Quality and Safety in Practice Committee

Guide for Providing Care for Lesbian, Gay and Bisexual Patients in Primary Care Quick Reference Guide

Authors:
Dr Des Crowley
Ms Paula Fagan

November 2020

Guide for Providing Care for Lesbian, Gay and Bisexual Patients in Primary Care Quick Reference Guide

---

Quality and Safety in Practice Committee

AUTHORS

Dr Des Crowley, Assistant Director, ICGP Addiction Management Programme

Ms Paula Fagan, CEO LGBT Ireland

Published: *November 2020*

Citing Quick Reference Guide

Irish College of General Practitioners Quick Reference Guide (ICGP QRG). A Guide for Providing Care for Lesbian, Gay and Bisexual Patients in Primary Care, Dublin: ICGP;2020 [cited 11 2020]. Available from URL: www.icgp.ie

Disclaimer and Waiver of Liability

Whilst every effort has been made by the Quality and Safety in Practice Committee to ensure the accuracy of the information and material contained in this document, errors or omissions may occur in the content. This guide represents the view of the ICGP which was arrived at after careful consideration of the evidence available at time of publication. This quality of care may be dependent on the appropriate allocation of resources to practices involved in its delivery. Resource allocation by the state is variable depending on geographical location and individual practice circumstances. There are constraints in following the guide where the resources are not available to action certain aspects of the guide. Therefore, individual healthcare professionals will have to decide what is achievable within their resources particularly for vulnerable patient groups. The guide does not however override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of individual patients in consultation with the patient and/or guardian or carer. The Quick Reference Guides are not policy documents. Feedback from local faculty and individual members on ease of implementation of these guides is welcomed.

Evidence-Based Medicine

Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. In this document you will see that evidence and recommendations are graded according to levels of evidence (Level 1 – 5) and grades of recommendations (Grades A-C) respectively. This grading system is an adaptation of the revised Oxford Centre 2011 Levels of Evidence.

Levels of Evidence

Level 1: Evidence obtained from systematic review of randomised trials
Level 2: Evidence obtained from at least one randomised trial
Level 3: Evidence obtained from at least one non-randomised controlled cohort/follow-up study
Level 4: Evidence obtained from at least one case-series, case-control or historically controlled study
Level 5: Evidence obtained from mechanism-based reasoning

*Level may be graded down on the basis of study quality, imprecision, indirectness (study PICO does not match questions PICO), because of inconsistency between studies, or because the absolute effect size is very small; Level may be graded up if there is a large or very large effect size. Where possible, systematic review evidence is presented.

ICGP Quality and Safety in Practice Committee

Dr Patricia Carmody
Dr Philip Sheeran Purcell
Dr Emma Wallace
Dr Velma Harkins
Dr Tony Cox
Dr Brian Osbourne
Dr Noirin O' Herlihy
Dr Nuala O' Connor
Dr Diarmuid Quinlan
Dr Joe Gallagher
Dr Dermot Nolan
Dr Mark P O' Kelly
Mr Nick Fenlon
Dr Helen McVeigh
Dr Tomás Barry
Dr Stella Burska
Dr Stephanie Dowling
Dr Una Kennedy
Dr Denise Lundon
Dr Paul Ryan

Correspondence

Please direct any queries to the following email address: qip@icgp.ie

Acknowledgements

The authors would like to thank the ICGP library for their assistance.

The authors also acknowledge the existing guidelines of the RCGPNI, their work in this area and the Sexual Health Centre in Cork for their contribution to the sexual health section of this guide. Finally, the authors would like to acknowledge Aoife McBride (ICGP) for her invaluable contribution to this document.

List of Abbreviations

ART	AntiRetroviral Therapy
BASHH	British Association of Sexual Health and HIV
DAHR	Donor Assisted Human Reproduction
EIS	Early Infectious Syphilis
GMHS	Gay Men's Health Service
GUM	GenitoUrinary Medicine
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSE	Health Service Executive
IBTS	Irish Blood Transfusion Service
LGBT	Lesbian, Gay, Bisexual and Transgender
LGV	Lymphogranuloma venereum
LMP	Last Menstrual Period
LSC	Last Sexual Contact
MSM	Men who have Sex with Men
NIAC	National Immunisation Advisory Committee
PEP	Post-Exposure Prophylaxis
PEPSE	Post-Exposure Prophylaxis after Sexual Exposure
PrEP	Pre-Exposure Prophylaxis
SHCPP	Sexual Health and Crisis Pregnancy Programme
STEIS	Sexual Transmitted Enteric Infections
STI	Sexually Transmitted Infection
TENI	Transgender Equality Network Ireland
WSW	Women who have Sex with Women

Contents

Introduction

The Irish College of General Practitioners (ICGP), in conjunction with LGBT Ireland and Transgender Equality Network Ireland (TENI), has developed two sets of guides to assist general practitioners (GPs) and other healthcare professionals in providing the best care possible to members of the Lesbian, Gay, Bisexual and Transgender (LGBT+) community.

This guide covers LGB health issues and the complementary guide addresses transgender health care. There is some overlap between these two guides, reflecting the reality of the LGBT+ community.

Through the collaborative work of the ICGP and LGBT Ireland, it is hoped that these guides will create a positive change in the way LGB people are cared for within health services in Ireland.

Both guides update the existing ICGP guidelines; Lesbian Gay and Bisexual Patients: The Issues for General Practice (2013).

Many important transformative changes have occurred since the publication of the 2013 guidelines, in particular, the legalisation of same-sex marriage in Ireland in 2015 and same-sex couples are now in law permitted to adopt. These changes emphasise the liberalisation of Irish society.

It is accepted that physical and mental health disparities exist between heterosexual and LGBT+ people. Many LGBT+ people experience stigma, social exclusion, discrimination and harassment, including within health care settings. Many fear disclosing sexual and/or gender orientation to their health care providers, including their GPs. Failing to disclose sexual orientation can have a negative impact on health and healthcare provision.

GPs play a critical role in providing a safe space for LGB people to disclose their sexual orientation. With a sensitive and non-judgemental approach to healthcare provision, GPs can help reduce the existing health disparities between this minority group and the general population.

Terminology

In order to support GPs to respond appropriately and effectively to LGB patients, this section will clarify terms and concepts relevant to this patient group.

It is important to note at the outset that some LGB people may understandably resist the fixed identity categories outlined below, however such categories can be useful when aiming to understand the health of LGB people and it is within this context that we use these terms.

*Terms relating specifically to **transgender people** are included in the second guide: ICGP Guide for Providing Care for Transgender Patients in Primary Care.*

Table 1: LGB Terminology

LGB Terminology	
Asexual	A person who experiences little or no sexual attraction to others and/or a lack of interest in sexual relationships/behaviour. They may or may not experience emotional, physical or romantic attraction. Asexuality differs from celibacy in that it is a sexual orientation, not a choice. People who are asexual may call themselves ace.
Bisexual or Bi	A person who experiences sexual, romantic, physical and/or spiritual attraction to more than one gender, not necessarily at the same time, in the same way or to the same degree.
Cisgender	A person whose sense of personal identity or gender corresponds to the gender they were assigned at birth.
Gay	Used in some cultural settings to represent men who are attracted to men in a romantic, erotic and/or emotional sense. Not all men who engage in same-gender sexual behaviour identify as gay and as such, this term should be used with caution. This term can also be used to a lesser extent by women who are attracted to women (see also Lesbian).
Heterosexism	Prejudice against individuals and groups who display non-heterosexual behaviours or identities, combined with the majority power to impose such prejudice. Usually used to the advantage of the group in power. Any attitude, action or practice backed by an institutional power that subordinates people because of their sexual orientation.
Homophobia	The fear, hatred, discomfort with, or mistrust of people who are lesbian, gay or bisexual.
Homosexuality	Refers to a romantic or sexual attraction or romantic or sexual behaviour between members of the same sex/gender. No longer frequently used to define a sexual orientation as it is usually covered by gay/lesbian. This term should be used with caution as it has negative historical connotations.
Lesbian	Women who experience sexual, romantic, physical and/or spiritual attraction to other women. Not all women who engage in same-gender sexual behaviour identify as lesbians and as such, this term should be used with caution.
LGBTI+	An umbrella term used to refer to the entire Lesbian, Gay, Bisexual, Transgender and Intersex communities including those who may not be comfortable with these terms and who do not identify as heterosexual and/or cisgender.
Minority stress	A term used to describe the mental health consequences of stigmatisation, social exclusion, discrimination and harassment of minority groups such as the LGB population.
MSM	Men who have sex with men. They may or may not identify as gay or bisexual.
Pansexual	A person who experiences sexual, romantic, physical and/or spiritual attraction regardless of gender identity/expression.
Queer	A multi-faceted word that is used in different ways and means different things to different people.

LGB Terminology	
	1) Attraction to people of many genders 2) Don't conform to cultural norms around gender and/or sexuality 3) General term referring to all non-heterosexual people Some within the LGBT community may feel the word has strong negative connotations and are reluctant to embrace the word. This term should be used with caution and only when/if the patient themselves self-identifies as queer.
Questioning	An individual who is unsure of and/or exploring their gender identity and/or sexual orientation.
Sexual Orientation	Refers to each person's capacity for profound affection, emotional and sexual attraction to, and intimate sexual relations with, individuals of a different gender, the same gender or more than one gender. Sexual orientation is separate from gender identity. People who identify as transgender may be gay, straight, bisexual or asexual. For example, a natal female who transitions from female to male and is attracted to other men would be identified as gay or as a gay man.
WSW	Women who have sex with women. They may or may not identify as lesbian or bisexual.

Section 1 Aims of this Guide

This guide aims to address the most common questions and information gaps that GPs may have in relation to providing primary care to LGB people.

To achieve these aims, this guide covers:

- Sexual orientation, concepts and language
- Key legislation for LGB people
- A review of LGB health issues
- Good practice in service provision to LGB patients

There are a number of specific health issues, which GPs should be aware of in relation to LGB patients particularly in the areas of:

- General health and screening
- Mental health
- Sexual health

A good understanding of these issues is the foundation of an inclusive practice.

This guide also contains a glossary of terms, a services directory, a list of resources for GPs and a bibliography of references.

Section 2 Key Recommendations

Table 2: Recommendations for good practice with LGB patients.

