

INTERSECTIONS

2.0

A deep dive into the
FRA LGBTIQ III Survey
results on Health

INTRODUCTION

In its 2023 LGBTIQ III Survey, the European Agency for Fundamental Rights (FRA), which had over 100,000 LGBTIQ respondents from the 27 EU Member States plus Albania, North Macedonia, and Serbia, asked respondents about their health using several questions, 10 of which are explored below. These questions asked about experiences in healthcare (C1 subpart D, C14, C15), health in general (G16, G17, G18), mental health (H3, H4), and cancer, HIV, and the respective screenings and treatments for these conditions (H5, H6). These questions were chosen to focus on experiences in health and current health status.

This briefing looks deeper into the responses to the questions on health, assessing the prevalence of various health issues and correlations of these issues to other experiences among the respondents.

BACKGROUND & METHODOLOGY

The purpose of this analysis was to determine which personal characteristics (e.g. sexual orientation, gender identity, sex characteristics, other minority status) correlate with health outcomes and to build probability profiles for those experiencing intersectional marginalisation.

To understand the respective prevalence, a Reference Profile was created based on two factors: the respondent type with the lowest exposure to conversion practices, relatively, and respondent type with the largest number of responses. These two factors led to a Reference Profile which is a cisgender endosex^[1] lesbian aged 55 or older with no history of suicidal ideation, very good health, tertiary education, no other minority statuses reported, and who is able to make ends meet easily. This Reference Profile allows for establishment of respective prevalence of various experiences among the respondent population – in most cases, the Reference Profile is more likely to have those experiences, and in a few cases, less. The Reference Profile was then used to develop odds ratios to others.

For example, if 5% of Group 1, the Reference Profile, (all cisgender endosex lesbians aged 55 or older with no history of suicidal ideation, very good health, tertiary education, no other minority statuses reported, and who are able to make ends meet easily) experienced discrimination in a health setting, the odds ratio tells us how much more or less likely persons in Group 2 (all **trans** endosex lesbians aged 55 or older with no history of suicidal ideation, very good health, tertiary education, no other minority statuses reported, and who are able to make ends meet easily) were to have experienced the same discrimination. Thus, if the odds ratio is 120% (compared to Group 1), one can extrapolate that 11% of Group 2 persons ($5\% + (120\% \times 5\%) = 5\% + 6\% = 11\%$) have experienced discrimination in a health setting.

[1] “Endosex” refers to persons who do not have variations of sex characteristics that differ from the male or female norms; in other words, to a person who is not intersex.

EXPERIENCES IN HEALTHCARE

To analyse experiences of difficulty in gaining access to healthcare, Figure 1 shows the probability of various respondent groups experiencing discrimination in healthcare or social services or not using/avoiding these services. Notably, while not using these services is relatively high for cis women and non-binary people, cis men and trans men were more likely to use these services and also to experience discrimination in these contexts.

FIGURE 1 LIKELIHOOD OF EXPERIENCING DISCRIMINATION IN HEALTHCARE OR SOCIAL SERVICES OR AVOIDING HEALTHCARE DURING THE PRECEDING 12 MONTHS (CI_D)

