Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby gran to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

_____ _____

Amanda Hussein Chahine Date

Approval Sheet

The Nature of LGBT-friendly Healthcare in Lebanon:

a comparative analysis of stakeholder experiences and perspectives

By

Amanda Chahine

MPH

Global Health

_____

[Cari Jo Clark, ScD]

Committee Chair

_____

[Karen Andes, PhD]

Committee Member

The Nature of LGBT-friendly Healthcare in Lebanon:

a comparative analysis of stakeholder experiences and perspectives

By

Amanda Hussein Chahine

B.S. Psychology, Wayne State University, 2015
Candidate for MPH, Rollins School of Public Health
Emory University, 2018

Thesis Committee Chair: Clark, Cari Jo, ScD

Committee Member: Andes, Karen, PhD

A thesis submitted to the Faculty of
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Global Health
2018

Acknowledgements

To LebMASH and their wonderful staff and board of directors, thank you for your incredible support, for your trust in me to carry out your mission with integrity, and for the privilege of working with your wonderful organization. Specific thanks to board members Dr. Sarah Abboud, RN, PhD. and Dr. Hossam Mahmoud, M.D., MPH, for your support and for making all this possible! It was a true privilege working with you both.

To Ms. Bianca Sallum, for your unwavering patience and support, for creating this opportunity for me, and for all that you do for LebMASH. Thank you for taking a chance on me.

To Mr. Hady Naal, it was a true privilege to have your expertise inform the logistics of the summer project, and to watch you lead our research team beyond the boundaries of heteronormative health research. I can't thank you enough for your encouragement and your insight throughout this process. Here's to our future working together.

I would like to thank my comrades Maryam Aziz, Rasha A. Almulaiki, Fairouz Shoubah, and the rest of The Z Collective for their constant love, solidarity, and support of all my passions.

To Dr. Elizabeth Walker, my mentor in all things qualitative, I couldn't have asked for a better educator. Your pedagogy, genuine affirmations, and true passion for the topic drove me, even at my lowest, and reminded me why this work is so important.

To my committee member, Dr. Karen Andes, I have infinite gratitude. You were truly my grounding force in moments of doubt. You are a mentor by trade, by character, and your passion for both work and life inspires me to be more. For that and for so much more, I thank you.

To my committee chair, Dr. Cari Jo Clark, I would not have had the opportunity to discover myself in my work were it not for your consistent mentorship throughout these two years. Thank you for pushing me, thank you for always supporting my passions, and thank you for your trust.

Table of Contents

Abstract

Background: LGBT health is overall poor and progressively worsens with the lack of proper access to quality healthcare. Not much is known about the experiences or perspectives of the LGBT community in Lebanon. Additionally, literature that examines and addresses the disconnect between LGBT health stakeholders is lacking, and could provide a holistic and multidisciplinary scope to the improvement of LGBT healthcare.

Methods: We examined semi-structured interviews with three key stakeholders of LGBT health--five physicians, six activists, and nine LGBT patients (N = 20)--regarding their perspectives on Lebanese healthcare. Thematic analysis was used to look at the various interview responses and draw conclusions based on core and connective themes.

Results: According to participant responses, three main themes surfaced across groups: *barriers* to LGBT-friendly healthcare and their consequences, defining what *LGBT acceptance* in healthcare should look like, and the ways LGBT individuals *experience* healthcare in Lebanon. Overall, participants reported that two core connective themes gave context to and explained the nature of LGBT healthcare in Lebanon: ***lack of LGBT awareness*** among healthcare providers as well as the LGBT community exacerbate the health consequences of a non-LGBT-friendly system; and ***social factors*** heavily influence the barriers faced by LGBT patients as well as how they receive healthcare.

Conclusion: Activists, patients, and physicians alike call for Lebanese healthcare policy and reform that explicitly condemns discrimination in healthcare and implements LGBT-inclusive standards of care. There is a need for reform in graduate medical education to include specific training in LGBT health topics and treatment.

Introduction

In recent years, there has been an increasing recognition of disparities found within the realms of research and healthcare. A reassessment of the lesbian/gay/bisexual/transgender/ queer (LGBTQ) patient demographic reveals the distressing conditions as among the worst in overall health (Fredriksen-Goldsen et al 2017). The prevailing conclusion among the academic and medical community primarily attribute this discrepancy to factors related to LGBTQ-specific health issues (Fish & Bewely 2010). Contemporary research challenges this pre-conception by highlighting the underlying nuances of social marginalization and discrimination as predictors of health (Fingerhut & Abdou 2017; Steele 1997). These social determinants of LGBTQ health have been largely neglected in attempts at policy, academic, and health reform. In the Middle East, distinctive social factors centered on religion and cultural traditions play a significant role in the establishment and enforcement of social systems, particularly that of healthcare. Unfortunately, the experiences and needs of the LGBTQ community throughout this region remains principally unknown.

As arguably the most liberal and cosmopolitan city in the Arab world, Beirut, Lebanon, has been at the forefront of shifting social attitudes toward LGBT identity and lifestyle. Activism and grassroots movements in the city have gained momentum over the last decade toward this changing zeitgeist (Rizk & Makarem 2015; Meem 2010). This impetus consequentially expanded the coverage and dissemination of health awareness campaigns and LGBT-acceptance advocacy efforts throughout urban cities. Among the leading NGOs in Beirut is the Lebanese Medical Association for Sexual Health (LebMASH). Under the supervision of healthcare providers serving on the organization's board of directors, LebMASH has focused its efforts on the expansion of LGBT health research, services, and advocacy in Lebanon. Their recent project, LebGUIDE, compiled a comprehensive directory list of LGBT-friendly physicians practicing throughout Lebanon. Serving as a resource guide, LebGUIDE was published in

October 2017 and has been disseminated to the LGBT community as well as other NGOs that can stand to benefit. The project consisted of mixed methods (interviews, focus groups, surveys, etc.) to determine LGBT-friendliness among providers and establish the needs of the Lebanese LGBT community. This study examines the interviews conducted with providers, activists, and LGBT patients, with a comparative focus on their differing and overlapping perspectives and observations of the way LGBT healthcare is conducted in Lebanon. LebMASH's efforts in LGBT advocacy were critical to the formation of this study, with the goal of expanding literature in LGBT health and healthcare and ultimately initiating healthcare reform.

Glossary

Heteronormativity: "the unspoken assumption that heterosexuality provides the framework through which everything makes sense;" the normalization of the heterosexual experience and context as the social standard. (Dean, *Keywords for Disability Studies*, 2015)

Heterosexism: "a term analogous to sexism and racism, describing an ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community." (*Definitions: Homophobia, Heterosexism, and Sexual Prejudice*, 2012)

Homophobia/Homonegativity: any attitude or action that associates homosexuality as unnatural or "alternative" given its deviation from heterosexuality, which has been the established norm. (*Revel & Riot* 2018; *American Heritage Dictionary* 2000)

Internalized Homonegativity: the recycling and internalization of heteronormative social forces, which fuels and rationalizes homophobic, oppressive, and often devaluing attitudes toward the self. (*Revel & Riot* 2018; Meyer & Dean 1998)

Queer: "an umbrella term that refers to a range of sexual identities that are 'not straight,' or *fluid*; in political and academic contexts, it's used as a term that calls into question the stability of any such categories of identity based on sexual orientation." (Somerville, *Keywords for American Cultural Studies*, 2014)

LGBTQ vs LGBT: Both acronyms represent the same communities in the context of this paper. Queer is used throughout the paper when referring to the general non-heterosexual and sexually fluid population. However, *queer* is a term primarily used within Western settings, and is therefore not ideal language to represent the population in Lebanon. Therefore, when describing study participants or the Lebanese community of non-conforming sexual orientations/gender identities (SOGIs), we label them simply as "LGBT".

Literature Review

The Problem

Globally, lesbian, gay, bisexual, transgender, queer (LGBTQ) and non-conforming individuals are among those with the highest health disparities. The LGBTQ community globally has seen poor overall health and high risk for developing chronic diseases (Fredriksen-Goldsen et al 2017; Wallace et al 2011). Studies have overwhelmingly shown higher rates of health risk behaviors among LGBTQ populations, including smoking, substance abuse, unsafe sexual practices, limited daily activity, poor diet, and prolonged medical visits (Emlet 2016; Dilley et al 2010; Conron, Mimiaga, & Landers 2010). Additionally, a majority of individuals with non-conforming sexual orientation/gender identities (SOGI) face the heightened risk and implications of poor mental health (Emlet 2016; Conron, Mimiaga, & Landers 2010). In 2015, nearly 30% of LGB-identifying adolescents in the US had attempted suicide, compared to 6% of their heterosexual counterparts; these outcomes persist despite the comparatively progressive approaches of our healthcare system (Kann et al 2016; CDC “LGBT Youth - Health Report” 2017). Considering the social taboo and stereotypes associated with LGBT identities, much of the literature on LGBT health and lifestyle has been either: a) conflated with sexual health and the STD-prevention sector, or b) limited to research on “LGBT” as one identity cluster without much delineation of identity-specific experiences, with the exception of men who have sex with men (MSM) (Fish & Bewely 2010). Emerging in the 1980’s and accelerating over the last decade, scholars have initiated a new wave of LGBT health research that unpacks the disparities associated with LGBT identity (Fish 2009). The results, however limited, were staggering.

In 2013, Fredriksen-Goldsen and colleagues wrote multiple papers examining the variations in health vulnerability within the LGBT community, with particular focus on the

lesbian/bisexual female community and the trans-identifying community. They found that lesbian and bisexual women face a higher risk for disability and developing mental health issues than their heterosexual female *and* homosexual male counterparts (Fredriksen-Goldsen et al 2013a; Emlet 2016). In comparison with heterosexual women, evidence has shown that lesbian/bisexual women are disproportionately at risk for physical health conditions that include obesity, asthma, arthritis, and cardiovascular disease (Simoni et al 2017). In a separate paper, Fredriksen-Goldsen and team also found that trans identity, more than any other non-conforming SOGI, increases risk for disability, perceived stress, and poor overall mental and physical health (Fredriksen-Goldsen et al 2013b). Although the past decade has seen an increase in LGBT-centered health research, the extent of the disparities in physical and mental health outcomes of LGBT individuals compared to heterosexuals are not common knowledge. We are just beginning to see a cultural shift in academic research to include macrosocial factors as determinants of health which has expanded our understanding of identity and social marginalization as direct predictors of physical health.

Stigma, social isolation, and discrimination of non-conforming and otherwise marginalized identities are evident even in “progressivist” societies; and it has been linked to health through multiple pathways. In 1995, Steele and Aronson published a paper that introduced the stereotype threat theory, which suggests that individuals who belong to negatively-stereotyped identities either: a) fear being judged through these stereotypes and/or b) fear their own potential to confirm those stereotypes (Steele 1997; Steele & Aronson 1995). Fingerhut & Abdou referenced Steele’s theory and hypothesized that stereotypes or threats of discrimination create a “downstream” effect (2017). Rather than process and dismiss the negative and typically inaccurate stereotypes, the stereotyped individuals are more likely to disengage entirely from the systems that recycle those ideas (Fingerhut & Abdou 2017; Meyer 2003; Steele 1997). When applying this theory to the queer experience, it is critical to consider

two questions: how do homophobic stereotypes persist in systems of healthcare, and could this form of social isolation have an influence on health outcome?