Stay informed on LGB health issues including key LGB-related legislation
Be aware of the following: • LGB people experience stigma and discrimination, including in health care settings which may impact their willingness to disclose their sexual orientation • Sexual orientation is different from sexual behaviour • 'Coming out' may be a period of heightened stress requiring medical and other supports • There are elevated levels of smoking, alcohol consumption and recreational drug use among LGB people compared to their heterosexual peers • There is an increased risk of depression, self-harm and suicidal ideation in LGB patients therefore, you should screen LGB patients for mental health risk factors if appropriate • In recent years, there has been an increase in the level of HIV and STI diagnoses among the MSM population in Ireland • Lesbian and bisexual women are less likely than heterosexual women to avail of or be referred for cervical smear tests and mammography or to examine their own breasts • Lesbian and bisexual women may be at higher risk of developing ovarian cancer than their heterosexual peers • Healthcare practitioners assuming that patients are heterosexual is a key barrier to providing appropriate healthcare services for LGB people
Use open language and questions to demonstrate to patients that you are not assuming they are heterosexual and to ensure that LGB patients feel comfortable disclosing their identity
Acknowledge when patients do disclose that they are lesbian, gay or bisexual
Take an affirmative approach and challenge bias
Recognise that conversion therapy is ineffective, inappropriate and potentially damaging
Be able to take an appropriate and confidential sexual history to assess risk of STIs in patients of all sexual orientations and offer testing on the basis of risk rather than sexual orientation
Be mindful that MSM or WSW may not always identify as LGB
Offer MSM a course of Hepatitis A+B vaccination and booster based on immunity
Encourage sexually active WSW to be screened for STIs in the same way as with heterosexual female patients and dispel the perception that the transmission of STIs between women is negligible
If you are seeing a child with same-sex parents, include both parents in the discussion
Demonstrate that your practice is welcoming of LGB patients by ensuring all relevant paperwork, information leaflets and history taking questions use language which is inclusive of LGB people and their family and by displaying LGB leaflets and/or posters in your waiting room

Section 3 Background

The ICGP and LGBT Ireland have written this guide to advance GPs' understanding of what they need to know when treating LGB people in primary care. A number of current national health strategies include LGB people as a priority population. These strategies advocate for their specific health needs to be considered by health professionals and for health care providers to be inclusive and welcoming of this patient group in their practices [1,2,3].

National and international research into the experiences of LGB people consistently shows that many are reluctant to disclose their sexual orientation to their healthcare provider, due to concerns of negative responses and discrimination from them [4]. This guide has been developed to support GPs to address these barriers by assisting them to provide appropriate and accessible services to LGB people in their care. In highlighting the specific health needs of this patient population it should go some way to identify possible strategies for improving their care.

Information specific to trans patients can be found in: ICGP Quick Reference Guide: A guide for the Care of Transgender Patients in Primary Care. We hope that both guides will be useful to the entire primary care team.

3.1 Prevalence of LGB people in Ireland

Estimating the number of LGB people in Ireland is difficult. It depends on people surveyed identifying as LGB and whether they feel able to disclose their sexual orientation.

According to the national census, the population in Ireland in 2016 was 4,761,865. The census does not collect data on sexual orientation; however, it does gather information on cohabiting couples. There were 6,034 same sex couples in Census 2016, an increase of just under 50% since 2011, of which 57% (3,442 couples) were male and 43% (2,592 couples) were female [5].

The biggest increases in people in same sex couples by age were in the older age groups. The number of people aged 50 or over in same sex couples has more than doubled from 1,140 to 2,307, while those aged 25 to 49 increased by 46% to 1,912 [5].

The Equality Authority, in its Implementing Equality for LGB People adopted the figure of 10% of the population to estimate the size of the LGB population [1]. Based on the last census, this gives an estimate of approximately 476,186 people [6].

Table 3: The number of same sex marriages conducted in the Ireland (2015-2018)

Year	Female	Male	Total
2015	44	47	91
2016	450	606	1,056
2017	335	424	759
2018	292	372	664

In the Sexual Orientation, UK 2017 Survey, 2.0 % of UK adults identified as LGB [7]. This is thought to be an underestimate, with both Stonewall UK and the UK Treasury estimating 5-7% [8].

3.2 Social Issues

LGB people can experience invisibility, violence, discrimination and prejudice throughout their lives [9,10]. These experiences of intolerance can have a negative impact on their emotional health and wellbeing [9].

It is often during school years that people become aware of their minority sexual orientation. The LGBT Ireland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland reported that approximately a quarter of the 14-18 year old (23.6%) and 19-25 year old (23.2%) participants reported missing or skipping school to avoid negative treatment related to being LGBT [9]. Table 4 summarises the results of the School Climate Survey.

Table 4: Results of the 2019 School Climate Survey [11]

Results of the 2019 School Climate Survey show that
73% of LGBTI+ students feel unsafe at school
77% of LGBTI+ students experience verbal harassment (name calling or being threatened)
38% experience physical harassment (being shoved or pushed)
11% experience physical assault (punched, kicked or injured with a weapon) based on their sexual orientation, gender or gender expression
68% of LGBTI+ students stated they hear anti-LGBTI+ remarks from other students
48% reported hearing homophobic remarks
As a result of feeling unsafe and unaccepted at school, LGBTI+ students are 27% more likely to miss school and 8% are less likely to pursue third-level education

The 2013 'Through our Minds' study of the experiences of LGBT people in Northern Ireland asked people about their experiences of school. More than 60% reported being called hurtful names related to sexual orientation and/or gender identity [10].

LGB people were also found to have had negative experiences in their everyday lives related to their actual or perceived sexual orientation [9,10]. These negative experiences included being threatened with physical violence or discrimination. One third had been threatened with being 'outed' at least once [10]. Social isolation can be a problem for LGB people. One study found that 41% of LGB people over the age of 55 live alone, compared to 28% of heterosexual people the same age [12]. Social isolation can be felt by LGB people of all ages and can be a particular problem in rural areas [13].

Domestic abuse in LGB communities often goes unreported and may be in the form of verbal, emotional or physical abuse [14].

Section 4 Key Legislation in Relation to LGB People

There have been significant advancements in LGB rights and recognition in Ireland in recent years. As primary healthcare providers, it is important for GPs to be aware of the legislation, particularly in the areas of relationship recognition and parenting rights.

4.1 Same Sex Relationship Recognition

4.1.1 Marriage Equality

The Marriage Act 2015 allows same sex couples to marry as provided for under Article 41.4 of the Irish Constitution. The positive result in the Marriage Equality referendum that paved the way for the Marriage Act was seen as a huge step forward in legal and societal recognition of same sex couples and LGB equality generally. The law means that same-sex married couples have the same legal rights and entitlements as opposite sex couples and GPs should treat them in the same way as they would a married opposite sex couple.

4.1.2 Civil Partnership

Preceding Marriage Equality, Ireland introduced a statutory civil partnership registration scheme for same-sex couples in January 2011 under the Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010. The enactment of the civil partnership legislation provided same-sex couples with many of the same rights and entitlements to marriage and equality legislation was amended to prohibit discrimination on the grounds of being in a civil partnership.

Following the introduction of the Marriage Act 2015, it is no longer possible to register a civil partnership. Couples already in a civil partnership can apply to marry or remain as they are. If they marry, their civil partnership is automatically dissolved.

4.1.3 Parenting Rights

The Children and Family Relationship Act 2015 modernised the law regarding children living in diverse family forms. This legislation is very significant for same sex parents and for same sex couples who are planning parenthood. It allows the non-birth parent to apply for guardianship and enables same sex couples to be eligible to adopt a child jointly.

The legislation also sets out how parentage is to be assigned in cases of donor assisted human reproduction (DAHR).

Parts 2 and 3 of the Act commenced on the 5th of May 2020 allowing same-sex female parents to register as legal parents of their child/children born through DAHR, and to obtain a birth certificate, which reflects this, in the following circumstances.

Retrospective recognition of children conceived pre-commencement

- Where a child was conceived using an anonymous sperm donor in a clinic in Ireland or abroad
- Where a child was conceived using a traceable sperm donor in a clinic in Ireland or abroad (i.e. child has a right to trace the donor when they reach 18 years of age)
- The date of conception is the relevant point in time, so a pregnancy ongoing at the time of commencement will not be affected and any children born as a result of that pregnancy will be covered by the retrospective provisions

Future recognition for children conceived post-commencement date

- Where a child is conceived using a traceable sperm donor in a clinic in Ireland only
- Where a child is conceived using a known donor in a clinic in Ireland only

This means that children conceived post-commencement in a clinic abroad or in a clinic using an anonymous donor will not be covered by the legislation.

It is important for GPs to know the eligibility criteria for establishing legal parentage as set out in the act when advising couples on DAHR options and to note that these criteria apply to both opposite sex and same sex couples.

For example, where an opposite sex couple accesses fertility treatment abroad using a donor gamete to conceive, under the Children and Family Relationship Act they will not be eligible to register both parents on their child's birth certificate.

In reality, however, these provisions will disproportionately affect same sex couples as no presumption of parentage applies, and they will need to produce evidence that they meet the criteria above, when registering the birth of their child/children.

Section 5 Sexual Orientation

Sexual orientation refers to each person's capacity for profound affection, emotional and sexual attraction to, and intimate sexual relations with, individuals of a different gender or the same gender or more than one gender.

Table 5: Recognised sexual orientations

Three sexual orientations are commonly recognised
Heterosexual (attraction to individuals of the opposite gender)
Homosexual (attraction to individuals of one's own gender)
Bisexual (attraction to members of any gender)

Many LGB people do not like the use of the term homosexual to describe their sexual orientation because of the negative historical associations with this word. Most people prefer the word gay if they are male and lesbian if they are female.

Sexual orientation is different from sexual behaviour because it refers to feelings and individuals' views about who they consider themselves to be. Sexual behaviour is simply how people behave in a sexual situation. Individuals may or may not express their sexual orientation in their behaviours. Being lesbian, gay or bisexual is not a preference or a choice. It is integral to a person's life and their identity rather than being a lifestyle. Our sexual orientation reflects a complexity of factors that determine who we are sexually attracted to and who we fall in love with.

Section 5.1 Sexual Orientation Disclosure (Coming Out)

Disclosure that one is lesbian, gay or bisexual is often referred to as 'coming out'. However, there is more to coming out than disclosure of sexual orientation. Coming out is an important and affirmative developmental process in the lives of LGB people with distinct phases. It first involves accepting one's own sexuality and then choosing to share this with others as well as developing a positive sexual identity.

It is important to remember:

- LGB people come out at all stages of life and to varying degrees (including not at all)
- Coming out can be different for everyone and should be taken at a person's own pace
- Getting appropriate information and support can really help with the coming out process (Appendix 1)

The recent HSE LGBT Ireland Report found what helped LGB people to come out was:

- Knowing they would be accepted and supported by family members, friends and others
- Greater visibility of LGB identities and more accepting societal attitudes

However, this study also found that fear of rejection and discrimination was one of the main reasons why people who had not come out continued to conceal their LGB identity. The assumption of heterosexuality by family, friends and society also acted as a barrier to coming out.

It is important for GPs to know that, while the majority of LGB people experience great relief when they come out, it can be a time of heightened stress, which may result in LGB people presenting to primary care and mental health services [15].