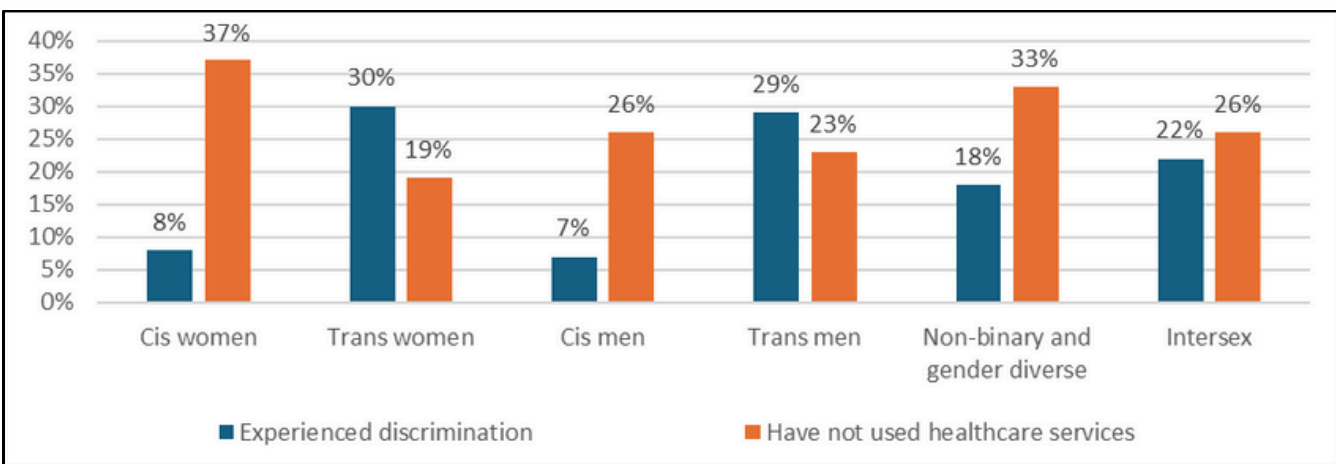


Table 1 shows how various trans experiences (having trans-specific healthcare (TSHC), avoiding expressing one’s gender for fear of reprisals, and having legal gender recognition (LGR)) impact whether a trans person has experienced discrimination in healthcare settings in the last 12 months or whether they have avoided healthcare during that period.

TABLE 1 EXPERIENCE OF FEELING DISCRIMINATED IN HEALTHCARE DURING THE LAST 12 MONTHS (CI_D) AMONG TRANS MEN AND TRANS WOMEN RESPONDENTS, DISAGGREGATED# BASED ON IF RESPONDENTS HAVE HAD ANY TRANS-SPECIFIC HEALTHCARE INTERVENTIONS (TR1), AVOID EXPRESSING THEIR GENDER (TR5) AND HAVE HAD LEGAL GENDER RECOGNITION (TR6)

| | | All trans respondents | Have you had any kind of intervention to change your body so it better matches your gender identity? | | Have you had your legal gender changed? | | |
|--|-------------|-----------------------|--|-----|---|-----|---------------------|
| | | | Yes | No | Yes | No | I am in the process |
| Yes, felt discriminated in healthcare | Trans men | 29% | 58% | 42% | 32% | 49% | 19% |
| | Trans women | 30% | 76% | 24% | 48% | 33% | 19% |
| Have not sought healthcare in the last 12 months | Trans men | 23% | 20% | 80% | 9% | 83% | 8% |
| | Trans women | 19% | 32% | 68% | 12% | 78% | 11% |
| All EU trans respondents | Trans men | - | 48% | 52% | 29% | 56% | 15% |
| | Trans women | - | 59% | 41% | 36% | 49% | 15% |

Note that percentages in the body of the table sum to 100% for each row. In other words, among trans men who felt discriminated in healthcare, 58% have had an intervention to change and 42% have not.

Notably, those who have had TSHC and those who have had LGR are more likely than all trans respondents to have experienced discrimination and less likely to have avoided healthcare services. Trans people who have had neither TSHC nor LGR are more likely to have avoided healthcare services. Interpreting these data is rather complex, because it appears that while TSHC and LGR make respondents more likely to seek healthcare services, they also increase their exposure to negative experiences in healthcare settings. The increased exposure to negative experiences could be simply because of seeking more healthcare, or because TSHC and LGR increase the likelihood of negative experiences, or a combination of both.

Table 2 looks into the phenomenon of feeling discriminated in healthcare or social services settings for intersex respondents, and cross-references this with intersex-specific experiences of type of variation of sex characteristics (IX1), having received a diagnosis (IX3), and having undergone interventions on their sex characteristics (IX6).

