demonstrates that lesbian, gay, bisexual and trans (LGBT+) people experience significant health inequalities across their lifespan, often starting at a young age. In this seminar academics, clinicians and policy experts would describe the inequality gap and suggest ways to close it.

Dr Joanna Semlyen began her presentation by discussing data on the size of the LGBT+ population. Although some estimates exist the most recent modelled estimate by Public Health England in 2017 using various survey data gave a range of 0.9-5.52%, giving a weighted estimate of 2.5%. Responses to surveys are dependent on how questions are asked and the wording used. Dr Semlyen pointed out that the Census 2021 offered an opportunity to establish the size of the LGBT+ population by including questions on sexual orientation (SO) identity and gender identity.

Dr Semlyen then discussed how inequalities for this group emerge, as a consequence of growing up in an intolerant society, through prejudice and discrimination experienced throughout life. This applies to experience in health contexts through negative attitudes of some healthcare professionals and the fact that health systems are largely heteronormative. Health behaviours also exacerbate inequalities, for example, some nightclubs and bars can be safe spaces but these are centred on alcohol and drugs.

The majority of research evidence on LGBT health inequalities is of low quality, comprising convenience samples which are not representative. However there are some improvements, with a few longitudinal cohort studies and cross-sectional health surveys now asking a question on sexual orientation. One key issue was that data on gender identity was not captured and that a question on this should be included in future health surveys.

Turning to mental health, Dr Semlyen highlighted a systematic review from 2008 which showed that there is a higher risk of poorer mental health in LGB populations when compared with the heterosexual population. There is increased risk for suicide attempts or ideation, alcohol dependence and drug dependence. This review was based on the available data largely from the US. An analysis of UK data pooled from 12 population surveys (94,818 participants) found that those identifying as lesbian/gay were at higher risk of poor mental health than heterosexuals and that this was most pronounced for those aged under 35 and those aged over 55. Furthermore, bisexual participants were at higher risk of poorer mental health.
There is very little data about the trans population, with no UK population studies on this group. Dr Semlyen called for trans data to be recorded in surveys in order to generate high quality evidence.

On physical health, Dr Semlyen presented that LGB identity is linked to increased tobacco smoking and hazardous alcohol drinking. Dr Semlyen announced that a study of sexual orientation identity and Body Mass Index in the UK population would be published shortly.

Dr Semlyen then highlighted that the LGBT population delay and sometimes avoid accessing healthcare, and qualitative data reposts demonstrates experiences of homophobic and transphobic behaviour in UK health services. There is also a lack of knowledge and understanding of LGBT+ health issues by healthcare professionals.

Dr Semlyen concluded by recommending that specific provision of services tailored to and provided by the LGBT population could go some way to improve health outcomes for this population. Interventions to address discrimination could include training for healthcare professionals, in the wider context of addressing homophobic and transphobic bullying behaviour in education and workplace settings, as well as wider society. Improving the quality of data and the evidence base was crucial, as was exploring causal pathways for disparities in health outcomes. Mandatory recording of sexual orientation and gender identity data in health and social care settings in line with the Equalities Act 2010 would be an important step in achieving this.

Dr Rachael Jones began by exploring what is meant by the term sexual health, which encompasses physical, emotional, mental and social wellbeing, rather than merely the absence of disease, dysfunction or infirmity. Sexual health or “Venereal Disease” clinics were established in 1916 following the Public Health (Venereal Disease) Regulations 1916. Attendance was voluntary, and patients were treated for free and in confidence.

Modern sexual health services – genitourinary medicine (GUM) – comprise a very wide range of services that continue to adapt to changes. For example a modern GUM clinic offers a range of core services including disease surveillance and screening, partner notification, contraception, sexual health promotion, diagnosis and treatment, training and teaching and research. Additionally some of the larger clinics also offer a very wide range of services including: psychosexual services; outreach; genital dermatology; drug and alcohol support; preventative measures (such as pre-exposure prophylaxis for HIV); sexual abuse support; adolescent care; and management of cervical and anal cancers.