Heteronormativity--the normalization of heterosexual experience as the standard for all social systems, rendering any alternative as “other”--has been and continues to be a universal standard for social systems (Sinclair 2017; Jackson 1999). For LGBT individuals who are forced to combat health disparities *and* navigate a firmly heteronormative society, the healthcare arena is but one of many systems built around these cultural constructs. Due to the healthcare system’s lack of proper awareness and consideration for LGBT identity/lifestyle, heteronormative assumptions ultimately dictate the way LGBT health is defined and diagnosed. Studies show that LGBT patients are more likely than heterosexuals to experience either misinformation, misdiagnosis, and/or inappropriate treatment/prevention recommendations when seeking healthcare (Harbin, Beagan, & Goldberg 2012). As a result, LGBT individuals are much more likely than heterosexuals to delay seeking necessary medical care, if not avoid it altogether (Fingerhut & Abdou 2017). Lesbians are reportedly less likely than heterosexual women to return for routine Pap smears and mammograms (Matthews, Brandenburg, Johnson, & Hughes 2004); and they are significantly less likely than heterosexual women to have ever received a pelvic exam (Cochran et al 2001). Similarly, MSM were significantly less likely than heterosexual men to have ever visited a healthcare provider over a two-year period (Alvy et al 2011). When asked about their main reasons for delaying healthcare, LGBT patients generally reported sexual identity, past negative experiences, and fear of discrimination as primary factors (Fingerhut & Abdou 2017; Harris Interactive 2005; Dibble 2001); rates of stigma in healthcare were highest among lesbian women and trans individuals (Fingerhut & Abdou 2017).

The Setting

Overall, LGBT individuals avoid seeking healthcare for fear of being marginalized for their sexual orientation or gender identity. By prolonging healthcare visits, LGBT patients are missing out on essential health care and disease prevention services, causing their health to deteriorate and chronic issues to develop. Though patterns like this can be seen across the globe, one of the more complicated experiences is the queer Lebanese experience (Meem 2010). Lebanon as a country is multisectoral, multiethnic, multilingual, and diverse in personal and political viewpoints. In the last two decades, its urban cities have witnessed a cultural shift towards tolerance and acceptance of lesbian, gay, and bisexual identities (Meem 2010). Throughout Lebanon's history of political and economic instability, and the resulting integration of various immigrants and refugees, three social pillars have crystallized and now saturate all aspects of society: religion, culture, and societal norms. As a result of these combined factors, sectors like the Lebanese healthcare system are influenced more by cultural acceptability standards than by ethical standards of practice.

According to state law, homosexuality is considered illegal as it "contradicts the laws of nature." Islam and Christianity, the two most populous and influential religions in the country, also vilify homosexuality as "unnatural." Because of its predetermined place in Lebanese society, LGBT identities are constantly at risk of facing stigma and discrimination in almost any social setting, especially in healthcare. Because LGBT individuals are more likely to avoid and eventually cease engaging in these systems, this reality can lead to severe health consequences community-wide ("stereotype threat theory" Steele & Aronson 1999; Fingerhut & Abdou 2017).

In addition to the lack of acceptance and LGBT-specific services in Lebanese healthcare, lack of health awareness throughout the LGBT community could be a primary contributor to their poor health outcomes. LGBT individuals frequently struggle to find spaces where they can feel comfortable seeking health information or discussing their health openly; this compromises their autonomy and ability to improve their own health, ultimately silencing the

queer patient narrative. Communities that lack awareness of their basic health needs are not only unable to protect themselves from poor health outcomes; they are also left powerless in stigmatic settings like healthcare, leaving them unable to advocate for themselves. Both are common consequences of living with an LGBT identity in a homophobic society, and both are likely to negatively impact health. Furthermore, LGBT health topics are seldom discussed outside the context of contracting STDs, especially in regions like Lebanon. As a result, general health awareness among the LGBT population in that region is extremely limited and likely dependent on multiple social factors.

Little is known about the healthcare experiences and barriers of LGBT individuals living in Lebanon. The size, demography, and features of this population are unknown due to lack of population census data on LGBT identity. Non-governmental organizations (NGOs) and other grassroots activity in Lebanon have pushed for the recognition of the LGBT population, a crucial first step towards improving their health and addressing inequality. More recently, Lebanese NGOs are requesting funding to implement a nationwide LGBT population survey, inspired by the PRIDE Study of UC-San Francisco (https://www.pridestudy.org/ , 2018). If successful, Lebanese activists will have initiated the first study of its kind in the Middle East that measures demography, health history, and prevalence of the Arab/Middle Eastern LGBT population. Until then, we must rely on the existing evidence of the health impacts of stigma and social discrimination. Due to heteronormativity and patriarchal social constructs, these patterns of social isolation and health can be compared to the LGBT population globally. Although the impact of Lebanon's geography and socio-cultural makeup on LGBT health are still unknown, we can reasonably hypothesize that LGBT health in Lebanon is disproportionately poor compared to that of heterosexuals. With this in mind, we can further question whether Lebanon's homophobic society influences healthcare, and how this has been observed in LGBT patient experiences.

The Reality

Regarding its approaches to medical education, professional training, and identity-specific care, the healthcare system in Lebanon is not equipped to serve the LGBT population. Healthcare is a sensitive and deeply personal arena in which marginalized individuals are particularly vulnerable to trauma and even exploitation. Modern healthcare is still very influenced by and catered to serve the heteronormative experience, identity, and lifestyle. Lebanon is a Middle Eastern country with one of the only few multi-sectarian governments in the world. Multi-sectarianism in political systems typically ensures that at least one representative from every major religious sect in the region be appointed to parliamentary positions (Henley 2016). The political and cultural dynamics between religious groups can sometimes cause tension; but because of their shared beliefs about sexuality, demonization of homosexuality creates overlap. The complex dynamics at play within Lebanese culture, politics, and religion exacerbate the effects of stigma and discrimination of LGBT patients in healthcare. However, unlike other countries in the region, Lebanon's grassroots movements for LGBT acceptance have been gaining momentum, especially in the urban capital, Beirut. Although over the years pro-LGBT activists have built a solid platform to shift cultural views in Beirut, the LGBT community--especially in rural villages--is still largely living underground with their identities hidden from the general public. Therefore, a slight shift in cultural attitude is not enough to address the health disparities that persist within the Lebanese LGBT community.

In order to better understand the factors that affect LGBT healthcare in Lebanon, we must consider the perspectives of all stakeholders in LGBT health including patients, healthcare providers, and pro-LGBT activists/NGOs. Systemic barriers and other social factors have wedged gaps between these groups, and has prevented them from communicating about LGBT health awareness. Homophobia in healthcare acts as a challenge not only for patient equity and overall health. Due to the lack of culturally-relevant evidentiary support, activists face challenges when pushing for policy change and advocating for LGBT-inclusion in healthcare. Healthcare

providers in Lebanon--specifically those who indicate they are willing to serve the LGBT population--may also be limited in capacity without comprehensive LGBT-specific training/health education. Lastly, LGBT patients--often the last recipients of health information, if at all--are likely to be misinformed or misdiagnosed by heteronormative clinical approaches, exacerbating their risk for poor health outcomes. There is a plethora of factors that either inhibit or support comprehensive approaches to LGBT healthcare, and Lebanon's culture and location in the Middle East make this issue immensely more difficult to address. Therefore, this goal of this study is to examine the perspectives of stakeholders on LGBT health care and equity, in order to identify potential causation and other factors influencing quality of care for LGBT patients. We will approach this research question by comparing the responses and reported experiences/observations of patients, providers, and activists, and highlighting concordance and discordance between them.

Methods

Study Design & Context

This study was led by a grassroots NGO based in Lebanon called LebMASH (Lebanese Medical Association for Sexual Health). LebMASH is a non-profit organization that works toward advocacy, education, and destigmatization of sexual and reproductive health (SRH), with a particular focus on supporting those with marginalized and non-conforming gender/sexual identities. Many of LebMASH's activities, including this project, are funded by the US Embassy in Beirut and supported by the greater SRH/LGBT activist community in Lebanon. Communal support, in addition to the well-connected and often combined efforts of activists in Lebanon, have contributed heavily to the visibility and continuation of LebMASH's initiatives.

This study was designed to inform the creation of the LebGUIDE Directory. LebGUIDE, finalized and published October 2017, is a centralized list of healthcare providers in Lebanon who--through this study--have been determined as "LGBT-friendly and -inclusive" in their practice. This study employed both quantitative and qualitative methods in order to determine LGBT acceptance. Data collection consisted mainly of semi-structured interviews; physicians were first asked to participate in a survey that would determine their general attitudes toward LGBT identity and their inclusion in the interviews. Based on survey and interview responses of the providers, the project team created a comprehensive list of providers who were determined as LGBT-friendly. LebGUIDE is also available virtually and is still being promoted by other active NGOs in Lebanon.

Target Populations

The interviewed individuals from each of the three stakeholder groups totalled to: 51 healthcare providers, 12 LGBT patients, and 7 social justice activists (total N = 70). Due to time constraints and limited resources, only 5 physician, 6 activist, and 9 LGBT interviews were analyzed (N = 20). The sample sizes, as well as which interviews would be analyzed, were driven by convenience sampling; the first transcripts ready for analysis were transferred to the data analyst. Participants across all stakeholder groups were deemed eligible for participation if they were aged 18+, gave clear consent, and had been living in Lebanon for 5+ years at the time of the study. Their geographies varied between rural and urban settings within Lebanon, although a majority of participants were based in Beirut (capital). Methods of recruitment were specific to identity groups and consisted of social media marketing/advertisement, email outreach, phone calls, and flyers posted in LGBT spaces. Additionally, determining inclusion in the study varied slightly across the groups.

Recruitment & Eligibility

LGBT Individuals

Inclusion of LGBT individuals in the study was based on their self-reported identity as LGBT or gender non-conforming, in addition to the eligibility factors mentioned above. Sensitive and identifiable information--names, health/family history, etc.--were omitted from all transcripts, and files containing identifiers (audio recordings, etc.) were deleted following transcription. LGBT individuals were given the option to remain anonymous throughout the study, either by using a code name or by withholding their name entirely. Consent agreements were established with this in mind. If the patient chose to keep their own name or use a code name, they were asked to sign consent agreements using those identifiers; if they chose to withhold their name

entirely, consent was confirmed verbally. Signed consent agreements with identifiers were kept in a locked file cabinet to which only project managers had access. Only the LebMASH executive director and the assigned project manager have access to this file.

Similar to their relationship with the activist community, LebMASH is very well-connected with the LGBT community in Lebanon. Given the taboo nature of LGBT health and SRH, the network of advocates for LGBT rights and SRH awareness is a small community. Due to their comradery with the broader activist and LGBT communities in the region, LebMASH's initiatives have been successful in community engagement and resource dissemination. The recruitment process proceeded mostly through marketing and advertisements using social media and posting flyers in LGBT community spaces. LebMASH's connections with the Lebanese queer community allowed for snowball sampling to recruit efficiently and ethically. Additionally, LebMASH, along with its activist/NGO collaborators, was created *by* the LGBT activist community. Hence the LGBT community in Lebanon are not only direct beneficiaries of this study; they are its drivers, facilitators, and disseminators.