Section 6 Review of LGB Health Issues

6.1 The Consultation

If patients feel able to disclose their sexual orientation to their GP, issues that disproportionately impact on their health can be identified and discussed [4]. Coming out is not a single event for LGB people, it is something they are required to do repeatedly over the course of their lives. Table 6 summarises a number of ways that a practice can demonstrate an open and inclusive clinical environment to LGB patients.

Table 6: Demonstrating an open and inclusive clinical environment to LGB patients

Demonstrating an open and inclusive clinical environment to LGB patients
Allow LGB patients to self-identify on new patient enrolment forms if they choose to do so
Consider an appropriate method to record/code a patient's LGB status with consent of the patient
Ensure that all practice staff demonstrate a positive attitude and use sensitive language
Provide sexual orientation training for all primary care staff
Display posters and leaflets reflecting LGB issues in the waiting room (see Appendix 2)
Include sexual orientation in a clearly displayed anti-discrimination policy
Include LGB patients in patient participation groups
During a consultation, do not make assumptions about a patient's sexual orientation or assume they are heterosexual. It is important to facilitate disclosure but also to respect non-disclosure.

A GP can make it easier for patients to disclose or talk about their sexual orientation by:

- Assuring the patient that consultations are confidential
- Adopting a non-judgemental attitude
- Using open questions such as "Do you have a partner?"

Where a patient chooses to disclose their sexual orientation as LGB it is important that this is acknowledged and the terms they use clarified. They can then be offered supportive information relevant to their sexual orientation and this should not focus solely on their sexual health. LGB patients report finding it difficult to bring a same sex partner to their consultation and should be encouraged to do so if they would find it helpful.

When treating a child with same sex parents, family diversity can be respected by involving the non-biological parent in the discussion. GPs should be aware of the need to support parents and other family members of teenagers who are coming out as LGB (Appendix 1).

6.2 General LGB Health and Screening

Most LGB people will present to GPs with the usual range of health issues seen in general practice and routine health recommendations will apply. There are a number of specific health issues and needs which GPs should be aware of in relation to LGB patients.

A good understanding of these issues is the foundation of providing an inclusive service to LGB patients. The issues can be grouped into the following areas:

- Drug and alcohol use
- Physical health
- Mental health
- Sexual health
- Ovarian cancer
- Fertility

6.3 Drug and Alcohol Use

Research on health-related behaviours among the LGB community has shown elevated levels of smoking, alcohol consumption and recreational drug use when compared to their heterosexual peers [16,17]. The two most commonly cited risk factors for elevated substance use in this population are the importance of bar and club scene in LGB communities and minority stress (including discrimination and internalised homophobia) [18–20]. The highest disparities occur in the 15-24 year-old age group and this, in part, may be due to the timing of young people dealing with their sexual orientation and coming out [17]. It is useful for GPs to be aware of these findings and to screen LGB patients for tobacco, alcohol and drug use and offer appropriate interventions. Sexualised drug use among MSM is of particular concern and is discussed further in the sexual health section [18,21] (see Chemsex).

6.4 Physical Health and Activity

In relation to physical activity, a study commissioned by Sport England into the sport and physical activity of LGB people found that higher percentages of LGB people compared to the general population were not active enough to maintain good health [22].

Key areas identified in order to address the under activity included:

- Tackling homophobic language within sport settings
- Making sport a more inclusive and welcoming place for LGB people
- Prevalence of anxiety regarding sports participation

For lesbian and bisexual women, the risk of obesity is also of concern. Studies show that lesbian and bisexual women had significantly greater body mass index (BMI) or a higher percentage had a BMI over 30 compared to heterosexual women [23].

Gay and bisexual men are more likely to suffer from eating disorders [24]. One in seven (13%) have had a problem with their weight or eating in the last year compared to 4% of men in general.

Practice Points

- Elevated levels of smoking have been found among LGB people when compared to heterosexual peers
- Elevated levels of alcohol consumption have been found among LGB people compared to heterosexual peers
- Elevated levels of recreational drug use have been found among LGB people when compared to heterosexual peers
- LGB people are less physically active than their heterosexual peers
- Lesbian and bisexual women are more at risk of obesity than their heterosexual peers

6.5 Health Screening

Research also indicates that lesbians are less likely than heterosexual women to avail of or be referred for cervical smear tests and mammography or to examine their own breasts [25,26]. GPs may incorrectly assume that lesbian and bisexual women are at low risk for cervical dysplasia and need less frequent cervical smears than heterosexual women. The Human Papilloma Virus (HPV) is sexually transmitted and HPV is a causative factor in the development of cervical cancer [27]. HPV-associated squamous intraepithelial lesions have occurred in lesbians who have never had sex with men [25].

Recommendations for cervical cancer screening in lesbian and bisexual women, regardless of their sexual history with men, should therefore not differ from screening recommendations for women in general. As physician recommendation appears to be a potent determinant of regular screening behaviour, GPs should encourage lesbian and bisexual women to have regular cervical smears.

We know that women who have sex with women (WSW) may or may not identify as LGB. Lesbian and bisexual women may be having penetrative sex with a man or have done so in the past. Other lesbian and bisexual women may never have had sex with a man, but these patients can transmit HPV and sexually transmitted infections (STIs) to their female partner from their sexual practice e.g. oral sex or sharing sex toys without use of a condom [26].

Girls who identify as lesbian and bisexual women should also be included in the HPV vaccination programme [28].

Practice Points

- Offer all women, including WSW, aged 25–60 a cervical smear regardless of their sexual orientation [29]
- Offer women information about safer sex practices to reduce risk of acquiring HPV regardless of their sexual orientation
- Ask inclusive questions when history taking around the smear test e.g. “Are you sexually active at present?” and if yes, “Do you have a regular partner?” making sure not to assume heterosexuality

Breast cancer is the most common form of invasive cancer among women in Ireland. The breast screening programme in Ireland provides breast screening every two years for all eligible women aged 50 and over [30].

All lesbian and bisexual women should be encouraged and supported to participate in the national breast screening programme. GPs should encourage lesbian and bisexual women to carry out regular breast self-examination.

6.6 Mental Health

A large body of published empirical research shows that given the stresses created by stigma, inequality and harassment, LGB people are at a heightened risk of psychological distress related to these experiences [17,28]. This is often referred to as minority stress, a term used to describe the mental health consequences of stigmatisation, social exclusion, discrimination and harassment of minority groups such as the LGB population [16]. This concept is particularly useful when explaining mental health issues related to being LGB because it is centred on an understanding that alienation from social structures, norms and institutions can create psychological distress and increase the risk of suicide.

Research consistently shows that the LGB population are at increased risk of depression, self-harm and suicide when compared to heterosexual people [20,31]. One meta-analysis showed a two-fold increase in suicide attempts in the preceding year in both men and women and a fourfold lifetime increase in gay and bisexual men [31].

6.7 The LGBTI Ireland Report 2016 [9]

The LGBTI Ireland Report details the findings of a national study of the mental health and wellbeing of LGBTI people in Ireland, with a special emphasis on young people. 2,257 people participated in this study, including 1,064 aged between 14 and 25. A key finding of this study was that LGBTI people, and young people in particular, are at an increased risk of suicidal behaviour, self-harm and severe stress, anxiety and depression.

Table 7: Key findings from LGBTI Ireland Report 2016 [9]

Key findings from LGBTI Ireland Report 2016
56% of 14 to 18-year olds had self-harmed with 77% doing so in the past year
43% of 19 to 25-year olds had self-harmed with almost half doing so in the past year
70% of 14 to 18-year olds had seriously thought of ending their own life (70% in the past year)
62% of 19 to 25-year olds had seriously thought of ending their own life (50% in the past year)
Attempted suicide was 3 times higher among 19 to 25-year old LGBTI people in comparison to a similar age group (17 to 25-year olds) in the My World national youth mental health study
Intersex, transgender and bisexual people were more likely to have self-harmed and to consider ending their own life than lesbian/gay females and gay males

In summary, compared to the wider population of young people in Ireland, LGBTI young people had:

- Two times the level of self-harm

- Three times the level of attempted suicide
- Four times the level of severe or extremely severe stress, anxiety and depression

Although social attitudes towards and visibility of LGB people have improved markedly in Ireland in recent years, LGB people can still experience discrimination, exclusion and harassment. Young people in particular may be affected by homophobic bullying, resulting in psychological distress and feelings of isolation.

Depending on their families and where they live, LGB people may have to struggle against prejudice and misinformation about their sexual orientation and often fear being rejected by family and friends if they come out [31]. This can be compounded by rural isolation for those living outside urban areas or by other intersectional issues (e.g. LGB refugee or asylum seeker) [13,32].

Research has also found that coming out and acceptance of one's LGB identity is strongly related to good psychological adjustment i.e. the more positive one's LGB identity is, the better one's mental health and the higher one's self-esteem [33].

GPs may provide LGB patients with opportunities to discuss experiences which have impacted on their mental health and where appropriate, screen LGB patients for mental health and suicide factors such as psychological distress, depression, anxiety, substance misuse and lack of social support. Referral to mental health services and other support services, such as counselling and psychotherapy, should be considered where appropriate. Patients can also benefit from referral to LGB organisations (Appendix 1).

Practice Points

- Minority stress leads to elevated levels of suicidal behaviour and self-harm among LGB people
- LGB people are at increased risk of psychological distress compared to heterosexual people as a result of minority stress
- LGB people are at increased risk for depression, anxiety and substance use disorders as a result of minority stress
- Lack of social support at the time of coming out can increase the risk of suicidal behaviour particularly among younger LGB people

6.8 Conversion Therapy

Being lesbian, gay or bisexual relates to sexual orientation. It is not a mental illness and cannot be 'cured'. Despite this, voluntary agencies still report meeting individuals who have been subjected to 'conversion therapy', also known as 'reparative' or 'gay-cure' therapy.

Extensive empirical research has been carried out on the use of reparative therapy with LGB people and this research has demonstrated that reparative therapy does not work and can be damaging to the mental health of LGB people who undergo it [34].

The College of Psychiatry of Ireland and the ICGP do not support referral to or the practice of reparative therapy or any approach aiming to change a person's sexual orientation and instead promote inclusive practice that is gay-affirmative (see Lesbian, Gay and Bisexual Patients: The Mental Health Issues, Section 3. Guide to Good Practice for more information on gay-affirmative practice) [3].

6.9 Sexual Health

There are particular sexual health issues that can be considered by GPs when assessing LGB patients. Provision of screening services for STIs for all patients at primary care level is under-developed in Ireland. This coupled with some patients' reluctance to disclose their sexual orientation to GPs and/or discuss their sexual behaviour, may result in inadequate sexual health screening and treatment [4].