TABLE 2 EXPERIENCE OF FEELING DISCRIMINATED IN HEALTHCARE DURING THE LAST 12 MONTHS (CI_D) AMONG INTERSEX RESPONDENTS, DISAGGREGATED# BASED ON WHAT KIND OF VARIATION OF SEX CHARACTERISTICS THEY HAVE (IX1), IF RESPONDENTS HAD THEIR VARIATION DIAGNOSED BY A MEDICAL PROFESSIONAL (IX3), AND HAVE HAD MEDICAL TREATMENTS TO MODIFY THEIR SEX CHARACTERISTICS (IX6)

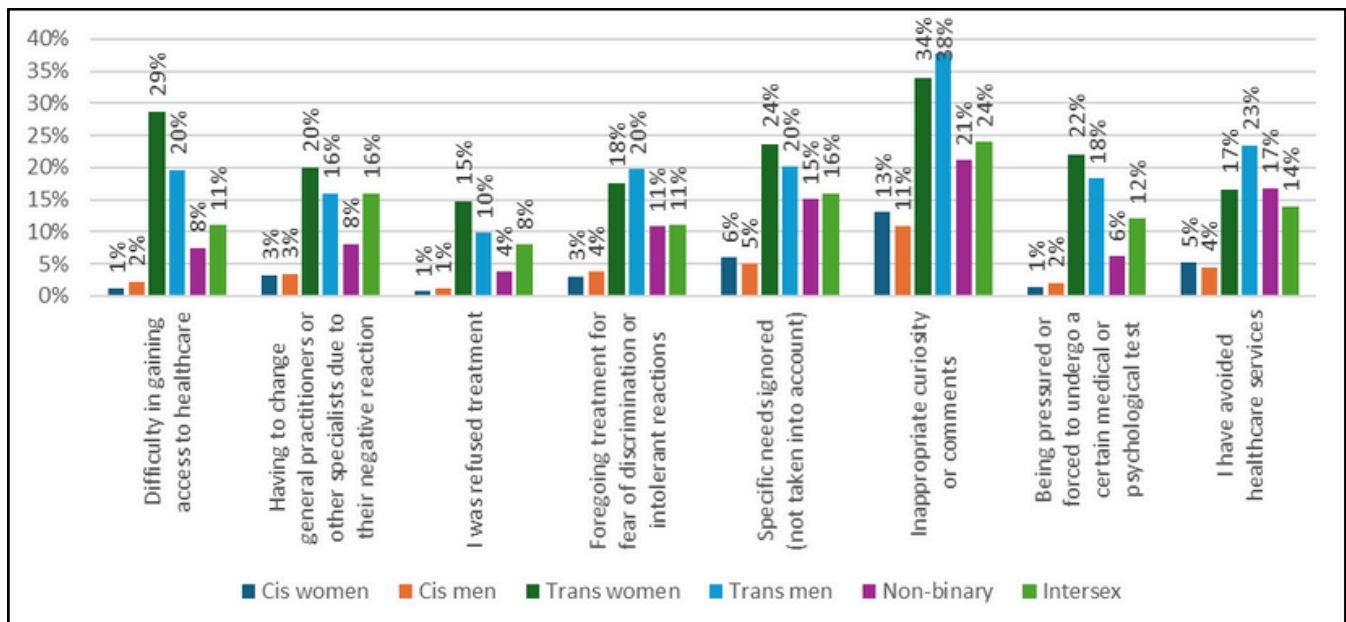
| | All intersex respondents | What type of variation of sex characteristics do you have (or were you treated for)? | | | Was your variation of sex characteristics determined by medical professionals? | | Have you had any medical treatment or intervention to modify your sex characteristics? |
|--------------------------|---|--|--------------------------------------|---|--|--|--|
| | Experience of feeling discriminated in healthcare during the last 12 months | Sexual anatomy and/or reproductive organs | Chromosomes and/or hormonal patterns | Secondary characteristics and anatomical features | Yes, a specific diagnosis and clear information was provided | Yes, but I did not get a specific diagnosis and/or clear information | Yes |
| Yes | 21% | 18% | 43% | 49% | 21% | 41% | 37% |
| No | 52% | 13% | 29% | 31% | 19% | 23% | 22% |
| Haven't done this | 26% | 9% | 19% | 25% | 11% | 12% | 10% |
| All intersex respondents | - | 13% | 28% | 32% | 18% | 23% | 22% |

Note that percentages in the body of the table are percentages based on all respondents in that same row. In other words, among intersex persons who felt discriminated in healthcare, 21% received a clear diagnosis from a medical professional.