Healthcare Providers

Healthcare providers of various specialties were contacted to participate in the study. However before interviewing, multiple steps were taken to determine inclusion, including a quantitative survey. LebMASH began recruitment by purchasing a list of nationwide data from the Lebanese Order of Physicians, consisting of 14,000 names and specialities of physicians practicing throughout Lebanon. Additionally, LebMASH project managers searched for lists of providers on websites from both the Lebanese Psychological Association (LPA) and the Lebanese Psychiatric Society (LPS). The lists of physicians were narrowed down based on the availability of their contact information, reducing the overall selection to 4,500. Project managers then blasted mass emails to all physicians on the narrowed list, inviting them to participate in a survey that would gauge their attitudes toward LGBT patients. From the list, 141 providers

replied and filled out the survey. Of the 141 surveyed, 51 providers scored positively for attitudes toward LGBT patients and consented to participate in the interview phase. All interviewed physicians were later included in the LebGUIDE directory of LGBT-friendly physicians practicing in Lebanon. At the end of the interview, LGBT-friendly providers were asked for additional recommendations and referrals to other potentially LGBT-welcoming providers.

Criteria for inclusion in the interviews and LebGUIDE was based on a two-phase process. The survey (Phase 1) consisted of roughly 15 questions--not including demographic information--which were phrased as "I believe that…" with a Yes/No/Maybe answer format. The last question on the survey asked if the participant would consent to being contacted again for Phase 2 follow-up. The project team agreed on a set of inclusion/exclusion criteria for each question, determining which "Yes's" and "No's" were critical to identifying acceptance/homophobic beliefs among the providers. For example, participants were immediately excluded from the study if they answered anything except "No" for the following questions: *"Do you believe homosexuality is unnatural/a sin?"*, *"Do you believe homosexuality can/should be treated as an illness?"*, etc. Furthermore, providers were only included in Phase 2 if the last survey question regarding consent for interview follow-up was answered "Yes".

Activists

When recruiting activists, LebMASH capitalized on its longstanding collaborative relationships with the broader activist community in Lebanon. LebMASH project managers reached out to allying activists and other NGOs based in Lebanon via email or phone call. Only organizations and activists who were focused on SRH and/or LGBT-related advocacy were contacted for recruitment. Eligibility for LGBT individuals and activists were similarly based on

their status as residents of Lebanon, though Lebanese ethnicity was not required. Lastly, as was the case for all participants, NGO/activists received follow-up communication only if they consented to participate. Additional recruitment was driven by snowball sampling based on recommendations given by current participants.

Instruments & Data Collection Procedures

The data collected throughout the study consisted of both quantitative and qualitative measures. This paper is a secondary analysis that will examine only the qualitative data; however, the measures of quantitative data collection will be briefly discussed, as this was used to determine which providers were eligible to participate in the qualitative stages.

Quantitative Data Collection

Physicians were asked to participate in a quantitative survey to determine their inclusion in the qualitative phase. Phase 1 surveys were used to identify which providers could be considered LGBT-friendly and, therefore, included in the rest of the study. Survey responses were coded using SPSS, and screened for “positive LGBT attitudes” using the established inclusion/exclusion criteria. Phase 2 interviews were meant to gain a better understanding of their approaches with LGBT patients, and the barriers to providing LGBT-inclusive and -specific healthcare. During interviews, consenting providers were asked to discuss their approaches to receiving and treating LGBT patients, their willingness to create gender-inclusive intake forms, and how they feel their education and training have prepared them to deal with LGBT health.

Qualitative Data Collection

The qualitative data collected for this study consists of three semi-structured interviews distributed across a sample size of 20. Though all the interviews were focused on LGBT disparities in healthcare, the three interview guides were tailored specifically to capture the perspectives and experiences of three different populations: pro-LGBT activists, LGBT patients, and LGBT-friendly healthcare providers (Appendices A, B, & C, respectively).

The processes leading up to the interviews were identical for the participating activists and LGBT individuals. The length of interviews varied, ranging anywhere from 7-15 minutes each. Brief interview guides were used to instruct the facilitators on staying intentional, respectful, and ethical throughout the interview process. Additionally, trauma-informed instructions and other disclaimers were included for LGBT patients, acknowledging their vulnerability to trauma and social violence. Before beginning the process, the interviewers were required to deliver a short prompt, explaining the purpose of the study and informing the participant of their liberties to withdraw participation at any time. Informed consent to participate and be audio-recorded was also established verbally before the interview began. If the participant did not give consent to being recorded, the facilitators would rely on note-taking to record participant responses, which only occurred in three physician interviews. After establishing informed consent and clarifying the study purpose, the facilitator initiated the interview.

Interviews were recorded using a smartphone application called Call Recorder (for iPhone or Android), which was able to record the phone conversations directly from the device in use. The audio files collected were initially stored on a password-protected laptop. Once all interviews were completed, they were collectively transferred to a password-protected drive on Dropbox, and deleted from the laptop. The interviews have been transcribed by volunteers contracted through the organization. All volunteers/project staff who assisted with transcription of interviews were asked to sign confidentiality agreements to maintain ethical handling of data.

To prevent the accidental release of identifiable data, the audio files were deleted from the shared drive immediately following the transcription of each interview.

Instruments

Though the interviews were all centered on the topic of assessing LGBT healthcare in Lebanon, each interview and its questions were tailored to each community to better understand the unique experiences and perspectives of each group. Activists were asked questions about their opinions regarding the healthcare system in Lebanon like *"What do you think healthcare providers can do to show LGBT-friendliness?"* (Appendix A). They were also asked about what they've observed as the most common types of violations in the healthcare code of conduct. Similarly, LGBT individuals were asked about their experiences in healthcare and how they believe their sexual orientation was a factor in their treatment. They were also asked to define, in their own opinions, *"the two biggest challenges of visiting a healthcare provider as an LGBT patient"* as well as *"what should LGBT-friendliness in the healthcare system ideally look like?"* (Appendix B). LGBT-friendly healthcare providers were asked to explain their attitudes on serving the LGBT population in Lebanon, as well as how they felt their medical training prepared them to deal with LGBT health. They were also asked questions about the inclusive nature of their clinical processes, including *"How do you ensure your patients are treated respectfully/without discrimination?"* and *"Are you willing to tailor your intake forms to be more inclusive of sexual minorities?"* (Appendix C). The interview guides for each group are displayed below as Appendices A, B, & C (*Activists*, *LGBT patients*, & *Providers*, respectively).

Setting

Regarding interview settings, participants were given the option to decide between an over-the-phone and in-person interview. Most interviews with healthcare providers were conducted over the phone, with few exceptions which took place at the preferred location of the

provider (place of clinical employment, personal offices, etc.). All interviews took place in secure settings, with particular consideration towards LGBT safety. Both the NGO activists and LGBT individuals were interviewed in private offices and rooms within LGBT community centers/safe houses throughout Beirut. The locations of such community "safe spaces" are not publicly known; such information is shared only among LGBT community members to maintain its security as a "safe space" for LGBT in a largely homophobic region. Recognition of these channels of communication and engagement within the LGBT community is critical to appropriately disseminating resources and information to the whole community. This proves the importance of LebGUIDE and rationalizes the methods chosen by LebMASH to make this information available and safe to access. To reiterate, LebMASH's collaborative relationship with grassroots LGBT community centers and other pro-LGBT organizations and activists, allowed for easy and ethical access to LGBT-safe spaces and enabled the recruitment/data collection processes to run smoothly.

Plans for Analysis

All participant interviews, as well as the transcription, translation, and preparation of the dataset, took place in Beirut, Lebanon. Following transcription, de-identified data were transferred to a secured Dropbox account shared among the project team. This study employed thematic analysis to examine and compare the data across groups (Clarke & Braun 2014). Thematic analysis focuses on identifying and examining patterns that emerge throughout data analysis (Clarke & Braun 2014). Instead of functioning on pre-generated assumptions, thematic analysis relies on the data itself to tell the story across participant perspectives.

Before analyzing the interviews, a preliminary codebook was created including common areas of inquiry across the different instruments. The preliminary codebook was tested by

running analyses in two transcripts from each participant group, totalling six preliminary analyses using the initial codebook. This pre-analysis screening allowed the codebook to undergo development to include more themes and delineate important subcodes found in the data. The revised codebook was then applied to the entire dataset; interviews examined during preliminary analysis were analyzed again using the new codebook. While coding the full set of 20 interviews, detailed memos were integrated throughout to highlight interesting patterns and important quotes; memos also informed and helped with the organization of the descriptive summaries and interpretations.

Following the coding process, we revisited each code in the dataset and created descriptive summaries of each code. Summary grids were used to examine responses from each participant, and form broader summaries of the general patterns of each code for each participant group. After summarizing the general patterns of each participant group by code, I generated a table that listed the overall summaries of each code, compared perspectives *between* the different participant groups, and demonstrated either disagreement or overlap. The compared summaries and emerging themes were discussed collaboratively with local project advisors, mentors in qualitative research, and LebMASH project managers. Overall, three primary themes were generated across participant groups, and two core "connective" themes were found to intersect with the primary themes across all participant groups. Comparative results are discussed in detail below.

Ethical Considerations

Due to research focus that involved the discussion of private and potentially sensitive information, this study required approval by the International Review Board (IRB). IRB was retrieved to ensure maximum protection of the vulnerable populations engaged in the study. Steps were taken to mitigate the potential risks and fear of participating among LGBT patients. For example, LGBT patients were given multiple anonymity options including using a code

name or refraining from using any name throughout the entire study process; consent was determined verbally if the participant decided to remain completely anonymous. Additionally, each participant was assured their protection of privacy and respect for autonomy via trauma-informed disclaimers delivered before each interview (i.e. *you have the freedom to refuse to answer a question or end the interview at any time*…).

Risks & Benefits

The processes of data collection and management did not warrant any adverse events as a consequence of the study. Overall, the project benefits apply to the broader medical and LGBT communities, and not necessarily aimed at each individual. Therefore, the risks among the participants are so low that they are outweighed by the benefits. Given that this project works with three different populations, we do acknowledge that although the total risk is generally low. LGBT individuals were asked to discuss their experiences seeking healthcare in Lebanon. Unpacking these personal stories regarding both positive and negative encounters have the potential to trigger feelings of anxiety associated with their past traumas.

The individual participants of this study do not immediately benefit from participating. Continued publishing and analysis of the data collected will help to inform gradual shifts in stigma, medical education and training, and LGBT-related policies. Such benefits are long-term and scaled to benefit the broader communities of those involved. Ultimately, the results and deliverable of this project will continue to contribute to changes in social attitude, reduction in poor health outcomes of LGBT individuals, and reforms in medical education in Lebanon to mandate training in LGBT health topics.

Results

Throughout the dataset, there were three primary findings that expressed the general perspectives of healthcare for LGBT in Lebanon: barriers, experiences, and views of acceptance. Patterns that stood out within certain themes were compared across and within different participant groups. Two connective themes were discussed at the core of every primary finding: **lack of LGBT awareness** and **influence of social factors**. These were identified as the connective themes because they emerged throughout the dataset and gave context to every primary theme. Both were pervasive when discussing the barriers to healthcare, defining LGBT-friendly healthcare, and the nature/types of experiences of LGBT patients.