6.9.1 Where Does General Practice fit in to Sexual Health Services?

The British Association of Sexual Health and HIV (BASHH) published comprehensive guidelines in the treatment of STIs (including in general practice) [35]. These are available here.

It is important that GPs practice within their scope of competence and refer to specialist services when required. Notification and contact tracing are essential aspects of STI management and should be fully addressed if managing STIs in primary care.

Practice Points

- Only practice STI screening and management within own level of competency and training; if feel out of depth – refer or sign post to specialist services
- Promote the 'safer sex message' to patients of all sexual orientations
- Be able to take an appropriate and confidential sexual history to assess risk of STIs in patients of all sexual orientations
- Be mindful that MSM or WSW may not always identify as LGB
- Offer STI testing on the basis of risk rather than sexual orientation
- Be aware that if the patient is symptomatic, they need to be offered a genital examination or referred to specialist services
- Check if the patient needs assistance in accessing an appointment with specialist services and act as an advocate if appropriate
- Become familiar with local sexual health services and community based services which can offer some STI outreach testing in venues and walk-in MSM clinics in GUM

6.9.2 Taking a Sexual History

When patients present with symptoms related to sexual activity, they may feel embarrassed. Gay men may find it difficult to discuss certain sexual practices such as anal sex while lesbian women report finding it harder to talk to a male doctor.

When taking a sexual history, you should consider the following:

- Ask to see the patient alone as this will reduce embarrassment and enhance disclosure
- Obtain consent and warn about the nature of the questions e.g. "I need to ask you some personal questions to help me advise you on the correct STI tests for you, would that be ok?"

- Normalise the process e.g. “We ask these questions to everyone with similar symptoms/difficulties”
- Be non-judgemental and emphasise confidentiality
- Try not to make assumptions about sexual practice or risk of STIs before you ask the questions
- Avoid the terminology of LGB unless the patient identifies as such
- Use professional language and individualise for the patient or health practitioner
- STI screening should not necessarily be the first thing the clinician offers when a patient comes out

GPs can help alleviate the patient’s discomfort by taking a sexual history in a sensitive, non-biased and comprehensive manner. It is important that the GP makes the patient aware of the necessity of having all relevant information to make an appropriate health assessment.

Each GP will have their own way of asking delicate sexual health questions and below are suggested questions for taking a sexual history from patients (Appendix 3).

Table 8: Taking a sexual history

Taking a sexual history
Ask ALL patients irrelevant of sexual orientation
• Are you sexually active? • Do you have sex with men, women or both? • How many partners have you had in the past six months? • What sexual acts do you engage in? (check for oral, vaginal and anal sex) • What do you do to protect yourself from STIs? • Have you any concerns about any sexual activity or risk that you feel you may have taken? • Do you have any questions or concerns about your sexual health?
Additional questions to consider for women
• Have you ever been pregnant or is there any chance you might be pregnant today? • Do you have any questions or concerns about your gynaecological health such as irregular bleeding, menstrual irregularities etc?

In order to understand the risks a patient might be taking it is important to take a more holistic view of their health. Engaging in high sexual risk behaviour may be an indication of other underlying problems, such as deteriorating mental health, social exclusion or substance misuse.

High-risk sexual behaviour puts people at risk of STIs, unplanned pregnancy and being in a sexual relationship before being aware of what makes a healthy relationship. Teens and young adults are at higher risk of high-risk sexual behaviour than older adults.

While being LGB is not a psychosexual problem, some LGB patients may have a psychosexual problem or suffer with sexual dysfunction. GPs should explore this in the same way as with their heterosexual patients and make appropriate referrals.

6.9.3 Sexual Health – MSM

When discussing men's sexual health, it is important to acknowledge that there will be a cohort of men who will present but will not identify as gay or bisexual. This population group will be referred to as MSM (men who have sex with men). MSM is an epidemiological term to encompass all men in this group.

STI screening and HIV prevention work remains central to primary health care for MSM. In recent years, there has been an increase in the level of HIV and STI diagnoses among the MSM population in Ireland [36].

6.9.4 HIV [36]

- MSM is the group most affected by HIV in Ireland and accounts for more than half of the diagnoses in recent years (56% in 2018)
- There are increasing numbers of HIV notifications among MSM in recent years (293 in 2018)
- An increasing proportion of MSM diagnosed with HIV in Ireland have a previous diagnosis obtained abroad (50% in 2018)
- The majority of these men have an undetectable viral load at the time of their diagnosis in Ireland (already on treatment and not a transmission risk)
- The median age of newly diagnosed MSM patients is declining – it was 33 years in 2016 (compared to 37 years in 2005)

6.9.5 Syphilis [37]

- Early infectious syphilis (EIS): the number of new infections among MSM has increased each year since 2013
- In 2018 notification rate among MSM increased by 13% to 356.6/100,000
- MSM accounts for 86% of EIS notifications (where mode of transmission is known)
- Most MSM who get infected with EIS acquire it in Ireland
- A large proportion of MSM diagnosed with EIS are HIV positive (40% where known)
- Majority of notifications (79%) among MSM are reported by the HSE East
- Median age of notifications is 34 years (range: 19-76 years)

6.9.6 Gonorrhoea [38]

- MSM are disproportionately affected by gonorrhoea in Ireland with 65% of cases among MSM in 2018 (where mode of transmission is known)
- In 2018 the rate of gonorrhoea notifications among MSM was 117 per 100,000 (double the rate reported in 2015)
- 25-29 year olds are most affected among MSM

6.9.7 Lymphogranuloma Venereum (LGV) [38]

- The number of LGV notifications increased in 2018, with all cases in MSM, half were born in Ireland and 64% were HIV positive

6.9.8 Hepatitis [38]

- Hepatitis A outbreaks can occur among MSM (most recent in 2017-2018, when 20 new cases were identified among MSM in Ireland)
- Increasing numbers of MSM being diagnosed with HCV infection with 72 cases identified since 2015
- 56% were HIV positive at the time of diagnosis

6.9.9 Sexual Transmitted Enteric Infections (STEIs) [38]

- Sexually transmitted shigellosis has been increasing among Irish MSM and is often associated with antimicrobial resistance

Further information is available at www.sexualwellbeing.ie and www.hpsc.ie.

6.9.10 HIV Infection and Prevention

There are several direct linkages between patients accessing sexual health services and HIV and STI infection rates. It is in the early stages of HIV that the condition is most highly transmissible. This is because the viral load is very high in the first few months.

An estimated 1 in 5 people living with HIV in the UK are undiagnosed and it is believed that most HIV infections are transmitted by those yet undiagnosed [39,40]. MSM who have been surveyed by Stonewall UK about their sexual health have disclosed that they have not been tested for STIs, including HIV, for a variety of reasons including:

- 'I don't think I'm at risk'
- 'I'm too scared to test'
- 'I'm too busy to get tested'
- 'I have no symptoms of infections'
- They have poor access to services

Conversely, MSM reported mostly being tested for HIV after an experience that they had classified as risky 'or having symptoms that they attributed to an STI' [42].

Patients unaware of their HIV status have an increased potential for further transmission. Early detection of infection at a time of high HIV infectivity will be more advantageous in lowering HIV incidence than later diagnosis and will improve management of HIV disease.

GPs should assess the STI-related risks for all male patients, including a routine inquiry about the gender(s) of sexual partners but not ruling out the possibility of same sex engagement that the patient does not want to disclose.

STI-risk level is influenced by factors including relationship status, HIV status, number of sexual partners and recreational drug use [24,42]. MSM at higher risk should be screened for STIs including HIV, syphilis, gonorrhoea and chlamydia at least annually (even in the absence of any symptoms) and immunisation against Hepatitis A and B is recommended [43].

MSM patients should always be advised of the importance of sexual hygiene due to the continued rates of shigella being reported in Ireland [38]. Increasing both the numbers and frequency of MSM accessing sexual health services is a critical part of HIV/STI prevention, both for patients and in reducing onward transmission rates.

GPs play a crucial role in normalising STI screening by having an open dialogue with patients. By discussing recent increases in STIs, explaining the transmission synergy between HIV and other STIs and helping patients understand how STIs are contracted, GPs can help reduce risky sexual behaviours.

Sexual health literature for gay and bisexual men is available from the various sexual health and LGB organisations, see www.man2man.ie

NICE guidance suggests that primary care providers offer annual HIV testing to men who are known to have sex with men [44]. This is not necessarily easy to do at a practice population level and raises issues with coding of sexual practice and sexual orientation in GP records.

Emphasis has shifted away from pre-test counselling for HIV towards normalisation of the test and increasingly offering the test.

Thought should be given to the practice systems regarding HIV testing e.g. how the test result would be given to the patient.

Table 9: Points GPs should be aware of in MSM patients

GPs should be aware that an MSM patient
Could be offered opportunistic HIV testing in primary care
Who are having unprotected sex with casual or new partners should have an HIV/Hepatitis B+C/ Syphilis/STI screen at least annually or every 3 months if changing partners regularly
May require triple site (urine, pharyngeal, anal) testing for chlamydia and gonorrhoea based on sexual practice
Should be offered a course Hepatitis A+B vaccination and booster based on immunity (this if offered free of charge at local sexual health clinics including the Gay Mens Health Service (GMHS))

6.10 Undetectable = Untransmissible (u=u)

There is now clear evidence showing that there is effectively no risk of HIV transmission among MSM through condomless sex when HIV viral load is suppressed (undetectable viral load) [45]. This is often described as undetectable = untransmissible (u=u). This evidence also supports the benefits of early testing and treatment for HIV. Further information is available here.

6.11 Post-Exposure Prophylaxis (PEP)

Post-Exposure Prophylaxis or PEP (sometimes referred to as PEPSE or Post-Exposure Prophylaxis after Sexual Exposure) is a 28-day course of antiviral tablets prescribed following high-risk exposure to HIV [46]. Its aim is to prevent HIV becoming established in the T-memory cells if the virus has been transmitted.

Treatment with PEP must be given within 72 hours of possible exposure. The earlier after exposure it is commenced the more effective it will be (level of evidence 3) [46]. PEP can only be accessed through specialised sexual health services and Accident and Emergency Departments.

When a patient presents requesting PEP, a sexual history will be taken and the risks versus benefits of PEP will be discussed. If PEP is deemed appropriate, baseline tests including HIV, Hepatitis immunity and renal function will be taken before medication is provided. Likely side-effects and the importance of adherence to the regimen and attendance for follow-up will be explained by the prescriber.

GP or practice nurse may:

- Be able to assess the patient's risk of HIV exposure in the preceding 72hrs or contact specialised sexual health services for advice
- Refer at risk patients urgently for same day assessment if you believe PEP should be discussed
- Refer the patient to Accident and Emergency for PEP if it is out of hours for GUM

Locations where PEP is available are listed here.