Those who experienced discrimination in healthcare or social services settings in the past 12 months were over-represented among intersex people with chromosomal, hormonal variations or variations related to their secondary sex characteristics or anatomical features, as well as among those who did not receive a specific diagnosis for their variation or the information they received was unclear, and those who had undergone interventions. All of these groups were additionally underrepresented among intersex respondents who had not had contact with healthcare or social services in the previous 12 months.

Figure 2 dives further into the phenomenon of discrimination in healthcare settings, revealing what kinds of difficulties respondents faced in these contexts (C14). Trans women were the most likely to have experienced difficulty in gaining access to healthcare, having to change practitioners, being refused treatment, having their specific needs ignored, and being pressured or forced into treatments. Trans men were the most likely to have foregone treatments for fear of discrimination, experienced inappropriate curiosity or comments, or avoided healthcare settings entirely. Among all groups, the most common experience was of inappropriate curiosity or comments. Cis men and women had much lower exposure to all negative experiences than trans, non-binary, or intersex respondents.

FIGURE 2 KINDS OF DIFFICULTIES EXPERIENCED WHEN TRYING TO ACCESS HEALTHCARE (C14) BY GENDER IDENTITY AND SEX CHARACTERISTICS



To build on this, Table 3 used the Reference Profile to build a model for relative exposure to difficulty in accessing healthcare among various groups. As various kinds of marginalisation are added, the likelihood of experiencing difficulties increases radically, with highly vulnerable trans people (those who have a disability, are of an ethnic minority, experience economic difficulties, have bad health, and are of a minority religion) being nearly 100 times more likely than cis people without these marginalisations to have this experience. Notably, being trans in itself is a significant factor, for setting all else equal, across all models, trans women are the most likely to experience difficulties, with trans men somewhat less likely but still much more likely than all cis people regardless of gender.

TABLE 3 ESTIMATE OF THE PROBABILITY OF HAVING DIFFICULTY IN GAINING ACCESS TO HEALTHCARE BY LGBTIQ GROUP, WITH RESPECT TO THE REFERENCE PROFILE (CI4)

| Intersectional Profile | All trans women | Lesbian trans women | Bisexual trans women | Straight trans women | All trans men | Gay trans men | Bisexual trans men | Straight trans men |
|---|-----------------|---------------------|----------------------|----------------------|---------------|---------------|--------------------|--------------------|
| A – Disability + ethnic minority + economic hardship | 15.2 | 15.6 | 13 | 9.6 | 6.8 | 7.9 | 8.7 | 7.5 |
| B – Ethnic minority + economic hardship + very bad health + minority religion | 24.9 | 27.5 | 23.5 | 18.1 | 12.1 | 14.8 | 16 | 14.8 |
| C – Highly vulnerable (all factors present) | 95.6 | 96.1 | 95.4 | 93.7 | 91.8 | 92.4 | 93.4 | 92.1 |
| Intersectional Profile | All cis women | Lesbian cis women | Bisexual cis women | - | All cis men | Gay cis men | Bisexual cis men | - |
| A – Disability + ethnic minority + economic hardship | 1 | 1 | 1 | - | 1.2 | 1.4 | 1.2 | - |
| B – Ethnic minority + economic hardship + very bad health + minority religion | 1.3 | 1.5 | 1.2 | - | 2.6 | 2.8 | 2.5 | - |
| C – Highly vulnerable (all factors present) | 43.6 | 52.9 | 42.1 | - | 65.1 | 67.1 | 62.5 | - |