Primary Findings

Barriers to Healthcare

The theme *Barriers* captured the various challenges to seeking and receiving LGBT-friendly healthcare in Lebanon. The barriers/challenges most commonly reported by participants were: the fear of facing *stigma/discrimination*, the fear of breaches of *privacy/trust*, and the challenge of *cost/accessibility*. Of the nine, eight LGBT patients identified stigma and discrimination as the largest barrier to healthcare; the one patient who did not report stigma as a main fear said it was because she is bisexual and "straight-passing." This was described by over half of patients as getting "looks of disgust from clinic staff," inappropriate questioning based on gendered assumptions, and reluctance of physicians to touch their patients. Two-thirds of LGBT patients interviewed said they faced stigma related to HIV/STD assumptions. After learning the patients' sexuality, providers would often assume they either have HIV or are

at risk and must be tested before receiving treatment; these assumptions are often accompanied by “looks of disgust” and mockery from the staff. Two LGBT participants referenced experiences in which the doctor--after learning the patient’s sexuality--became hesitant and “doubled up their gloves” before continuing. One patient said they have never been asked about their sexual orientation, nor have they ever disclosed it to providers.

> *It’s a bit frustrating. A couple of family members were at the hospital [with me] and I’m always like, I’m not sure if I should answer truthfully or not, specifically for [sexuality] questions.* (Patient #5)

Patients overall report confusion or fear about the fact that their sexuality may be brought up in a clinical setting; some have reported that they prefer not to be asked, whereas others preferred that the physician initiate that conversation.

Similar to the narrative of LGBT patients, all activists interviewed named discrimination as the most commonly reported barrier when seeking LGBT-friendly healthcare. Additionally, all activists agreed on two common types of healthcare discrimination against LGBT patients: a) wrongful association with STD-related issues and b) clinical approach based on the assumption that homosexuality is an illness or abnormal. All six activist participants linked healthcare discrimination to negative health outcomes. They all stated that stigma in healthcare reduces the likelihood that LGBT patients will revisit providers or continue seeking healthcare altogether, and that this has a direct “effect on poor health [outcomes].” A third of LGBt patients said they currently avoid seeking healthcare in Lebanon “especially for sexual and mental health,” unless recommended by an NGO/LGBT community network. Physicians overall did not explicitly talk about stigma as a barrier to LGBT patients; however, they unanimously describe their own practices as “respectful towards everyone.” Two physicians simply said that they frequently work to keep their staff and clinical environment “stigma-free.”

Another major healthcare barrier was the fear associated with a lack of *privacy or trust* in the healthcare system. Almost all LGBT participants identified breaches of privacy and

confidentiality as the most threatening “risk” for LGBT patients seeking healthcare. Activists shared a similar perspective, with most participants identifying breach of privacy as “among the most frequently reported violations” against LGBT in healthcare. STD/HIV testing was identified by most activists and patients as the most risky clinical process for the LGBT community in Lebanon, because the confidentiality breaches could have the most damaging health and social effects. Other consequences of lack of privacy were described similarly across the LGBT patient group: facing homophobic judgement by staff, stereotyping, exposure/“outing” of identity, and in two interviews, criminal charges were brought up. Additionally, when asked about LGBT patients’ trust in the healthcare system, a third of activists identified the “patient-provider relationship” as a critical, yet lacking, component in Lebanese healthcare.

Physicians were asked about their current approaches to maintaining confidentiality with patients. Overall, there was no consistency in approach or systematic standard for confidentiality. Each physician described their unique methods to ensure ethical storage and handling of patient information. Some of these included password-protected computers/laptops, access limited to physician only, vigilant communication with staff about respecting privacy, intentional spacing of appointments, and establishing verbal agreements of confidentiality. Of the five, two identified and described a lack of consideration for ethics and privacy throughout the Lebanese medical community:

> *Confidentiality is relative and not well-maintained. Many doctors in Lebanon don’t take it seriously; and you cannot criticize what is accepted, you know?* (Physician #11)

Both physicians called for a system of accountability that would ensure that providers uphold basic ethical standards of care.

Lastly, *cost and accessibility* of quality healthcare were addressed as barriers and major determinants of health/healthcare-seeking for the LGBT community. Two-thirds of LGBT participants said cost was a concern that affected both healthcare access and guarantee of privacy. Almost all of them followed up by saying this would make them much less likely to get

regular testing for STDs. Due to the lack of accessibility to LGBT-friendly healthcare, two LGBT participants said they currently seek specific healthcare services out of the country; one said that she sees an OBGYN in Paris to avoid stigma and judgement by a Lebanese doctor. One participant gave detail and context to the culture of testing and getting results in Lebanese healthcare.

> *CMC has an agreement of anonymity, so they don't use my actual last name and my records are completely secret; [but] the finances are a bitch. It's not easy to afford those kinds of tests. [...] It's four hundred dollars here, three hundred-fifty dollars there for tests that have to be done yearly. [...] USJ does have it cheaper, but they do not have anonymity, so your name is on record and if anybody has private insurance, they're screwed. Apparently [Hospital] Rizk has it cheaper as well, and they do have anonymity, but the tests take longer to obtain. [...] So either you get your results within two weeks but your name is [not protected]; or you have to wait two months but you don't have to give your name; or you [pay more] and don't have to give your name, and you only wait two weeks…* (Patient #4)

Nearly all activists as well as a third of LGBT patients mentioned geography and specifically living in an urban area as contributors to healthcare accessibility. According to activists, LGBT-specific services, which are already limited in number and capacity, are primarily located within Beirut. Two-thirds of activists attributed lack of accessibility to insufficient funding; one participant hinted at the sometimes competitive nature of grant funding and the tension it creates between NGOs. Nearly all activists also attributed accessibility issues to the lack of awareness of available services among LGBT. Physicians as a whole do not address cost or accessibility as challenges potentially facing their LGBT patients. Overall, the data shows that access to LGBT-friendly healthcare is limited to urban centers like Beirut, and price is an indicator of care quality. High costs may signal LGBT-friendly care; however, this limits accessibility for many and creates even more hesitation in LGBT patients to seek healthcare.

Lastly, activists and LGBT patients were asked about their opinions regarding the likely *consequences* of having to navigate non-LGBT-friendly services. A third of patients reported that they avoid seeking healthcare in Lebanon altogether. Over half of patients reported that they feel forced to withhold crucial information in order to protect themselves from discrimination; they also expressed fear that this barrier would influence diagnoses and poorly affect their health.

> *Some of my friends, for example, would have hemorrhoids, and they would go to a doctor, and they would not open up about their sex life, about their partners, about anything, because of familial referral. And they would end up finding out later on that it was because of [their sexual behaviors]. Dots would have connected a lot better if secrecy would have been provided.* (Patient #4)

Similar to LGBT patients, all activists identified "delaying or avoiding healthcare" as the most damaging consequence of poor/homophobic healthcare. Two-thirds of activists listed the major consequences of delayed healthcare as developing physical conditions, having chronic issues, and resulting in poor overall health. Half of activists also named poor mental health as a likely consequence of poor healthcare. A third of LGBT patients and two-thirds of activists agreed that delaying STD testing would have the most detrimental health effects on both the LGBT and broader Lebanese community. One activist discussed the psychological implications of the lack of trust in healthcare, saying that LGBT patients whose identity or privacy had been repeatedly violated by healthcare providers were likely to "internalize [feelings of] worthlessness." Comparatively, one LGBT patient discussed the psychological implications of facing consistent discrimination by providers:

> *I: How did these [experiences] affect you when you wanted to visit the doctor?*
>
> *P: I hated myself.* (Patient #12)

Overall, patients are aware and concerned about the physical and mental health implications of poor and, eventually delayed, healthcare.

LGBT Healthcare Experience

This theme captured the *positive* and *negative experiences* of LGBT patients seeking healthcare in Lebanon, as well as the typical *process of seeking healthcare* for the LGBT community. Activists and LGBT participants were asked to share their experiences and/or observations of the healthcare system in Lebanon as it relates to LGBT health. Regarding *negative experiences*, activist and LGBT groups generally demonstrated patterns of similarity within groups. However, the data showed some variation across groups, especially between what activists have seen and what patients report as their experiences. Nearly all of the LGBT participants reported at least one negative experience with a healthcare provider. The two who did not report negative experiences gave additional context: one exclusively seeks healthcare through NGO/LGBT network referrals, and the other said that they never disclose their sexuality in healthcare. Over half of LGBT patients and all activists described the types of negative experiences in healthcare as including (in order of commonality): judgement, stigma/ stereotyping related to STDs/HIV, humiliation and disrespect by clinic staff, and criticism from physician for their lifestyle. One LGBT patient describes a negative experience where after disclosing her sexuality to psychologists, they expressed “too much fascination” with her sexuality; she described the feeling as uncomfortable and being “treated like a case study.”

When asked about the most frequently observed types of healthcare violations, activists reported three similar issues: misdiagnosis, conversion therapies, and denying/refusing care. Refusal/denial of healthcare was mentioned by only one LGBT patient; however, this patient reported facing multiple incidents of refused care. Some severe violations were shared by activists, including trans patients whose providers had purposely botched surgical procedures out of homophobic intent. Another severe violation reported by activists, but not by LGBT patients, was “sexual objectification.” Two activists mentioned this issue, attributing it to the

social taboo and shame that associates LGBT identity with “sex work.” Both activists said that as a result of this stereotype, they encountered LGBT patients who had reportedly been sexually objectified, harassed, or assaulted in the clinical setting. They noted that a majority of the incidents do not get reported to authorities for fear of further persecution.

LGBT participants were also asked to describe any *positive experiences* they had with the healthcare system. Almost all LGBT patients reported having at least one *positive experience* when receiving healthcare in Lebanon. Of these, over half reported that their positive experiences occurred exclusively with psychologists or therapists. Additionally, a quarter of the positive experiences occurred with a provider through an NGO or LGBT network referral. One participant attributed his good experience to his financial privilege, saying that this allowed him to access quality care. Overall, *positive experiences* were described by patients as being treated with respect by physician and staff and not being judged or criticized for sexuality; “they treat me like they treat anyone else.”

Participating physicians were interviewed as LGBT-friendly providers; they were asked about their standards of practice and specific attitudes regarding serving the LGBT population. All five physicians described their attitudes very similarly as “treating all patients with respect, regardless of any factor.” Despite the growing number of providers who are aware of/collaborate with NGOs in Lebanon, two activists reported that positive healthcare experiences among LGBT individuals are “rare.” Similar to the LGBT patients, activists listed the exceptions to poor healthcare as either: a) having NGO/LGBT community referral or b) seeking counseling/ psychological services. One activist explained that LGBT patients who do experience positive healthcare are among the few “fortunate and privileged.”

The responses regarding *process of seeking provider* described the methods employed by LGBT patients to seek LGBT-friendly providers in Lebanon. Two-thirds of LGBT patients indicated that their process relies on the referrals and recommendations made by NGOs/LGBT community members. One LGBT-friendly physician said that his patients have recommended

him to others in the LGBT community, which has expanded his LGBT client base. An LGBT participant referred to this process as “word of mouth,” but criticized the process as “ridiculous” and “risky.” Similarly, over half of activists discussed the *process of seeking healthcare* as a major risk for LGBT patients. Overall, activists said that because of the “constant anxiety associated with” seeking LGBT-friendly healthcare, LGBT patients are much more likely to not seek healthcare at all, rather than opening themselves up to risks of discrimination. Additionally, two LGBT participants named their familial networks as their primary source for healthcare referrals; however, both participants said that they do not disclose their sexuality to physicians at all. According to a third of activists, NGOs are working to expand on tools that help to ensure LGBT healthcare needs are met, such as a directory of LGBT-friendly providers & specialties, insurance consultations, free testing and counseling, etc.