6.12 Pre-exposure Prophylaxis (PrEP)

HIV Pre-Exposure Prophylaxis (PrEP) is the pre-emptive use of oral antiretroviral therapy (ART) in HIV negative people to reduce the risk of HIV infection (level of evidence 1). PrEP is the newest HIV prevention tool available and is best used in combination with other HIV prevention measures. PrEP consists of a fixed dose combination of oral emtricitabine/tenofovir disoproxil 200mg/245mg film-coated tablets. PrEP has been shown in many studies to be safe and highly effective at preventing HIV [47,48]. When taken correctly PrEP has been found to be about 99% effective [47,49].

Since November 2019, the HSE commenced the roll out of the national PrEP programme. PrEP is now available free of charge to MSM at risk of HIV infection living in Ireland.

To date there are eight public services and six private services authorised to prescribe free PrEP. An updated list of approved services can be found here.

GPs can apply to the HSE Sexual Health and Crisis Pregnancy Programme (SHCPP) for approval as a PrEP service. A comprehensive set of guidelines has been issued by the HSE for those wishing to prescribe and monitor patients on PrEP. These guidelines can be found here.

The application to register as a PrEP service provider can be found in Appendix 4 HIV PrEP Programme Service Application Form.

6.13 Chemsex

National and international research reports increasing levels of sexualised drug use among MSM often referred to as Chemsex [21][50]. The most common drugs used are:

- Methamphetamine (Crystal, Crystal Meth, Tina, Meth)
- Mephedrone (meph, drone, M-Cat, Meow-Meow)
- GHB/GBL (G, Gina, Liquid E)

The use of these drugs is associated with increased sexual risk taking, STIs and HIV [41]. Their use is also associated with the development of dependence and addiction along with the risk of both non-fatal and fatal overdoses [18].

Patients experiencing difficulties with Chemsex issues can be referred to the following specialist services:

- Gay Men's Health Service (chemsex detox and support): 087 229 1860
- Gay Switchboard Ireland: 01 872 1055
- Man2Man.ie
- Rialto Community Drug Team: 01 454 0021

6.14 Human Papilloma Virus Vaccination

In July 2018, the National Immunisation Advisory Committee (NIAC) recommended the HPV vaccine for men and women living with HIV up to and including 26 years of age and for MSM (including MSM living with HIV) up to and including 45 years of age. This vaccination is available free of charge at sexual health clinics nationally.

6.15 MSM and Blood Donation

Prior to January 2017 MSM were permanently deferred as blood donors in Ireland [51]. In 2016, the Irish Blood Transfusion Service (IBTS) recommended changes to the deferral of blood donors. These changes were accepted by the Department of Health. Since January 2017 the lifetime deferral of MSM donors was reduced to a 1-year deferral. This means that potential MSM donors can now give blood if they have not had sex with another man in the previous 12 months.

Other restrictions to blood donation apply to all prospective donors irrespective of sexual orientation and can be found here.

6.16 Sexual Health – WSW

Lesbian and bisexual women have some specific sexual health needs. When discussing women's sexual health, it is important to acknowledge that there are women who present but not identify as lesbian or bisexual. The term WSW should be used in this instance.

WSW have been perceived as a low risk group for STIs by both lesbian and bisexual women and healthcare providers. WSW often report they do not feel at risk of STIs and are too scared to get tested. This view may also impact on safe sexual practices. As a result, they can run the risk of being largely over-looked in terms of sexual health and cervical cytology screening initiatives.

A significant number of WSW have a history of having previous or current sexual contact with men. This demonstrates that a woman's sexual identity is not always an accurate predictor of her sexual behaviour or risk level, with women who define themselves as lesbian sometimes engaging in high-risk sexual contact with men. In addition, many STIs can be contracted through other sexual practices more common to lesbian and bisexual women such as oral sex and the use of sex toys. WSW have both oral and penetrative sex and can share fluids through hands, mouth and sex toys.

All STIs can be transferred between women. Educating lesbian and bisexual women about the risks of STIs and dispelling the perception that the transmission of STIs between women is negligible will help patients make more informed decisions [51]. GPs should encourage sexually active WSW to be screened for STIs in the same way as with heterosexual female patients.

6.16 Ovarian Cancer

While many lesbian and bisexual women have children, they have significantly fewer pregnancies, miscarriages and abortions than heterosexual women, as well as a lower use of the oral contraceptive pill. These factors may place lesbian women at higher risk of developing ovarian cancer [53].

6.16.1 Why lesbian and bisexual women may have increased risks for ovarian cancer [53]

- Lesbian and bisexual women are less likely to have used the oral contraceptive pill
- Pregnancy and breastfeeding, especially before age 30, have been shown to reduce the risk for ovarian cancer. Lesbian and bisexual women are less likely than heterosexual women to have biological children
- As a group, lesbian and bisexual women have a higher Body Mass Index (BMI) than heterosexual women
- Lesbian and bisexual women are more likely to smoke cigarettes or have used tobacco in the past
- Lesbian and bisexual women are less likely to get regular medical/gynaecological care than heterosexual women

6.17 Fertility

Lesbian and bisexual women may present requesting referral to fertility clinics. Private fertility clinics now provide services to LGB people such as intrauterine insemination (IUI) and IVF with donated sperm but this method can be very costly. Many lesbian and bisexual women choose self-insemination to conceive. This raises issues of safety and the health of the sperm donor. Also, this method of conception is not included under the Children and Family Relationships Act 2015 and therefore both partners cannot apply for legal parentage where this method is used.

Section 7 Good Practice in Service Provision to LGB Patients

This section will describe the different ways that GPs can improve service provision to ensure that their practice is inclusive of the needs of LGB patients. Given that approximately 8% of the population identify as LGB, it follows that a similar percentage of patients attending a given general practice are likely to be LGB on a probability basis [1].

Research on the experience of LGB people has consistently found a reluctance among this population to disclose their LGB identity to their healthcare providers, for the following reasons [4]:

- A perception that health practitioners are not sufficiently aware or understanding of LGB identities and unaware of the appropriate language or terminology to use
- Fear that the health service might not protect their LGB identity
- Fear of misunderstanding, that the person's LGB identity would be seen as the problem

Research from a European focus study group with healthcare professionals revealed that many healthcare professionals were not aware that assumptions that patients are heterosexual/cisgender/non-intersex was a key barrier to providing appropriate healthcare services for LGB people [54].

7.1 Stay Informed on LGB Health Issues

While LGB people are as diverse and varied a group as heterosexual people, these patients can face a number of barriers to receiving quality health care, including

- Doctors' assumptions that patients are heterosexual and hesitancy to inquire about sexual orientation
- Doctors' lack of understanding of LGB health issues
- LBG patients' fear of negative reaction when disclosing their identity or previous experience of negative responses from practitioners
- LGB patients discomfort discussing their sexual behaviour

Being aware of the health needs of this patient group and of the barriers they can face in having their health needs met is key to improving service provision to LGB patients.

7.2 Using Inclusive Language

Good communication with LGB people encourages them to be involved in their own healthcare and promotes better health outcomes. Any person who uses your service may identify as LGB and some patients may or may not have come out. By asking open and inclusive questions when taking a patient's medical history, you are demonstrating to LGB patients and those questioning their sexual orientation that they are welcome to disclose their LGB identity to you. This disclosure may help them to discuss issues related to their sexual orientation that may be relevant to their health needs.

Be aware that you already have LGB patients even if you do not know who they are. Using open language and questions is a very good way of demonstrating to patients that you are not assuming they are heterosexual.

Examples of open and inclusive questions include:

- Do you have a partner?
- Are you in a relationship?
- What is your partner's name?

A situation that may arise is that you think a patient is struggling to disclose their sexual orientation to you. In this instance, as with any sensitive matter, you can encourage them to disclose by providing them with reassurance and showing interest in understanding them. The following are some suggested approaches to use:

- Reassure the patient that all personal information disclosed is confidential and that you provide a non-judgemental service
- Explain the importance for you as their GP in understanding issues that are relevant to their health so that you can identify the appropriate treatment or support that they may need
- Enquire about relationships both current and past

If someone is hinting at an LGB issue, you could try asking something like "It sounds as if you are questioning your feeling/orientation, has that been on your mind?"

7.3 Acknowledge when Patients Disclose they are LGB

Young LGB people in particular may be questioning their sexual orientation. Helping young people to feel safe and supported will facilitate their process of self-acceptance and coming out. Just as we know that talking with teens about sex does not increase their sexual behaviour, talking about sexual orientation does not make a teen more likely to be LGB.

Coming out is an important time in LGB people's lives and asking LGB patients about their experience of coming out demonstrates your understanding that this is an important part of their lives. Clinically, it is potentially also a time of heightened mental health risk, particularly for young LGB people [55]. Ways of asking patients about coming out and related experiences include:

- "Do any of your friends know you are lesbian/gay/bisexual?"
- "Have you come out to anyone in your family?"
- "How have things been for you since you came out?"
- "Have you had any negative experiences since coming out?"
- "Are there lesbian/gay/bisexual/ people you know that you can talk to? Are they supportive?"
- "Are there any issues you would like to discuss with me related to your sexual orientation or gender identity?"

While these questions may be relevant to ask, LGB patients' sexual orientation may not be relevant to their use of your service at a particular time. Also remember that some LGB patients may not have fully accepted their sexual orientation and may only be in the early stages of coming out. GPs should deal with this sensitively.

If a young person tells you they may be LGB, it is appropriate to respond in a positive and supportive way. Try to avoid making the assumption that they are going through a phase or are too young to make such a declaration. Provide information that will support and reassure the young person and consider referring them to an LGB organisation for support (Appendix 1).

7.4 Take an Affirmative Approach and Challenge Bias

Take an approach that affirms LGB identities as equally positive human experiences and expressions to heterosexual identities. This type of LGB affirming approach is increasingly considered the preferred method to work in a culturally competent manner with this patient group [3].

While anti-LGB bias is something that many GPs would not consider an issue in their own practice, it is important to acknowledge that where it does exist, it results in LGB patients receiving suboptimal care [56,57].

Even the most subtle or indirect forms may have an adverse effect on the doctor-patient relationship and the person's willingness to disclose relevant personal information and health concerns to their GP. The characteristics of professional anti-LGB bias are

- Presuming patients are heterosexual
- Pathologising, stereotyping and stigmatising LGB patients
- Failing to empathise with or recognise LGB patients' health concerns
- Failing to appreciate any non-heterosexual form of behaviour, identity, relationship, family or community

Reparative therapy or any attempts to alter an LGB patient's sexual orientation should be avoided by GPs. All guidance and counselling offered to these patients should be person-centred and LGB-affirmative.