In terms of what works well, accessible services are key. Chelsea and Westminster NHS Foundation Trust runs several community-based services. The Dean Street clinic in Soho is well situated for delivering care to its target population. Embracing technology in delivering care has proved invaluable, for example some patients are more likely to give relevant information about their needs when asked using a computer touch screen than face to face. Similarly, improved diagnostic technologies mean that clinicians can access fast test results and expedited treatment for patients, and improves knowledge about at-risk populations.
A success story is the ongoing decrease in new HIV diagnoses in the UK, as a consequence of education, health promotion, better access to testing, more testing, early treatment and access to PrEP. Challenges included the rising rate of some sexually transmitted infections, notably syphilis and gonorrhoea, which had both increased by about 20% in England in 2017. The groups at most risk were young people aged 15-24, and men who have sex with men. The STI rate in London is 83% higher than all other regions. It was suggested that this rise in STIs might be partly explained by the use of PrEP, however closure of STI services may also be affecting rates.

Dr Jones highlighted the increased pressure on services in the context of clinic closures, reduced opening hours and budget cuts of up to 30%. Some services had restructured in response to this, but even so, were unable to provide the same level of care. The greatest impact seemed to be on testing and appointment access, which was significantly constrained. It also meant that patients were likely to experience longer waits to access care; this could have consequences for STI rates, health of the population and rates of unplanned pregnancies.

Dr Tristan Barber, described the range of specialist services offered by Chelsea and Westminster NHS Foundation Trust. For example, cliniQ is a service for trans individuals, in partnership with the Dean Street clinic. Dr Barber went on to describe that 84% of trans people have thought about suicide, and that 48% have made suicide attempts. One meta-analysis found that transwomen have a 49% higher likelihood of acquiring HIV. CliniQ offers a sexual health service as well as offering hormone therapy and cervical screening.

Dr Barber than highlighted that there was a poor level of awareness of HIV prevention intervention in the trans community and a low willingness to take PrEP. This demonstrates that there needs to be increased visibility of trans people and their partners in both general and PrEP-specific health campaigns. There was also a requirement for better clinical knowledge of trans issues.

Dr Barber went on to outline the dedicated LGBT weekly specialist sexual health service, Refresh, running in the John Hunter Clinic on the main Chelsea and Westminster site. All medical and non-medical staff were trained on LGBTQ sexual health issues and some club drug issues. Patients were satisfied with the service, with 81% rating it as excellent, and the majority felt that they were treated with respect and dignity.

These open access services are really important and are often the first point of contact for a wide range of health needs, including specialist sexual health services. These are being threatened by lack of funding and commissioning decision. There is underdeveloped specialist primary care for the LGBT community.

Dr Laetitia Zeeman focussed her presentation on the findings of an EU-funded programme called Health4LGBT which aimed to understand health inequalities and barriers faced by the LGBT community and to set out the tools that healthcare professionals need to overcome the barriers. The project team comprised 5 centres: ILGA-Europe, Eurohealthnet, the University of Brighton, Poland’s National Institute of Public Health and the Azienda Ospedaliera Universitaria Integrata Verona (the
Integrated University Hospital of Verona). Dr Zeeman played a short video comprising personal accounts of experiences of LGBTI people accessing healthcare. One important point to take into consideration is that healthcare professionals assume that LGBT people’s health needs are the same as those of heterosexual people but this is not the case. Many health inequalities are preventable and the project recommended that EU member states should develop services that are equally accessible to all.

The project was divided into four tasks: global literature reviews on LGBTI health and healthcare inequalities, focus groups in six countries, development of training modules and pilots for training modules in six countries. The main findings from the literature review were that LGBT people face significant mental and physical health inequalities and are at particular risk of mental ill health compared with the general population. They are also at risk of poorer physical health, with evidence for a higher risk of some cancers at a young age. All risks were dependent on age, socioeconomic status, gender and geographical location and between LGBT groupings.

Cultural and social norms prioritised heterosexuality, with health services designed and operating with that group in mind. Homophobic discrimination was widely reported, with 11 of the 28 EU member states offering conversion therapies. There are 72 states globally in which same sex activities are criminalised. Legal protection and recognition was an important measure, for example the UK Equality Act 2010.