Defining “LGBT Acceptance” in Healthcare

In this theme, both activists and LGBT individuals were asked to define, from their own perspectives, the ideal “LGBT-friendly” healthcare provider and “accepting” healthcare system or setting. Overall, activists and LGBT individuals gave very similar descriptions when defining LGBT acceptance in healthcare. Nearly all activists and over half of LGBT patients described the ideal provider as having a basic awareness, or making a conscious effort to understand, LGBT identity, lifestyle, and specific needs. Awareness of LGBT identity and their specific needs was said to be demonstrated by: showing empathy and sensitivity to intimate topics, ensuring clinic staff is trained to show respect to all beneficiaries, and demonstrating gender sensitivity by avoiding gendered pronouns or assumptions. Two LGBT participants specified that ideal providers would make a sincere effort to “bond” or form relationships with their patients and “help LGBT individuals feel comfortable.” A subset of both activists and LGBT patients emphasized that ideal providers separate social norms from medicine by “keeping their personal

beliefs out of [clinical process].” About half of patients described the ideal healthcare provider as someone who treats everyone with respect, and shows an accepting attitude towards the LGBT community. Similarly, the descriptive terms used most frequently within the activist group included “non-judgemental in attitude, approach, or practice,” “gender sensitivity,” and “friendliness.”

Although they were not explicitly asked to define the healthcare system, all activists and over half of LGBT patients shared their perspectives on what an *ideal healthcare system or setting* should look like. Overall, the descriptors that were common across groups were: a) “a welcoming and safe environment” and b) explicit policies mandating that all doctors adhere to “strict standards of practice.” Activists and patients alike emphasize the importance of creating an environment where LGBT patients can feel welcome, as well as the need for policies to reflect strict standards of practice. Additionally, one patient identified the need for an efficient and secure “digitized or paper patient records” system. Another stated that an ideal healthcare setting would be an environment that is built to welcome “someone like [them]”: “I want to see something that looks like [it was meant for] me, not just for the hetero [person].” Although definitions and key traits were individualistic, nearly all activist and LGBT participants discussed the need for major reforms in healthcare, specifically regarding inclusion of all identities and regulation of ethical practice. Additional descriptions given by activists included regular trainings on health disparity for providers, “gender-inclusive patient intake forms,” policies that explicitly accept LGBT and condemn discrimination, “options for anonymity,” and expansion of LGBT-specific services.

Connective Themes

Lack of LGBT Awareness

Lack of LGBT Awareness in the context of this study includes “any mention of training or education of medical professionals as a contributor to the way LGBT individuals experience healthcare”. Responses that highlighted this theme included any mention of LGBT awareness among physicians, as well as the stereotypical assumptions frequently made about LGBT health by providers in Lebanon. Overall, treatment of LGBT individuals in healthcare is poor, oftentimes in the form of stereotype-based discrimination. A common assumption among healthcare providers in Lebanon is that LGBT patients—due to their “unnatural” sexual preferences—are likely associated with STDs, sex work, and other negative stigmas. As a result, they face multiple challenges seeking equitable and LGBT-friendly healthcare. Participants express that the lack of LGBT awareness and acceptance among healthcare providers directly affects both mental and physical health of the LGBT community; and the resources in existence are limited. Additionally, any discussion of health knowledge and awareness of services among the LGBT population was included in Lack of LGBT Awareness. This core theme was discussed commonly across groups, and was contextually relevant to each primary code.

Barriers & Lack of LGBT Awareness

Training/education and social factors were both heavily integrated in the participant responses regarding healthcare barriers. Activists and patients alike are aware of LGBT stigma in healthcare and the consequences to facing discrimination by providers. Half of activists attributed stigma in healthcare to a lack of awareness and knowledge among providers. This is supported by LGBT patient responses, of whom two-thirds reported stigmatic experiences due to the stereotypical assumptions made by providers. Provider assumptions were linked--by both

activists and LGBT patients--to a lack of awareness of LGBT health, disparities, and specific needs. Additionally, nearly all activists and one patient indicated that lack of awareness of resources among the LGBT community also exacerbates the barriers they face.

LGBT Experiences & Lack of Awareness

Training and education factored in as a major determinant for positive and negative experiences. On *negative experiences*, both activist and LGBT groups talked about LGBT identity being conflated to include STD-related health; similarly, *positive experiences* described the providers as having no reaction to their patients' sexuality or STD status. Participants described positive experiences as having providers who had a solid awareness of LGBT health and understanding their specific needs.

> *She understands the differences, for example, [how] gay people are exposed to more STDs, they're exposed to more dangerous [health] behaviors, etcetera. She takes that into account when she talks to me.* (Patient #7)

LGBT-friendly physicians reported that their level of LGBT awareness was due to either: a) accumulated experience with diverse patients or b) a Western-educated background. Additionally, patients and activists reported that a majority of positive experiences typically occur within counseling/psychological practice. A commonly recycled misconception is that mental health and sexual health specialists are the only practitioners who require training in LGBT health. Lack of awareness among both providers and patients further crystalize this perspective, and demonstrates the insufficiency of training and education of physicians in Lebanon.

LGBT Acceptance & Lack of Awareness

The connection between *acceptance* and *lack of LGBT awareness* is similar to what has been seen with the other primary codes. Activists and patients overall reported that "ideal" LGBT-friendly providers should have some level of LGBT awareness. Again, this speaks to the inadequate training and education of providers in Lebanon. The participating physicians discussed their approaches to receiving LGBT patients and whether they felt their medical

training had prepared them to deal with LGBT health. Overall, some physicians indicated that they received their training outside of Lebanon, typically in France or the US; however, those who were trained in Lebanon expressed that they had to seek learning material themselves. More often than not, physicians would have to rely on their clinical experience to learn how to receive and interact with LGBT patients. This presents risks for LGBT patients because many providers lack the knowledge capacity to effectively welcome LGBT patients and guarantee them quality treatment. At best, LGBT patient health is approached by providers as a "learning experience."

Social Factors

The theme of social factors is defined as "any discussion of the influence or impact of cultural and social contexts on the healthcare experience in Lebanon". This concept emerged whenever participants discussed socio-cultural or socio-environmental factors that could explain patterns in healthcare. This included, but was not limited to, the nature of patient-provider interactions, the lack of social accountability for physicians, and the influence of social factors on medical practice. Participants report multiple experiences and observations of social constructs influencing the way healthcare is conducted. Like most countries, homosexuality in Lebanon is condemned religiously, socially, and legislatively. This, too, has reportedly been linked to mistreatment and discrimination of LGBT individuals in healthcare, ultimately leading to poor health outcomes. Humiliation, outing, and judgmental attitudes were reported as common incidents of discrimination in healthcare. Culture as a connective theme was pervasive throughout primary themes and contextually informative of the patterns seen both across and within groups.

Barriers & Social Factors

While half of activists attributed barriers in healthcare to widespread lack of LGBT health competency, a third also identified culture and social taboos as main drivers of non-LGBT-

friendly healthcare. In addition to lack of LGBT awareness within the medical community, activists and patients claimed that provider assumptions ultimately stem from socio-cultural misconceptions. These misconceptions and the social setting itself were described as major influencers of healthcare experience, especially regarding barriers like *privacy/trust* and *cost/accessibility*. When commenting on the poorly-structured Lebanese healthcare system, one LGBT patient stated that "the social setting doesn't make [healthcare-seeking/experiences] any better." The participant refers here to the general shame and isolation of LGBT individuals in Lebanese society. A third of patients said that the social taboo attached to homosexuality has major health and behavioral implications such as delaying testing, inconsistent treatment follow-up, and ultimately poor health outcomes. According to some physicians, activists, and LGBT patients, doctors in Lebanon are not held accountable for LGBT-related discrimination or breaches in patient confidentiality. One LGBT patient discussed the lack of accountability or "supervision over the proper regulation of healthcare." They discussed the concept of "social law," explaining that in Lebanon, social values have a greater influence on healthcare than national law, or even medical science. Regarding this issue of accountability, two physicians identified problems of maintaining ethical practice within the medical community. Similar to the patient, the two physicians identified social factors and social hierarchy as the reasons for the lack of accountability of doctors. Overall, the three participant groups said they believe that the social setting--and the extent to which it influences healthcare--complicates both the process of seeking LGBT-friendly healthcare and the efforts of activists to expand LGBT-specific services and reform healthcare policy.

LGBT Experiences & Social Factors

Some of the negative experiences shared in connection to social factors included stereotypical assumptions made by providers and conversion therapy. Activists as a whole identified these as severe forms of healthcare violation, and linked them to the homophobic standards of Lebanese society. Among the many stereotypes that drive provider assumptions,

one activist references the cultural myth that homosexuality is “unnatural,” and therefore must be associated with other sexual taboos such as “sex work.” As a result, according to activists, some LGBT patients have encountered sexual harassment and abuse in the clinical setting. Another commonly cited violation is the misconception that LGBT health is only relevant in the contexts of mental and sexual health; some physicians said they were prepared to deal with LGBT health topics simply due to their exposure to sexual health education. As a result of this persistent stereotype, patients have been refused blood testing on the basis of their sexuality, for fear of them carrying an STD. Additionally, many patients recalled negative experiences where--only after learning the patient’s sexuality--providers had asked whether they were HIV positive, or insisted that the patient get tested before being treated.

One LGBT patient described conversion therapy as another common violation that is influenced more by socio-cultural factors than written law. The patient gave context to the official status of conversion therapy in Lebanon as an approach to treat homosexuality, and described physicians’ lack of consideration for official decrees by either governmental bodies or medical associations.

> *Take for example mental health and psychiatry. Conversion therapy is illegal by decree of the Lebanese Psychiatric and Psychological Associations. Not long after that decree, I had come out to my family, and I had played along with their idea of [me going to a] psychiatrist... where there were people like right in front of my face practicing conversion therapy. So it’s not as clear cut as, for example, Americans or Europeans would say “oh the law says you shouldn’t do [something].” Here you have your law and you have your “social law.” And the fact of the matter is a lot of doctors still practice the social law. So that’s never a comforting idea that when I go to a doctor, I don’t know what to expect when I tell them about [my sexuality].* (Patient #4)

This emphasizes that social ideologies take precedence over what medical and political law consider ethical practice. The lack of regulation and punishment of such violations feeds directly

into homophobic social constructs, and becomes further embedded in healthcare practice, setting, and infrastructure.

Lastly, LGBT patients described health-seeking behaviors in Lebanon as a process that is largely situated within social networks, as a majority of LGBT patients seek healthcare through LGBT community referrals/NGO networks. The two patients who indicated they use familial networks for healthcare referrals, which is also common, said this affects whether they can be honest about their sexuality. This fear associated with health-seeking processes is also embedded deeply in culture, and further increases the risks of being discriminated and reduces the likelihood that LGBT patients will seek healthcare at all.

LGBT Acceptance & Social Factors

Overall, patients are looking for providers to be aware of social contexts and how they impact LGBT health, their ability to seek healthcare, and their ability to trust in providers. The most common message across the two groups was for providers to serve and respect all patients “despite their own personal beliefs.” This requires providers to be critical of their cultural norms and when to separate it from clinical processes. Activists and patients alike emphasize the importance of creating an environment where LGBT patients can feel welcome. Additionally, activists and patients call for explicit policy that prioritizes equity and is officially disengaged from socially-constructed stigmas against LGBT identity. They emphasize the need for a shift in culture within healthcare by normalizing basic standards of ethical care and by explicitly stating its condemnation of discrimination and its acceptance for the LGBT community. By suggesting policy reform with consideration for social factorss, activists, patients, and a few physicians pushed for a shift in healthcare standards that are *not* dictated by “social law.”