GPs should also be mindful of bias when treating a child with same-sex parents [58]. If you are seeing a child with same-sex parents, include both parents in the discussion. Health care may be compromised if one of the primary caregivers is excluded.

LGB people may wish to be parents, and lesbian or bisexual women may intend future pregnancies and have concerns about their fertility. Questions about planning a family are an important part of their sexual health assessment. Biological parent and non-biological parent are the respective terms to describe the parent who did and did not conceive the child.

Table 10: Questioning patients while respecting family diversity

RESPECTING FAMILY DIVERSITY	
Ask	**Instead of**
Who is the child's parent or guardian?	Who is the child's mother/father?
Who is the biological parent?	Who is the real mother/father?

Parenting information for Transgender people is available in the ICGP Transgender guidelines.

7.5 Demonstrate that your Practice is Welcoming of LGB Patients

There are a number of practical things you can do to demonstrate your openness to and inclusion of LGB people in your practice, including the following:

- Ensure all relevant paperwork, information leaflets and history taking questions use language which is inclusive of LGB people and their families
- Consider displaying LGB leaflets and/or posters in your waiting room e.g. leaflets from an LGB service, LGB Helpline poster or specific LGB information (available from your local LGB organisation (Appendix 1 and Appendix 2)).

This practice values the dignity of all patients and does not discriminate on the basis of gender, marital status, family status, age, disability, race, nationality, sexual orientation, or religious belief

Figure 1: Inclusive Practice – Suggested Wording for Waiting Room Poster

- Include LGB people in general health information e.g. in sexual health leaflet for female patients, include information for lesbian and bisexual women, such as the need for smear tests
- Name LGB people in service ethos statement e.g. that your service recognises and respects the diversity of patients based on age, race, gender, sexual orientation, etc
- Provide LGB awareness training for all staff, including reception and administrative staff

The doctor-patient relationship is central to the quality of care provided and health outcomes achieved when treating all patients. These recommendations address the different ways of communicating your openness, respect and understanding to LGB patients. This will promote an optimum doctor-patient relationship between you and your LGB patients. By following these recommendations, you can ensure you are providing an accessible and appropriate primary care service to LGB patients attending your practice.

Conclusion

LGB patients face minority pressure, stigmatisation and the pressure of coming out on a daily basis. They have higher rates of depression, self-harm and suicide. They are more likely to smoke, take alcohol to excess and take illegal drugs. Their complex needs in primary care go far beyond STI screening. This guide aims to suggest ways in which practices can be more inclusive, allowing patients to self-disclose if they choose to and improve health outcomes as a result.

References

[1] The Equality Authority. *Implementing Equality for Lesbians, Gays and Bisexuals.* Dublin: The Equality Authority; 2002. [Online] Available from: https://www.ihrec.ie/app/uploads/download/pdf/implementing_equality_for_lesbians_gays_and_bisexuals.pdf [Accessed 20th Oct 2020]

[2] Department of Health & Children. *A Vision for Change: Report of the Expert Group on Mental Health Policy.* Dublin: Government of Ireland; 2006. [Online] Available from: https://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf [Accessed 20th Oct 2020]

[3] The College of Psychiatry of Ireland; GLEN; HSE National Office for Suicide Prevention. *Lesbian, Gay & Bisexual Patients: The Issues for Mental Health Practice.* Dublin: The College of Psychiatry of Ireland; 2016. [Online] Available from: https://www.ilga-europe.org/sites/default/files/lesbian_gay_and_bisexual_patients_-_the_issues_for_mental_health_practice.pdf [Accessed 20th Oct 2020]

[4] Brooks H, Llewellyn CD, Nadarzynski T, Pelloso FC, De Souza Guilherme F, Pollard A, et al. Sexual orientation disclosure in health care: a systematic review. *Br.J.Gen.Pract.* 2018 Mar;68(668):e187-e196.

[5] CSO. *Census of Population 2016 - Profile 4 Households and Families.* Dublin: Central Statistics Office; 2016. [Online] Available from: https://www.cso.ie/en/releasesandpublications/ep/p-cp4hf/cp4hf/fmls/ [Accessed 20th Oct 2020]

[6] Health Service Executive. *LGBT Health: Towards meeting the health care needs of Lesbian, Gap, Bisexual and Transgender People: Report and findings from a Mapping Exercise undertaken by the HSE National Social Inclusion Governance Group.* Dublin: HSE; 2009. [Online] Available from: https://www.hse.ie/eng/services/publications/topics/sexual/lgbt-health.pdf [Accessed 20th Oct 2020]

[7] Office for National Statistics. *Sexual Orientation, UK: 2017. Experimental statistics on sexual orientation in the UK in 2017 by region, sex, age, marital status, ethnicity and socio-economic classification* [Online] Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2017 [Accessed 20th Oct 2020]

[8] Royal College General Practitioners Northern Ireland. *Guidelines for the care of lesbian, gay and bisexual patients in primary care.* [Online] Available from https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/RCGPNI-Guidelines-for-the-care-of-LGB-patients-in-primary-care-2015-web.ashx?la=en [Accessed Nov 10th 2020]

[9] Higgins A, Doyle L, Downes C, Murphy R, Sharek D, et al. *The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland.*Dublin: GLEN and BeLonG To; 2016. [Online] Available from: https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/lgbt-ireland-pdf.pdf [Accessed 23rd Oct 2020]

[10] O'Hara M. *Through Our Minds: Exploring the Emotional Health and wellbeing of Lesbian, Gay, Bisexual and Transgender people in Northern Ireland.* The Rainbow Project, 2013. http://www.rainbowproject.org/assets/publications/through%20our%20minds.pdf

[11] Oren Pizmony-Levy & BeLonG To Youth Services. *The 2019 School Climate Survey Report: The experience of lesbian, gay, bisexual and trans young people in Ireland's schools. Research Report.* Dublin: BeLonG To Youth Services; 2019. [Online] Available from: https://belongto.org/wp-content/uploads/2019/11/BeLonG-To-School-Climate-Report-2019.pdf [Accessed 20th Oct 2020]

[12] Stonewall. *Lesbian, Gay & Bisexual People in later life.* London: Stonewall; 2011. [Online] Available from: https://www.stonewall.org.uk/system/files/LGB_people_in_Later_Life__2011_.pdf [Accessed 22nd Oct 2020]

[13] O'Doherty J. *Outstanding in your field: exploring the needs of LGB&T people in rural Northern Ireland.* Belfast: The Rainbow Project; 2016. [Online] Available from: https://www.rainbow-project.org/Handlers/Download.ashx?IDMF=75981d9c-f647-46bf-86e2-a27b566cfe63 [Accessed 22nd Oct 2020]

[14] Burke TW, Jordan ML, Owen SS. A cross-national comparison of gay and lesbian domestic violence. *Journal of Contemporary and Criminal Justice*, 2002 Aug; 18(3): 231-257.

[15] Ryan C, Huebner D, Diaz RM, Sanchez J. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics* 2009 Jan;123(1):346-352.

[16] Cochran, S. D., & Mays, V. M. Estimating Prevalence of Mental and Substance-Using Disorders Among Lesbians and Gay Men From Existing National Health Data**.** In A. M. Omoto & H. S. Kurtzman (Eds.), Contemporary perspectives on lesbian, gay, and bisexual psychology. Sexual orientation and mental health: Examining identity and development in lesbian, gay, and bisexual people (p. 143–165). American Psychological Association; 2006.

[17] Shahab L, Brown J, Hagger-Johnson G, Michie S, Semlyen J, West R, et al. Sexual orientation identity and tobacco and hazardous alcohol use: findings from a cross-sectional English population survey. *BMJ Open* 2017 Oct 25;7(10):e015058-2016-015058.

[18] Schmidt AJ, Bourne A, Weatherburn P, Reid D, Marcus U, Hickson F, et al. Illicit drug use among gay and bisexual men in 44 cities: Findings from the European MSM Internet Survey (EMIS). *Int.J.Drug Policy* 2016 Dec;38:4-12.

[19] Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol.Bull.* 2003 Sep;129(5):674-697.

[20] Hafeez H, Zeshan M, Tahir MA, Jahan N, Naveed S. Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review. *Cureus* 2017 Apr 20;9(4):e1184.

[21] Barrett P, O'Donnell K, Fitzgerald M, Schmidt AJ, Hickson F, Quinlan M, et al. Drug use among men who have sex with men in Ireland: Prevalence and associated factors from a national online survey. *Int.J.Drug Policy* 2019 Feb;64:5-12.

[22] Englefield L, Cunningham D, Mahoney A, Stone T, Torrance H. *Sport, physical activity & LGBT: a Study by Pride Sports for Sport England.* London: Sport England; 2016. [Online] Available from: https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/pride-sport-sport-physical-activity-and-lgbt-report-2016.pdf?HWrXN2KhPLBV8mmOIEqCEh7E1FFOxZKM [Accessed 22nd Oct 2020]

[23] Boehmer U, Bowen DJ, Bauer GR. Overweight and obesity in sexual-minority women: evidence from population-based data. *Am.J.Public Health* 2007 Jun;97(6):1134-1140.

[24] Feldman MB, Meyer IH. Eating disorders in diverse lesbian, gay, and bisexual populations. *Int.J.Eat.Disord.* 2007 Apr;40(3):218-226.

[25] Marrazzo JM, Koutsky LA, Kiviat NB, Kuypers JM, Stine K. Papanicolaou test screening and prevalence of genital human papillomavirus among women who have sex with women. *Am.J.Public Health* 2001 Jun;91(6):947-952.

[26] Tracy JK, Lydecker AD, Ireland L. Barriers to cervical cancer screening among lesbians. *J.Womens Health.(Larchmt)* 2010 Feb;19(2):229-237.

[27] Burd EM. Human papillomavirus and cervical cancer. *Clin.Microbiol.Rev.* 2003 Jan;16(1):1-17.

[28] HSE. *HPV Vaccination Programme.* Dublin: HSE; 2020. [Online] Available from: https://www.hse.ie/eng/health/immunisation/pubinfo/schoolprog/hpv/hpv-vaccination-programme/hpv-vaccination-programme.html [Accessed Oct 22nd 2020]

[29] HSE. *Cervical Screening - CervicalCheck.* Dublin: HSE; 2020. [Online] Available from: https://www.hse.ie/eng/cervicalcheck/ [Accessed Oct 22nd 2020]

[30] HSE. Breast screening information. Dublin: HSE; 2019. [Online] Available from: https://www2.hse.ie/services/breast-screening/breast-screening-overview/breast-screening-information.html [Accessed Oct 22nd 2020]

[31] King M, Semlyen J, Tai SS, Killaspy H, Osborn D, Popelyuk D, et al. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry* 2008 Aug 18;8:70-244X-8-70.