Dr Zeeman then outlined the barriers LGBTI people may encounter when accessing healthcare which included poor communication by health professionals, cultural or social norms that assume heterosexuality, the fear of coming out and possible hostile reactions by health professionals, and lack of knowledge about LGBT needs amongst health care professionals. The project found that LGBT people reported being refused care, particularly trans people, and that healthcare professionals found it difficult to challenge negative attitudes amongst colleagues. LGBT people found it useful to see services identifying as being LGBT friendly.

Training modules developed by the project recognised that changes in language were important and that LGBT people should be included in policy and decisions about healthcare delivery related to their needs. It also identified that anti-discrimination laws which cover health be adopted, so that LGBT healthcare is part of mainstream health services. Training for health professionals and student curricula is needed to enhance cultural competence and knowledge of LGBT health needs and it should be reflective of current data and research.

Luis Eduardo Guerra began his presentation by saying that the debate was dominated by a deficit based narrative that perpetuated stereotypes. Study data consistently showed inequalities, but was of variable quality and sometimes conflicting. Men’s health predominates the field, with a focus on HIV and STIs. A positive story was that life expectancy for those with HIV had increased.

Various reports have been published recently, notably the Government’s LGBT Action Plan, based on data collected from 108,000 people. Public Health England (PHE) published a review of health inequalities for MSM in 2014. The three key health
inequalities were mental health and wellbeing; alcohol, drugs and tobacco use; and sexual health and HIV. Inequalities for lesbian, bisexual women and other women who have sex with women (WSW) were mental health; pregnancy and reproductive health; some cancers; alcohol, drugs and tobacco use; intimate partner violence; and musculoskeletal and respiratory conditions.

For trans and non-binary communities the inequalities were focused on mental health; alcohol, drugs and tobacco use; and violence. This group was a focus for significant discrimination. PHE will publish a report of the first national survey of trans reproductive health in 2018/19.

Guerra went on to describe minorities within minorities, in which people may have multiple identities that can be a source of support but also be linked with isolation.

A key strategy is to use a community-centred approach in which LGBT people are involved in the work of high level Boards within PHE, and feeding into decision-making.

A range of stakeholder organisations were involved in the co-production of knowledge and building toolkits to facilitate improvements, they include the National LGBT Partnership, the National LGBT Academic & Research Network, cross-Government partnerships and various advisory boards within PHE and at community levels. There are a number of PHE projects to build the evidence base including systematic reviews and work to establish the national LGB prevalence. Other projects were looking at minority groups, and developing specific action plans.

Discussion
The audience and panel discussed the importance of minorities within minorities and a PHE project to collect data on black and minority ethnic men who have sex with men was underway. It was noted that PrEP was predominately accessed by white MSM. It was noted that sexual health services can offer a better service if they have good knowledge of their local community and its needs.

Members of the audience noted there was evidence available demonstrating that WSW start to have sex at a younger age than their heterosexual peers and that this might have consequences for the teenage pregnancy rate. It was noted by the panel that data about women who have sex with women is not collected as standard in GUM clinic data management, but that this was easy to do and should be recorded. It was pointed out that lesbian women often missed having cervical cancer screening. Sexual health services are not paid to do smear tests and this was an issue given that many other providers have stopped offering cervical cytology. There was inconclusive evidence for an increased risk of breast cancer in WSW.

The audience and panel discussed the use of recreational drugs during sex, referred to as chemsex. There was some interaction between mental health services for those individuals engaging in chemsex as a consequence of some of the effects of the drugs used. It was important that health services adapt to change and to be able to change referral pathways as appropriate, and introduce other ways to offer support if necessary.
It was noted that sexual health services often become the first point of contact for a range of health needs, for example drug use. The Club Drug clinic was set up to help manage some of the gaps that arise from gaps in services. This is in the wider context of the lack of a more strategic approach overall.

The panel discussed how the LGBT community tend to view sexual health services as approachable and friendly and are often accessed as a way of bypassing heteronormative services that could normally be considered the first point of call. Problematically this can often mean a conflation of (gay men’s) sexual health and the wider topic of LGBT health.

The audience and panel then discussed end of life care, highlighting that the care of the elderly and discussions about advanced decision making was crucial, and that WSW and MSM were at more risk of not having planned ahead. This was compounded by false beliefs about spousal rights to make decisions about end of life care.