Discussion

Interpretations & Supporting Evidence

The dataset unearthed three key messages regarding LGBT-friendly healthcare in Lebanon. Non-LGBT-friendly healthcare has a direct impact on mental health, physical health, and internalized homonegativity. Additionally, limited competency in LGBT health topics among providers significantly limits their ability to properly treat the LGBT community; this was said to lead to negative health. Lastly, the heteronormative mores of modern society--which are embedded in Lebanese history and cultural tradition--reinforce homophobic attitudes in healthcare. These are known to be macrosocial determinants of LGBT health and care.

LGBT patients are aware of homophobia in healthcare and typically expect negative and stigmatic reactions to their sexuality. Participants overwhelmingly reported that a fear of discrimination in healthcare triggers negative mental and physical symptomatology. In a study conducted in 2014, Denton and colleagues confirmed that perceived experiences of discrimination in healthcare among LGBT patients were associated with two proximal stressors: expectations of rejection and internalized self-hatred and homonegativity (2014). These stressors were linked to poor mental health through lower coping self-efficacy, as well as higher levels of “self-reported physical symptom severity” (Denton, Rostosky, & Danner 2014). Additionally, research has shown that poor psychological outcomes as well as delays in health-seeking behaviors are the consequences of clinical staff projecting judgement and discrimination on their LGBT patients (Utamsingh, Lebron, Kenya, & Carrasquillo 2017; Durso & Meyer 2013). Delays in healthcare have been known to lead to adverse health effects (Fingerhut & Abdou 2017); and in the context of avoiding discrimination, mental health is at particular risk (Utamsingh et. al 2017). Overall, both the dataset and supporting literature have

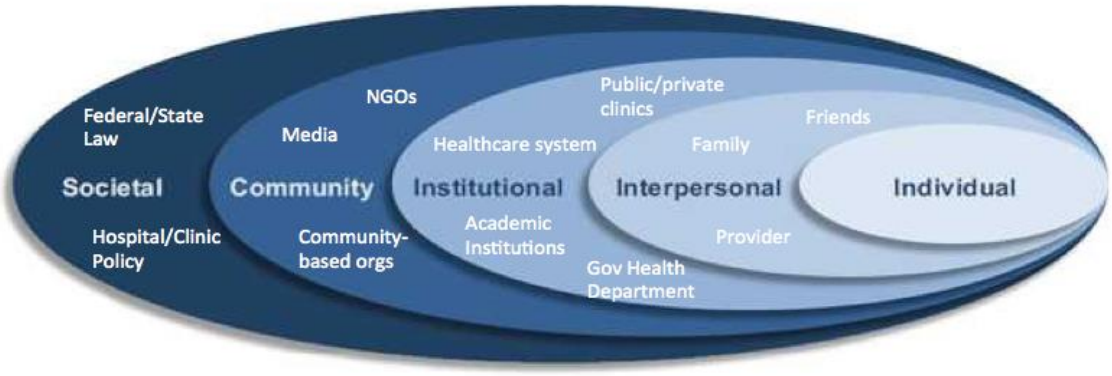
linked discrimination and homophobic healthcare services to the community-wide health disparities among LGBT.

Insufficient education and training of providers affects their ability to treat all patients with the highest quality care. LGBT patients overall reported their ideal healthcare provider as being aware of LGBT health and their specific needs. Additionally, providers who don't receive training in LGBT-specific health found that it was difficult to understand LGBT patient needs. Despite the health disparities, medical education has yet to see a standardized shift towards LGBT-inclusive education (Hollenbach, Eckstrand, & Dreger 2014). A study done in 2011 showed that most medical schools in the U.S. do not discuss LGBT topics regarding chronic health issues or body image; less than half address intimate partner violence and identity transitioning (Obedin-Maliver et al 2011). As a result, many medical students expressed that they feel ill-prepared or uncomfortable treating non-heterosexual patients (Utamsingh et al 2017; Hollenbach et al 2014; Obedin-Maliver et al 2011). Since then, studies have confirmed the great need for inclusion of LGBT topics in medical training, and that LGBT-health training would have a positive impact on healthcare quality and efficiency (Jaffee, Shires, & Stroumsa 2016; Shindel, Baazeem, Eardley, & Coleman 2016).

LGBT individuals are frequently at risk for discrimination, stigmatizing, and various forms of abuse in Lebanese society; patients and activists report that these social issues appear in healthcare as well. Patients overall report experiences of discrimination and stigma in healthcare, among a variety of other healthcare violations. In a separate primary analysis of the activist interviews, the researchers concluded that trans women experience the highest rates of discrimination in Lebanese healthcare due to social attitudes (Wright, Peplinski, Abboud, & Harfouch 2017). This was said to lead to more severe forms of state and social violence, and symptoms of poor overall health (Wright et al 2017). Additionally, sexual minority women (SMW) in Lebanon reported that social factors created significantly more barriers to healthcare and health-promoting behaviors (Gereige, Zhang, & Boehmer 2018). SMW also reportedly

experience more sexual harrassment by healthcare providers in Lebanon than heterosexual women (Gereige, Zhang, & Boehmer 2018). In an article that unpacks the relationship between Israel's invasion of Lebanon in 2006 and LGBT activism, Nadine Naber and Zeina Zaatari make the argument that systems of heteronormativity are ever present, even in post-war and political activism discourses (Naber & Zaatari 2014). They challenge that even though LGBT activists used their grassroots force in times of war and occupation to advocate for the liberation of *all* Lebanese, heterosexism in society persevered nonetheless; and queer identity, despite their survival through occupation and dedicated presence in political activism, was once again excluded from society and post-war discourse (Naber & Zaatari 2014). Overall, the participants, as well as supporting evidence, suggest that asymmetrical social systems of gender and sexuality--which continue to repress the LGBT narrative--permeates social systems despite historical conditions of war and occupation. These contextual factors contribute, if not exacerbate, the health disparities seen among LGBT individuals.

Social-ecological models (SEMs), particularly ecological systems theory, demonstrate the potential interplay and impact of different socio-environmental factors on an individual (CDC 2018; Stokols 1996). The ecological systems model suggests that the levels of social systems that influence the individual are (in ascending order): microsystem (interpersonal factors), mesosystem (institutional factors), exosystem (community-level factors), and macrosystem (policy-level factors) (Bronfenbrenner 1989). The socio-ecological model (SEM) framework (Figure 1) illustrates the dynamics that exist between these different social systems, and theorizes how this could have an effect on individual health (CDC 2018); the model was adapted to examine the layers that influence LGBT-friendly healthcare and consequently, LGBT



health.

Figure 1: Social Ecological Framework adapted for LGBT healthcare (CDC 2018)

This model illustrates the potential mechanism through which social norms filter into each societal level, ultimately impacting individual health. According to the framework, policy-level factors help shape the nature of the community and its perspective on other systems; in Lebanon, the law condemning homosexuality as “unnatural and punishable” has an effect on the way social norms are constructed on the community-level. Community socialization--or the common mindset recycled throughout a community--influences the way organizational/institutional systems are conducted; institutions can include healthcare systems

and academic and medical institutions. Because healthcare providers are products of their society, they are likely to echo social values in their practice and patient approach, without comprehensive training of values and patient care. Studies have shown that providers attribute their struggles of counseling patients on sensitive health topics (i.e. safe sex) to the pervasive nature of societal norms (Paul et al 2016). Additionally, in a study done in Kenya regarding stigma of healthcare providers toward their abortion patients, evidence found that providers are conflicted between societal norms and the basic human rights of the patient (Hakansson et al 2018). This evidence supports the idea illustrated in the SEM that societal values trickle down into institutional systems like healthcare, ultimately influencing the general approach of physicians toward their LGBT patients. To reiterate, the healthcare system is still largely heteronormative in structure and services, and its lack of capacity to receive and properly treat LGBT patients is resultant of heteronormative social factors.

By reference of participant responses, supporting evidence, and the adapted SEM, we can say that Lebanon's multifaceted social environment is likely to affect individual health. It can be inferred that LGBT health in Lebanon is impacted by a similar mechanism, potentially via more salient and harmful social attitudes.

Limitations

Although the study findings generally aligned with supporting literature, social attitudes toward homosexuality created many limitations for the study. Study samples of activists and LGBT individuals were very small, which affected generalizability of the data. Due to the relatively hidden nature of the LGBT community in Lebanon, participant recruitment and outreach were compromised significantly. Potential LGBT study participants may have been hesitant to be interviewed due to social taboo and judgemental associations with homosexuality. This presented limitations due to the restricted access to the LGBT community, ultimately

resulted in a small sample size. However, steps were taken to mitigate the risks associated with participating in LGBT-focused research. LebMASH employees involved in the study informed LGBT participants of their options for anonymity and using code names when giving consent. Furthermore, LebMASH belongs to a small well-connected network of pro-LGBT NGOs in Beirut, Lebanon. Their methods to engage vulnerable populations were trauma-informed, including the secure handling of participant information, non-intrusive consent processes and outreach methods, and utilizing LGBT safe spaces.

Recommendations

Policy-Level

Although social factors at the macro- and exosystemic levels are likely indicators of how LGBT healthcare is conducted in Lebanon, heteronormativity and patriarchal mores have been the social standard, which would take generations to deconstruct. We therefore recommend strategic approaches toward a shift in the *culture of healthcare*, by starting with the outermost social level: macrosystem. As suggested by many participants, the Lebanese healthcare system should work towards imposing strict regulations on healthcare and approach. Instead of abiding by social beliefs, the structure and purpose of Lebanese healthcare must be redefined to reflect ethical and inclusive standards of care; and this purpose should be reflected in state policy.

Grassroots efforts in Lebanon and elsewhere have played a powerful role in advocating for policy change and creating comprehensive LGBT health services. For instance, the cultural and legal shift toward LGBT acceptance in Mexico began with the fight against HIV/AIDS, which still disproportionately affects MSM and trans individuals (Vera-Bachmann & Salvo 2016). Similar to the States, the HIV/AIDs epidemic in Mexico ignited large-scale LGBT activism and

movements that called for the legal prohibition of LGBT-related discrimination within all social systems (academia, healthcare, justice, etc.) (Zuniga, Rodriguez, & Garcia 1998). In April of 2003, the Mexican Federal Congress passed the "Federal Law to Prevent and Eliminate Discrimination," which legally condemned discrimination based on any identity factor, including sexual orientation (www.outrightinternational.org, 2003). In 2009, the General Law of Health was ratified to specifically include efforts toward trans health improvement and prevention related to STDs, psychological distress, and hormone therapy/evaluations (Rabasa 2016). Implementation of this law also endorsed the creation of La Clinica Especializada Condesa (CEC), which exists to provide comprehensive LGBT-inclusive health services, including health education campaigns, testing for HIV/STDs, and services tailored specifically for LGBT identities (http://condesadf.mx/, 2011). To date, CEC is the only public clinic to provide trans-specific health services in Mexico City (Sanchez 2016). The shift in legislation affected the way homosexuality was addressed on the community- and institutional levels. Overall, it allowed for interdisciplinary collaboration between grassroots activists and governmental departments that oversee community health.