[31] Katz-Wise SL, Rosario M, Tsappis M. Lesbian, Gay, Bisexual, and Transgender Youth and Family Acceptance. *Pediatr.Clin.North Am.* 2016 Dec;63(6):1011-1025.

[32] Keuroghlian AS, Shtasel D, Bassuk EL. Out on the street: a public health and policy agenda for lesbian, gay, bisexual, and transgender youth who are homeless. *Am.J.Orthopsychiatry* 2014;84(1):66-72.

[33] Russell ST, Fish JN. Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth. *Annu.Rev.Clin.Psychol.* 2016;12:465-487.

[34] Flentje A, Heck NC, Cochran BN. Experiences of ex-ex-gay individuals in sexual reorientation therapy: reasons for seeking treatment, perceived helpfulness and harmfulness of treatment, and post-treatment identification. *J.Homosex.* 2014;61(9):1242-1268.

[35] BASHH. *Standards for the management of sexually transmitted infections (STIs).* Cheshire: British Association for Sexual Health and HIV; 2019. [Online] Available from: https://www.bashh.org/about-bashh/publications/standards-for-the-management-of-stis/ [Accessed Oct 22nd 2020]

[36] Health Protection Surveillance Centre. *HIV infection in Ireland.* 11 June 2020. [Online] Available from: https://www.hpsc.ie/a-z/hivandaids/ [Accessed Oct 22nd 2020]

[37] Health Protection Surveillance Centre. *Syphilis.* 23 October 2019. [Online] Available from: https://www.hpsc.ie/a-z/sexuallytransmittedinfections/syphilis/ [Accessed Oct 22nd 2020]

[38] Health Protection Surveillance Centre. *Sexually Transmitted Infections.* [Online] Available from: https://www.hpsc.ie/a-z/sexuallytransmittedinfections/ [Accessed Oct 22nd 2020]

[39] Public Health England. *Sexually transmitted infections and screening for chlamydia in England, 2018.* Health Protection Report. Vol. 13, No. 19. London: Public Health England; 2019. [Online] Available from: https://pcwhf.co.uk/wp-content/uploads/2019/06/hpr1919_stis-ncsp_ann18.pdf [Accessed 23rd Oct 2020]

[40] Aghaizu A, Brown AE, Nardone A, Gill ON, Delpech VC & contributors. *HIV in the United Kingdom 2013 Report: data to end 2012.* November 2013. Public Health England, London. [Online] Available from: https://www.unaids.org/sites/default/files/country/documents/GBR_narrative_report_2014.pdf [Accessed 23rd Oct 2020]

[41] Lorenc T, Marrero-Guillamon I, Llewellyn A, Aggleton P, Cooper C, Lehmann A, et al. HIV testing among men who have sex with men (MSM): systematic review of qualitative evidence. *Health Educ.Res.* 2011 Oct;26(5):834-846.

[42] Bradshaw D, Matthews G, Danta M. Sexually transmitted hepatitis C infection: the new epidemic in MSM? *Curr.Opin.Infect.Dis.* 2013 Feb;26(1):66-72.

[43] HSE National Immunisation Office. *Immunisation Guidelines for Ireland.* Dublin: HSE; 2020. [Online] Available from: https://www.hse.ie/eng/health/immunisation/news/niacupdates.html [Accessed Oct 23rd 2020]

[44] NICE. *HIV Testing: encouraging uptake, Quality Standard [QS157]*. London: National Institute for Clinical Excellence; Sept 2017.[Online] *Available from: https://www.nice.org.uk/guidance/qs157* [Accessed 23rd Oct 2020]

[45] Rodger AJ, Cambiano V, Bruun T, Vernazza P, Collins S, Degen O, et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study.

Lancet 2019 Jun 15;393(10189):2428-2438.

[46] HSE. *EMI Toolkit: Guidelines for the* Emergency Management of Injuries and Post-exposure Prophylaxis (PEP) *(including needlestick and sharps injuries, sexual exposure and human bites) where there is a risk of transmission of bloodborne viruses and other infectious diseases.* Dublin: HSE; 2016. [Online] Available from: https://www.hpsc.ie/a-z/EMIToolkit/ [Accessed Oct 23rd 2020]

[47] Molina JM, Capitant C, Spire B, Pialoux G, Cotte L, Charreau I, et al. On-Demand Preexposure Prophylaxis in Men at High Risk for HIV-1 Infection. *N.Engl.J.Med.* 2015 Dec 3;373(23):2237-2246.

[48] Fonner VA, Dalglish SL, Kennedy CE, Baggaley R, O'Reilly KR, Koechlin FM, et al. Effectiveness and safety of oral HIV preexposure prophylaxis for all populations. *AIDS* 2016 Jul 31;30(12):1973-1983.

[49] McCormack S, Dunn DT, Desai M, Dolling DI, Gafos M, Gilson R, et al. Pre-exposure prophylaxis to prevent the acquisition of HIV-1 infection (PROUD): effectiveness results from the pilot phase of a pragmatic open-label randomised trial. *Lancet* 2016 Jan 2;387(10013):53-60.

[50] Frankis J, Flowers P, McDaid L, Bourne A. Low levels of chemsex among men who have sex with men, but high levels of risk among men who engage in chemsex: analysis of a cross-sectional online survey across four countries. *Sex.Health.* 2018 Apr;15(2):144-150.

[51] Irish Blood Transfusion Service. *MSM: Change to deferral criteria for MSM giving blood.* [Online] Available from: https://www.giveblood.ie/can-i-give-blood/keeping-blood-safe/msm/ [Accessed Oct 23rd 2020]

[52] Gorgos LM, Marrazzo JM. Sexually transmitted infections among women who have sex with women. *Clin.Infect.Dis.* 2011 Dec;53 Suppl 3:S84-91.

[53] National LGBT Cancer Network. *Bisexual Women and Ovarian Cancer.* Providence, RI: National LGBT Cancer Network; 2020. [Online] Available from: https://cancer-network.org/cancer-information/bisexuals-and-cancer/bisexual-women-and-ovarian-cancer/ [Accessed Oct 23rd 2020]

[54] McGlynn N, Browne K, Sherriff N, Zeeman L, Mirandola M, Gios L, et al. Healthcare professionals' assumptions as barriers to LGBTI healthcare. *Cult.Health.Sex.* 2020 Aug;22(8):954-970.

[55] Mustanski B, Liu RT. A longitudinal study of predictors of suicide attempts among lesbian, gay, bisexual, and transgender youth. *Arch.Sex.Behav.* 2013 Apr;42(3):437-448.

[56] Sabin JA, Riskind RG, Nosek BA. Health Care Providers' Implicit and Explicit Attitudes Toward Lesbian Women and Gay Men. *Am.J.Public Health* 2015 Sep;105(9):1831-1841.

[57] Morris M, Cooper RL, Ramesh A, Tabatabai M, Arcury TA, Shinn M, et al. Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: a systematic review. *BMC Med.Educ.* 2019 Aug 30;19(1):325-019-1727-3.

[58] von Doussa H, Power J, McNair R, Brown R, Schofield M, Perlesz A, et al. Building healthcare workers' confidence to work with same-sex parented families. *Health.Promot.Int.* 2016 Jun;31(2):459-469.

Appendix 1 – Key Contacts

National Organisations

LGBT Ireland

National organisation providing support, training and advocacy which aims to improve the lives of LGBT+ people across Ireland

T: 1890 929 539

E: info@lgbt.ie

BeLonG To youth project

Supporting and resourcing lesbian, gay, bisexual and transgender young people aged 14-23.

T: 01 6706223

Email: info@belongto.org

Website: www.belongto.org

Transgender Equality Network Ireland (TENI)

Advice, help and support for trans* people and their families.

T: 01 8733675

Email: office@teni.ie

Website: www.teni.ie

HSE LGBT staff network

Lgbti@hse.ie

Bi+ Ireland

Biirelandnetwork@gmail.com

Helplines

National LGBT helpline

1890 929 539

Website www.lgbt.ie

Gay Switchboard Ireland

01 8721055

Website: www.gayswitchboard.ie

Gender Identity Family Support Line

01 907 3707

Lesbian Line

Dublin: 01 872 9911 (Mon – Thurs 9.30 – 6)

Cork: 021 4318318 (Weds 7pm – 9pm)

Drugs / HIV helpline

1800 459 459

Sexual Health Services – National

www.Man2man.ie – sexual health for men who have sex with men

LGBT Gay Health Network (GHN)

T: 01 8734832

Regional Organisations

Dublin and the East – Health Supports

Gay Men's Health Service (GMHS) HSE

Free sexual health clinics for MSM and trans* people, Monday to Thursday, Baggot Street Hospital, 18 Upper Baggot Street, Dublin /

T: 01 6699553

Website: www.gmhs.ie

St James' GUIDE clinic

Sexual health clinic, St James' Hospital, Dublin 8

T: 01 4162315 or 01 416 2316

HIV Ireland

70 Eccles Street, Dublin 7

T: 01 873 3799

E: info@hivireland.ie

Website: www.hivireland.ie

Dublin and the East – Social Supports

Dundalk Outcomers

8 Roden Place, Dundalk

T: 042 932 9816

Website: www.outcomers.org

Outhouse

105 Capel Street, Dublin 1

T: 01 873 4999

E: info@outhouse.ie

Amach Wicklow

Gay and lesbian group, meets in Ashford 2nd Wednesday of every month.

E: amachwicklow@gmail.com

Dublin and the East – Student LGBT+ Societies

National College of Ireland

E: nci.lgbt@gmail.com

National College of Art and Design

E: ncadlgbt@gmail.com

Trinity College Dublin

E: lgbisoc@csc.tcd.ie

University College Dublin

E: lgbt.society@ucd.ie

Dublin City University

E: dculgbt@gmail.com

Dún Laoghaire IADT

E: iadtgsa@gmail.com

Dublin Institute of Technology

E: lgbt@socs.dit.ie

NUI Maynooth

E: lgbt@niumsu.com

Tallaght IT

E: supres@it-tallaght.ie

Institute of Technology, Blanchardstown

E: colourssoc@gmail.com

Cork and the South – Health Resources

STD Clinic at Victoria Hospital, Cork

T: 021 496 6844

STD Clinic at Waterford Regional Hospital

T: 051 842 646

Cork and the South – Social Supports

LINC Resource Centre for LBT women

11A White Street, Cork.

Tuesday & Wednesday 11am – 3pm; Thursday 11am – 8pm.