Institutional-Level

Secondly, I recommend a reform in graduate medical education and training to include detailed curricula on LGBT health and other community-specific information. Although no country has seen widespread reform in academic curricula, some academic institutions in the US and the UK have been independently involved in piloting inclusive-curricula projects and integrating more discussion of LGBT-specific health. In 2014, the Association of American Medical Colleges (AAMC) published the first guidelines for graduate medical curriculum that expounds on treating LGBT and gender non-conforming patients, with over 30 competencies for improving LGBT healthcare (Krisberg 2016). In an effort to pilot the AAMC recommendations, the University of Louisville School of Medicine integrated the eQuality project in 2014, which

added dozens of hours of curriculum on the sexuality spectrum, how to use inclusive language, and what LGBT-specific care looks like (Holthouser et al 2017). Stacie Steinbock, director of the LGBT Center's satellite office at Louisville, added that the project curriculum is always evolving to include the feedback and needs of the Louisville LGBT community, therefore fostering sustainability and community engagement with healthcare (Holthouser et al 2017). In Cleveland, Case Western Reserve University School of Medicine has mandated 4 hours of required LGBT health curriculum for all first-year medical students; curriculum includes discussions on the barriers to healthcare for LGBT patients, as well as the best language to use when interacting with trans patients (Krisberg 2016; Mehringer, Bacon, Cizek, Kanters, & Fennimore 2013). These are but a few examples of the gradual strides being made in graduate medical education reform.

Given that NGOs are a critical link to the LGBT community, I recommend that the activist/NGO community expand their efforts to engage academic institutions in a shift toward curriculum change. In a collaborative effort, Stonewall, a UK organization that campaigns for LGBTQ equality, and Cardiff University School of Nursing implemented an inclusive curricula project that exposes students to LGBT health topics and allows them to reflect on how their curriculum can be more LGBT-inclusive (Pearce 2017). This project also incorporated the perspectives of healthcare students by encouraging them to be critical of the way their curricula is currently structured and how it can be improved. Engaging healthcare and academic institutions with community organizing is an interdisciplinary strategy that allows stakeholders to collaboratively addresses the barriers to LGBT-friendly healthcare. The collective effort of Stonewall and Cardiff allowed for an introductory, yet comprehensive, transition toward LGBT-inclusive health curricula (Pearce 2017).

Collaboration between NGO and medical communities is a critical first step to reframing the way LGBT health topics are discussed or included in graduate medical education; the same story applies to Lebanon. To pilot these efforts, I recommend that the efficient and well-

connected network of NGOs in Lebanon collectively contact the American University of Beirut (AUB) School of Medicine, and one partnering healthcare institution, with a resolution to address the lack of LGBT competency among physicians and the resulting disparities in LGBT health. By building allyship with leading academic institutions in the region, NGOs in Lebanon may begin to see an expansion of funding and support for continuing research. Given that there was no standardized approach to confidentiality, as reported by most LGBT-friendly physicians, improved training and NGO collaboration could foster a shared goal to reduce LGBT-related discrimination and stigma in Lebanese healthcare.

Interpersonal-Level

As was suggested by participants, we recommend that LGBT-friendly providers be placed at the frontlines of expanding LGBT health awareness among their patients. This would be helpful in securing patient-provider relationships that are built on trust and comprehensive education. The Pedagogy of Action (POA) Program of the University of Michigan, created by Dr. Nesha Haniff, is a transformative educational process that focuses on learner self-empowerment and teacher critical self-reflection (https://sites.lsa.umich.edu/nzh/, 2015). POA philosophies have been used to inform different health education projects, the most popular being the Oral Methodology for HIV/AIDS Education Module (https://sites.lsa.umich.edu/nzh/, 2015). Specific POA approaches that could be usefully employed in Lebanese healthcare include training providers on how to disseminate health awareness to their patients in a way that fosters sustainability and ownership of one's own health. Additionally, this program would encourage physicians to critically reflect on the teacher-learner power dynamic; in this way, POA promotes an egalitarian relationship in which the provider and the LGBT patient are both *learners* and *experts* of LGBT health (Haniff 2005). These ideas were constructed by Dr. Haniff, who heavily incorporated Paulo Freire's "Pedagogy of the Oppressed" and his teachings on social justice theory and self-empowerment (https://sites.lsa.umich.edu/nzh/, 2015). By

integrating themes like critical reflection, self-empowerment, and knowledge ownership into the patient-provider relationship, and by centering LGBT-friendly providers as community educators, patient advocacy in Lebanon will transform to include interdisciplinary collaboration involving all stakeholders in LGBT health.

Furthermore, continuing the creation of informative and accessible tools is key to ensuring LGBT health needs are met. Due to LebMASH's personal relationship with the LGBT community, tools like LebGUIDE have been disseminated throughout the LGBT community via community centers/LGBT safe spaces and social media marketing. LGBT individuals living in Lebanon now have access to a list of providers in Lebanon who are officially confirmed as "LGBT-friendly," easing the challenge of seeking LGBT-friendly healthcare. However, as voiced by both activists and patients, insufficient funding and capacity of NGOs complicates the efficiency of their marketing and outreach to the LGBT community. I therefore recommend that current funders like the U.S. Embassy in Beirut continue their support for grassroots NGOs in Lebanon, like LebMASH, and increase their funding to further academic research and coverage of services. This will increase visibility of local NGOs and the extraordinary strides they have and continue to make, therefore maximizing the potential reach of NGO-prepared support and services.

Conclusion/Future Implications

Despite the lack of comprehensive research on Arab/Middle Eastern queer identity statistics, pro-LGBT activism in the region has witnessed an exponential growth in fervor and publicity. Countries such as Turkey, Iran, and Lebanon are making headway in the gradual cultural shift toward tolerance and LGBT acceptance. In Lebanon, grassroots organizations like LebMASH and Marsa are among the local leaders in LGBT health awareness and social/legal advocacy. They have collaboratively created and disseminated a wide array of educational tools that inform the LGBT community of their own health and existing resources throughout Lebanon/Middle East (i.e. LebGUIDE). In addition to the work done by NGOs to uplifting the queer narrative and identity, it is critical to also engage the academic and medical communities in LGBT patient advocacy. NGOs throughout Lebanon, including Meem, Nasawiya, Helem, and Sawt Al-Niswa (Feminist Voices), are currently working to expand their reach on LGBT patients and improve healthcare by engaging the medical community for a thoroughly-informed approach toward eliminating these egregious disparities. Overall, Lebanese scholars, activists, and physicians are calling for collaborative engagement between the Lebanese medical community and NGOs like LebMASH who directly serve the LGBT community (Byne 2014; Wright et al 2017).

Due to its normalization in society and among providers, many patients often expect stigmatic treatment in healthcare. As a result of its normalization, discrimination in healthcare is often ignored by systems of justice. There is a critical need for an LGBT-centered *training and education* for healthcare providers in Lebanon that intervenes on the dangerously myopic methods of the past. This cohesive approach would work toward reconciling the relationship between empirical evidence and the *socio-cultural factors* identified, fostering an inclusive framework for tackling inequalities in the Lebanese healthcare system.

Appendices

Appendix A: Interview guide for the NGO stakeholders/activists

Questions pertaining to healthcare providers/system in Lebanon

*In your opinion as a stakeholder:

1- What constitutes an LGBT-friendly healthcare provider?
    a. Could you list some of the criteria that LGBT-friendly healthcare providers have/employ in their practice?
    b. Do you think these criteria can motivate LGBT people to visit healthcare providers?
2- What types of violations of the healthcare code of conduct have you received from beneficiaries you work with?
    a. What are the most commonly reported violations?
    b. How do you think this affects LGBT-people's visiting healthcare providers?
3- How can the healthcare system in Lebanon be improved to be more LGBT-friendly?
4- What can healthcare providers do to show LGBT-friendliness?

Appendix B: Interview guide for the LGBT patients

1. Tell me about your positive and negative experiences with the health-care system/providers in Lebanon.
2. Do you feel your gender identity and/or sexual orientation affected your experience with health-care providers in Lebanon? If so, how?
3. If you are discriminated against because of your gender identity and/or sexual orientation, what kind of discrimination do you face?
4. Ideally speaking, how would you like your experience with the health-care system/providers to be?
5. What do you think are the two biggest challenges of visiting a health-care provider as an LGBT patient?

Appendix C: Phase 2: Interview guide for LGBT-friendly physicians

[First phase of the project was the survey. Based on your answers and your consent to being contacted again, we are reaching out for phase 2 which is a brief interview to better understand your reception of LGBT clients. Disclaimer: we are not assessing your medical knowledge or judging the quality of your practice; we just want to understand how you receive LGBT patients. Disclaimer: we are not assessing your medical knowledge or judging the quality of your practice; we just want to understand how you receive LGBT patients. Any questions before we begin?]

The suggested questions are below:

- Can you tell me what are your thoughts and attitudes regarding attending to the medical needs of sexual minorities, such as LGBT people?
- How do you ensure that your clients are being treated respectfully, in a non-discriminatory manner? Do you have any policies, do you train your staff about these things, etc.?
- Are you willing to tailor your intake/admission forms in order to be more inclusive of sexual minorities? Are you willing to add questions regarding sexual orientation and/or gender identity?
- How much do you think your education and training have prepared you to deal with LGBT health topics? Are you willing to undergo training? What kind of training would you like to receive? (e.g. Workshop, online courses, etc.)
- What are some of the steps/standards that you follow in order to ensure confidentiality and privacy of your clients? Are they standardized or do they vary according to the client? Are they standardized as per your recommendation or as per your organization's recommendation?
- What are some sources that you seek in order to gain information about LGBT health?
- Are there any other healthcare providers that you would recommend for us to reach out to for inclusion in the directory?

References

Abdou, C. M., Fingerhut, A. W., Jackson, J. S., & Wheaton, F. (2016). Healthcare stereotype threat in older adults in the Health and Retirement Study. *American Journal of Preventive Medicine*, **50**(2), 191–198.

The American Heritage dictionary of the English language. (2000). Boston :Houghton Mifflin, Print.

Aronson, J., Burgess, D., Phelan, S. M., & Juarez, L. (2013). Unhealthy interactions: The role of stereotype threat in health disparities. *American Journal of Public Health*, **103**, 50–56.

Bronfenbrenner, Urie (1989). "Ecological systems theory". In Vasta, Ross. Annals of Child Development: Vol. 6. London, UK: Jessica Kingsley Publishers. pp. 187–249.

Burgess, D. J., Warren, J, Phelan, S., Dovidio, J., & van Ryn, M. (2010). Stereotype threat and health disparities: What medical educators and future physicians need to know. *Journal of General Internal Medicine*, **25**, S169–S177.

Byne, W. (2014). Forty years after the removal of homosexuality from the DSM: Well on the way but not there yet.

CDC. (2018). The Social-Ecological Model: A Framework for Prevention. Violence Prevention. Retrieved April 23, 2018, from https://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html

CDC. (2017). Lesbian, Gay, Bisexual, and Transgender Health. Retrieved April 07, 2018, from https://www.cdc.gov/lgbthealth/youth.htm

Clarke V., Braun V. (2014) Thematic Analysis. In: Teo T. (eds) Encyclopedia of Critical Psychology. Springer, New York, NY.

Clínica Especializada Condesa. (2011). Retrieved April 24, 2018, from http://condesadf.mx/

Compton, D. A., & Whitehead, M. B. (2015). Educating Healthcare Providers Regarding LGBT Patients and Health Issues: The Special Case of Physician Assistants. American Journal Of Sexuality Education, 10(1), 101-118.

Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. American journal of public health, 100(10), 1953-1960.

Dean, Tim. (2015). "Queer." Keywords for Disability Studies. Eds. Rachel Adams, Benjamin Reiss and David Serlin. New York: New York University Press.