Gay Project Cork

Gay, Bi+, Queer, MSM and Trans* NGO

4 South Terrace, Cork City, Cork.

T: 021 430 0430

W: www.gayproject.ie

Tipperary LGBT Adult Support Group

Clonmel Community Resource Centre

T: 052 6129143

M: 085 854 1514

GOSHH

Redwood House, 9 Cecil Street, Limerick

T: 061 314 354

E: lgbt@gossh.ie

Cork and the South – Student LGBT+ societies

Cork IT

E: lgbtcit@gmail.com

Waterford IT

E: witlgbt1@gmail.com

University College Cork

E: lgbt@uccsocieties.ie

Limerick IT

E: litisout@gmail.com

University of Limerick

E: outinul@gmail.com

Galway, West and Northwest – Health Resources

AIDS West

T: 091 566 266

E: info@aidswest.ie

Galway, West and Northwest – Social Supports

Teach Solais LGBT+ Resource Centre

1 Victoria Place, off Eyre Square, Galway

E: resourcecentre@amachlgbt.com

T: 089 252 3307

Website: www.amachlgbt.com

8 Rays Leitrim LGBTIQ+ Social and Community Support Group

E: contact@8raysleitrim.com

Website: www.8raysleitrim.com

Smily LGBT Youth Group, Sligo

T: 089 4820330 or 071 914 4150

E: smilyyouthlgbt@gmail.com

BreakOut LGBTI+ youth groups, Donegal

Meetings in Ballybofey, Glenties, Letterkenny and Moville.

T: 086 124 7698 or 074 912 9630

E: lgbt@donegalyouthservice.ie

Galway, West and Northwest – Student LGBT+ Societies

Sligo IT

E: itslgbt@gmail.com

GMIT

E: GMITEquality@hotmail.com

NUI Galway

E: gigsoc@soc.nuigalway.ie

Appendix 2 – Sample Waiting Room Poster Information

This practice is an inclusive practice

What does this mean?

This means that we value the dignity of all patients in this practice.

We do not discriminate based on any of the following:

- Gender
- Marital status
- Family status
- Age
- Disability
- Race
- Sexual orientation
- Religious belief
- Membership of the traveller community

Where can I find more information on this?

<<ENTER RELEVANT PRACTICE INFORMATION HERE>>

Appendix 3 – Minimum Data for Sexual History Taking

Adapted from UK national guideline for consultations requiring sexual history taking (BASHH, 2013).

Minimum sexual history for symptomatic female patient attending for STI testing

- Symptoms/reason for attendance
- Date of last sexual contact (LSC), partner's gender, anatomic sites of exposure, condom use and any suspected infection, infection risk or symptoms in this partner
- Previous sexual partner details, as for LSC, if in the last three months and a note of total number of partners in last three months if more than two
- Previous STIs
- Last menstrual period (LMP) and menstrual pattern, contraceptive and cervical cytology history.
- Pregnancy and gynaecological history
- Blood-borne virus risk assessment and vaccination history for those at risk
- Past medical and surgical history
- Medication history and history of drug allergies
- Agree the method of giving results
- Establish competency, safeguarding children/vulnerable adults
- Recommend/consider recognition of gender-based violence/intimate partner violence
- Alcohol and recreational drug history

Minimum sexual history for symptomatic male patient attending for STI testing

- Symptoms/reason for attendance
- LSC, partner's gender, anatomic sites of exposure and condom use, any suspected infection, infection risk or symptoms in this partner
- Previous sexual partner details as for LSC, if in the last three months, and a note of total number of partners in last three months if more than two
- Previous STIs
- Blood-borne virus risk assessment and vaccination history for those at risk
- Past medical and surgical history
- Medication history and history of drug allergies
- Agree method of giving results
- Establish competency, safeguarding children/vulnerable adults
- Recommend/consider recognition of gender-based violence/intimate partner violence
- Alcohol and recreational drug history

Appendix 4 – HIV PrEP Programme Service Application Form

Sláinte Ghnéis & Clár Thoirchis
Ghéarchéime,

Urlár 4, 89 – 94 Sráid Chéipil,

Baile Átha Cliath 1,
T:076 695 9130 Email: info@crisispregnancy.ie

www.sexualwellbeing.ie

Sexual Health & Crisis Pregnancy Programme,

4th Floor, 89 – 94 Capel Street,

Dublin 1.

Health Service Executive (HSE)

National HIV Pre-exposure prophylaxis (PrEP) Programme

Service Application Form

Background

HIV Pre-Exposure Prophylaxis (PrEP) is the pre-emptive use of oral antiretroviral therapy in HIV negative people to reduce the risk of HIV infection. The HSE Sexual Health and Crisis Pregnancy Programme is making PrEP medication free of charge to those who meet clinical eligibility criteria and are deemed to be at substantial risk of acquiring HIV. HIV PrEP should be provided as part of a combination HIV (and STI) prevention approach within services that meet national standards.

Applying to be a HIV PrEP Service

To apply as a HIV PrEP service, your service is required to meet the core National Standards for the Delivery and Management of HIV PrEP in Ireland, available on www.sexualwellbeing.ie/prepproviders.

Assess your service against the core standards, and complete the checklist on page 3.

If you are satisfied that your service meets the core standards, complete the application form on page 2 and submit this with the completed checklist, to HSE Sexual Health & Crisis Pregnancy Programme (SHCPP) for approval.

Completed application forms should be sent to Caroline Hurley, Project Manager, by email to caroline.hurley1@hse.ie or by post to: HSE Sexual Health & Crisis Pregnancy Programme, 4th Floor, 89 - 94 Capel Street, Dublin 1, D01 P281.

Your application will be assessed by SHCPP and where appropriate, your service will be approved. Following approval you will be provided the HIV PrEP Service Agreement. This needs to be completed, signed by your Service Clinical Lead for HIV PrEP and returned to SHCPP.

Sláinte Ghnéis & Clár Thoirchis Ghéarchéime,

Urlár 4, 89 – 94 Sráid Chéipil,

Baile Átha Cliath 1,
T:076 695 9130 Email: info@crisispregnancy.ie

www.sexualwellbeing.ie

Sexual Health & Crisis Pregnancy Programme,

4th Floor, 89 – 94 Capel Street,

Dublin 1.

Service Application Form

Information and data protection notice
Please complete all sections below (preferably electronically, or in block capitals if being completed by hand) Data protection notice: This information, including personal data, is collected and used by the HSE for the purpose of providing a health service. It is required, stored, processed and disclosed to other bodies in accordance with the laws relating to proper treatment of personal data.

1.	Name of service (hospital or practice)	
2.	Service Address	
3.	Service Clinical Lead for HIV PrEP (Full name as on Irish medical council register)	
4.	Irish Medical Council Number	
5.	Email Address	
6.	Telephone Number	

Core National Standards for HIV PrEP: Self-assessment Checklist

Please complete the checklist below on the core National Standards for HIV PrEP. Please refer to full standards document regarding footnotes and provide written documentation where required.		
Core Standard 1: Access		
People seeking PrEP will be able to do so without a referral letter	Y	N
Core Standard 2: Service configuration and structure: availability of the following core services		
Condoms[1]	Y	N
HAV, HBV, HPV vaccination in line with national immunisation guidelines	Y	N
HIV testing using accredited diagnostics	Y	N
STI testing using accredited diagnostics	Y	N
STI treatment within service[2]	Y	N
HIV Post Exposure Prophylaxis (PEP) in line with national PEP guidelines[3]	Y	N
Partner notification for incident STIs	Y	N
Safer sex, alcohol and substance misuse advice	Y	N
Referral mechanism for attendees to additional services as required	Y	N
Meet statutory disease notification & surveillance requirements within a reasonable timeframe	Y	N
Participate fully in national PrEP monitoring and evaluation within a reasonable timeframe	Y	N
Core Standard 3: Clinical Assessment and Management		
All PrEP patients will have their clinical eligibility criteria assessed and documented at visits	Y	N
All PrEP patients will have their sexual history documented at visits	Y	N
All PrEP patients will have their HIV negative status confirmed prior to each PrEP prescription	Y	N
All PrEP patients will have appropriate renal monitoring	Y	N
All PrEP patients with incident STIs will be contacted within 10 working days of final results being available	Y	N
All PrEP patients with incident STIs will have partner notification undertaken	Y	N
All PrEP patients will be offered appropriate vaccination as part of their care	Y	N
All PrEP patients will be offered condoms as part of their care[1]	Y	N

[1] SHCPP approved services will have access to condoms through SHCPP
[2] Please refer to the Standards for requirements on STI treatment. Where syphilis treatment is not available, written documentation of an agreement for treatment with another service must be provided with this application.
[3] Please refer to the Standards for requirements regarding PEP. Where PEP is not available, written documentation of an agreement for treatment with another service must be provided with this application.

All PrEP patients will be offered syphilis, gonorrhoea and chlamydia testing at visits	Y	N
All PrEP patients will be offered HCV testing in line with national testing guidelines	Y	N
Core Standard 4: Management of results		
Mechanism(s) in place for management of all abnormal or inconclusive results in PrEP patients in a reasonable timeframe	Y	N
All PrEP patients with abnormal or inconclusive results will be informed within 10 working days of the final result being available	Y	N
Core Standard 5: Information Governance		
Compliant with national data protection and infectious diseases legislation	Y	N
Core Standard 6: Patient and Public Engagement		
Mechanism for receiving patient and public feedback (including complaints) and suggestions in place	Y	N
Information available to patients and the public on how to provide feedback	Y	N
Mechanism in place to respond to patient and public feedback	Y	N

Appendix 5 – Useful Reference Documents

- LGBT Ireland's Strategic Plan 2018 – 2020
- LGBT Health: Towards Meeting the Health Care Needs of Lesbian, Gay, Bisexual and Transgender People
- ICGP Guide for Providing Care for Transgender Patients in Primary Care
- Information for General Practitioners Working with Transgender People
- Guidelines for the Care of Lesbian, Gay and Bisexual Patients in Primary Care
- Guidelines for the Care of Trans Patients in Primary Care
- Guidelines for Good Practice with Lesbian, Gay and Bisexual Clients
- LGBT+ Awareness and Good Practice Guidelines for Occupational Therapists

Appendix 6 – ICGP Vision, Mission and Values

ICGP Vision

An Irish healthcare system where general practice is central to providing excellence in continuing personal care for all.

ICGP Mission

As the professional membership body, the ICGP will support its members to deliver healthcare of the highest possible standards to patients and communities.

ICGP Core Values

The core values of the College are quality, leadership, service and care expressed through:

- The fostering of high-quality evidence-based patient care delivered through a service resourced to support the complex and comprehensive nature of general practice patient centred consultations
- The provision of appropriate and high-quality training, research and continuous medical education in support of continuous quality improvement
- Advocacy for the centrality of general practice in the delivery of an effective and equitable healthcare system designed to meet the needs of patients including acute, chronic and continuing care
- The alignment of policies, guidelines, structures and services to provide leadership to members in what is a very complex and demanding role
- The encouragement and support of members to enable them to maintain a healthy work/life balance and to work towards having a rewarding and valued career.