Definitions: Homophobia, Heterosexism, and Sexual Prejudice. (2012). Retrieved April 24, 2018, from http://psychology.ucdavis.edu/rainbow/html/prej_defn.html

Denton, F. N., Rostosky, S. S., & Danner, F. (2014). Stigma-Related Stressors, Coping Self-Efficacy, and Physical Health in Lesbian, Gay, and Bisexual Individuals. Journal Of Counseling Psychology, 61(3), 383-391.

Dilley, J. A., Simmons, K. W., Boysun, M. J., Pizacani, B. A., & Stark, M. J. (2010). Demonstrating the importance and feasibility of including sexual orientation in public health surveys: health disparities in the Pacific Northwest. American journal of public health, 100(3), 460-467.

Emlet, C. A. (2016). Social, Economic, and Health Disparities Among LGBT Older Adults. Generations, 40(2), 16-22.

Fingerhut, A. W., & Abdou, C. M. (2017). The Role of Healthcare Stereotype Threat and Social Identity Threat in LGB Health Disparities. Journal Of Social Issues, 73(3), 493-507.

Fish, J., & Bewley, S. (2010). Using human rights-based approaches to conceptualise lesbian and bisexual women's health inequalities. Health & Social Care In The Community, 18(4), 355-362.

Fredriksen-Goldsen, K. I., Kim, H. J., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013a). Health

disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. American journal of public health, 103(10), 1802-1809.
Fredriksen-Goldsen, K. I., Cook-Daniels, L., Kim, H. J., Erosheva, E. A., Emlet, C. A., Hoy-Ellis, C. P., ... & Muraco, A. (2013b). Physical and mental health of transgender older adults: An at-risk and underserved population. The Gerontologist, 54(3), 488-500.
Fredriksen-Goldsen, K. I., Hyun-Jun, K., Chengshi, S., & Bryan, A. B. (2017). Chronic Health Conditions and Key Health Indicators Among Lesbian, Gay, and Bisexual Older US Adults, 2013-2014. American Journal Of Public Health, 107(8), 1332-1338.
Gereige, J. D., Zhang, L., & Boehmer, U. (2018). The Sexual Health of Women in Lebanon: Are There Differences by Sexual Orientation?. LGBT health, 5(1), 45-53.
Håkansson, M., Oguttu, M., Gemzell-Danielsson, K., & Makenzius, M. (2018). Human rights versus societal norms: a mixed methods study among healthcare providers on social stigma related to adolescent abortion and contraceptive use in Kisumu, Kenya. *BMJ global health*, *3*(2), e000608.
Haniff, N. Z. (2005). The Pedagogy of Action. MPublishing, University of Michigan Library Passages. Retrieved April 24, 2018, from http://hdl.handle.net/2027/spo.4761530.0010.022
Harbin, A., Beagan, B., & Goldberg, L. (2012). Discomfort, judgment, and health care for queers. Journal of bioethical inquiry, 9(2), 149-160.
Harris Interactive Poll. (2005). New national survey shows top causes for delay by lesbian in obtaining health care. Retrieved from http://www.prnewswire.com/news-releases/new-national-survey-shows-financial-concerns-and-lack-of-adequate-health-insurance-are-top-causes-for-delay-by-lesbians-in-obtaining-health-care-54217237.html
Henley, A. D. (2016). Religious Authority and Sectarianism in Lebanon. Retrieved April 23, 2018, from https://carnegieendowment.org/2016/12/16/religious-authority-and-sectarianism-in-lebanon-pub-66487
Hollenbach, A. D., Eckstrand, K. L., & Dreger, A. (Eds.). (2014). LGBT DSD health. Retrieved July 31, 2015, from http://offers.aamc.org/lgbt-dsd-health
Holthouser, A., Sawning, S., & Leslie, K. (2017). EQuality: A Process Model to Develop an Integrated, Comprehensive Medical Education Curriculum for LGBT, Gender Nonconforming, and DSD Health. Medical Science Educator, 27(2), 371-383.
Internalized Homophobia | Revel & Riot. (2018). Retrieved April 23, 2018, from http://www.revelandriot.com/resources/internalized-homophobia/
International Gay and Lesbian Human Rights Commission (23 April 2003). "Mexico protects its gay and lesbian citizens with new law". Retrieved 23 April 2018.
Jackson, S. (Ed.). (1999). Heterosexuality in question. Sage.
Meem. (2010). Arab Queer Women and Transgenders Confronting Diverse Religious Fundamentalisms: The Case of Meem in Lebanon. Retrieved 23 April 2018 from http://www.wluml.org/sites/wluml.org/files/Arab%20Queer%20Women%20and%20Transgenders%20Confronting%20Diverse%20Religious%20Fundamentalisms_The%20Case%20of%20Meem%20in%20Lebanon.pdf
Meyer, I. H. (2003). Prejudice, social stress and mental health in lesbian, gay, bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129, 674–697.
Meyer, I. H., & Dean, L. (1998). Internalized Homophobia, Intimacy, and Sexual Behavior among Gay and Bisexual Men. Stigma and Sexual Orientation: Understanding Prejudice against Lesbians, Gay Men, and Bisexuals, 160-186.
Jaffee, K. D., Shires, D. A., & Stroumsa, D. (2016). Discrimination and delayed health care among transgender women and men. Medical Care, 1.
Kann L, Olsen EO, McManus T, et al. Sexual Identity, Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9-12 – United States and Selected Sites, 2015. MMWR Surveill Summ 2016; 65(9): 1-202.

Krisberg, K. (2016). New Curricula Help Students Understand Health Needs of LGBT Patients. AAMC News. Retrieved April 23, 2018 from https://news.aamc.org/diversity/article/bring-lgbt-patient-care-medical-schools/

Lebanese Medical Association for Sexual Health. (2017). Retrieved April 23, 2018, from https://www.lebmash.org/

Makarem, G. (2011). The story of Helem. Journal of Middle East Women's Studies, 7(3), 98-112.

Mehringer, J., Bacon, E., Cizek, S., Kanters, A., & Fennimore, T. (2013). Preparing future physicians to care for LGBT patients: a medical school curriculum. MedEdPORTAL Publications, 9, 9342.

Mexico: Mexico Becomes the Second Country in Latin America to Provide National Anti-Discrimination Protection for LGBTs. (2012, August 14). Retrieved April 24, 2018, from https://www.outrightinternational.org/content/mexico-mexico-becomes-second-country-latin-america-provide-national-anti-discrimination

Mohr, J. J., Chopp, R. M., & Wong, S. J. (2013). Psychotherapists' stereotypes of heterosexual, gay, and bisexual men. *Journal of Gay & Lesbian Social Services*, 25, 37–55.

Naber, N., & Zaatari, Z. (2014). Reframing the war on terror: Feminist and lesbian, gay, bisexual, transgender, and queer (LGBTQ) activism in the context of the 2006 Israeli invasion of Lebanon. Cultural Dynamics, 26(1), 91-111.

Obedin-Maliver, J., Goldsmith, E. S., Stewart, L., White, W., Tran, E., Brenman, S., ... Lunn, M. R. (2011). Lesbian, gay, bisexual, and transgender–related content in undergraduate medical education. JAMA, 306(9), 1–7.

Paul, M., Näsström, S. B., Klingberg-Allvin, M., Kiggundu, C., & Larsson, E. C. (2016). Healthcare providers balancing norms and practice: Challenges and opportunities in providing contraceptive counselling to young people in Uganda – a qualitative study. Global Health Action, 9(1), 30283.

Pearce, L. (2017). MAKING NURSE EDUCATION LGBT-FRIENDLY. Nursing Standard, 31(23), 22-24.

Pedagogy of Action: Attempting to Transform Ourselves and Our World Through the Process of Teaching a Simple Oral HIV Module. (2015). Retrieved April 24, 2018, from https://sites.lsa.umich.edu/nzh/

Rabasa, A. P. (2016). From Representation to Corposubjectivation. TSQ: Transgender Studies Quarterly, 3(3-4), 388-411.

Rizk, A., & Makarem, G. (2015). Masculinity-under-threat": Sexual rights organizations and the masculinist state in Lebanon. Civil Society Review, 1, 97-108.

Sanchez, M. (2016). Transgender People in Mexico City Resort to Dangerous Unsupervised Procedures. Retrieved April 23, 2018, from https://globalpressjournal.com/americas/mexico/transgender-people-mexico-city-resort-dangerous-unsupervised-procedures/

Sexton, P., Flores, D., & Bauermeister, J. (2018). Young sexual minority women's definition of community:
Toward addressing health disparities in the LGBTQQ community. Journal Of Community Psychology, 46(1), 133-145.

Shindel, A. W., Baazeem, A., Eardley, I., & Coleman, E. (2016). Sexual health in Undergraduate medical education: Existing and future needs and platforms. The Journal of Sexual Medicine, 13(7), 1013–1026.

Simoni, J. M., Smith, L., Oost, K. M., Lehavot, K., & Fredriksen-Goldsen, K. (2017). Disparities in Physical Health Conditions Among Lesbian and Bisexual Women: A Systematic Review of Population-Based Studies. Journal Of Homosexuality, 64(1), 32-44.

Sinclair, A. (2017). "It's a real negotiation within yourself": Women's stories of challenging heteronormativity within the habitus. Women's Studies International Forum, 641-9.

Somerville, Siobhan B.. (2014). "Queer." Keywords for American Cultural Studies, Second Edition. Eds. Bruce Burgett and Glenn Hendler. New York: New York University Press. 203. Print.

Steele, L. S., Tinmouth, J. M., & Lu, A. (2006). Regular health care use by lesbians: A path analysis of predictive factors. *Family Practice*, **23**, 631–636.

Steele, C. M. (1997). A threat in the air: How stereotypes shape intellectual identity and performance. *American Psychologist*, 52, 613–629.

Steele, C. M., & Aronson, J. (1995). Stereotype threat and the intellectual test performance of African Americans. *Journal of Personality and Social Psychology*, 69, 797–811.

Stokols, D (1996). "Translating social ecological theory into guidelines for community health promotion". Am J Health Promot. 10: 282–98.

Utamsingh, P. D., Kenya, S., Lebron, C. N., & Carrasquillo, O. (2017). Beyond Sensitivity. LGBT Healthcare Training in U.S. Medical Schools: A Review of the Literature. American Journal Of Sexuality Education, 12(2), 148-169.

van Dam, M. A., Koh, A. S., & Dibble, S. L. (2001). Lesbian disclosure to health care providers and delay of care. *Journal of the Gay and Lesbian Medical Association*, **5**, 11–19.

Vera-Bachmann, D., & Salvo, S. (2016). Cierre de escuelas rurales y salud colectiva. Salud Pública De México, 58(2), 4-5.

Wallace, S. P., Cochran, S. D., Durazo, E. M., & Ford, C. L. (2011). The health of aging lesbian, gay and bisexual adults in California. Policy Brief (UCLA Center for Health Policy Research), 1.

Wright, K., Peplinski, B., Abboud, S., & Harfouch, O. (2017). A Stakeholder Analysis of the Current Lebanese Context for Transgender Healthcare: The Perspectives of Non-Governmental Organizations. Retrieved from https://www.lebmash.org/stakeholder-analysis-current-lebanese-context-transgender-healthcare-perspectives-non-governmental-organizations/

Zúñiga, P. U., Rodríguez, C. M., García, E. B. (1998). "AIDS in Mexico". The Boda. Complete HIV/AIDS Resource.