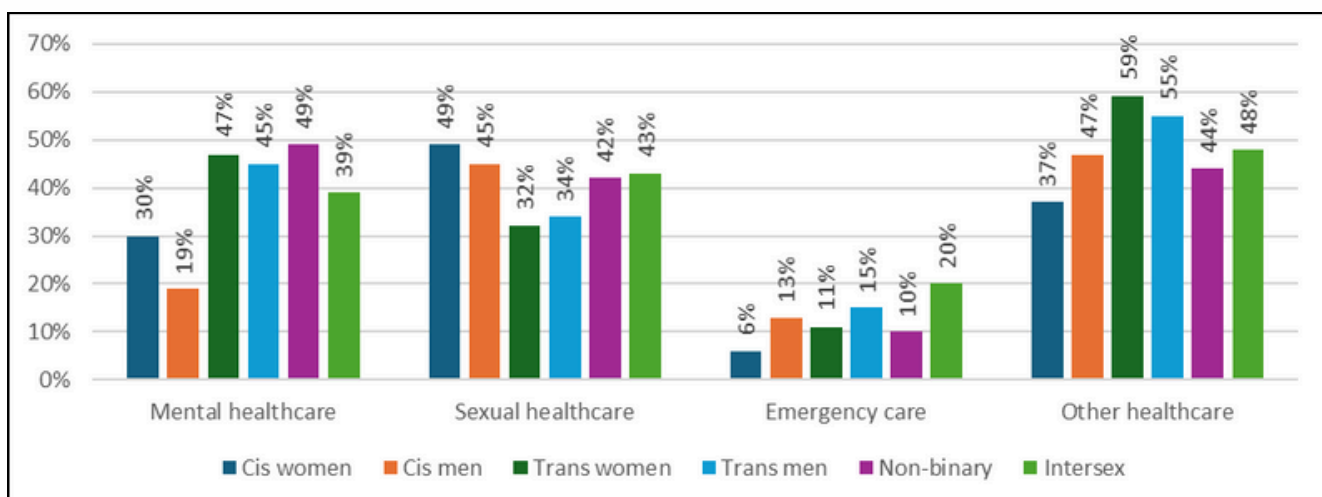
The risk matrix in Table 4 highlights the power of the intersectional approach in understanding health inequalities. Trans people, particularly trans women with “less normative” sexual orientations, face increased risk resulting from the combination of multiple axes of vulnerability. Data indicates that gender identity and sexual orientation act as structural discriminatory factors even when the same socio-health conditions are present.

TABLE 4 ESTIMATE OF THE PROBABILITY OF HAVING DIFFICULTY IN GAINING ACCESS TO HEALTHCARE (C14) BY INTERSECTIONAL PROFILES

| Profile | Lesbian trans women | Severe disability | Ethnic minority | Economic difficulty | Avoids openness in healthcare | Open to all medical staff | Tertiary education | Age 25-39 | Very bad health | Minority religion | Estimated probability (%) | Relative to Reference profile |
|--|---------------------|-------------------|-----------------|---------------------|-------------------------------|---------------------------|--------------------|-----------|-----------------|-------------------|---------------------------|-------------------------------|
| A – Baseline (reference profile) | - | - | - | - | - | - | - | - | - | - | 0.25% | - |
| A.1 – Trans lesbian | X | - | - | - | - | - | - | - | - | - | 2.6% | 10.4 |
| B – Economic hardship | X | - | - | X | - | - | - | - | - | - | 5.6% | 22.4 |
| C – Openness + educated | X | - | - | - | - | X | X | - | - | - | 11.2% | 44.8 |
| D – Disability + ethnic minority + very bad health | X | X | X | - | - | - | - | - | X | - | 21.4% | 85.6 |
| E – Avoids openness + fully out to healthcare staff | X | - | - | - | X | X | - | - | - | - | 26.7% | 106.8 |
| F – Ethnic minority + economic hardship + average age + | X | - | X | X | - | X | - | X | - | - | 40.5% | 162 |
| G – Ethnic minority + economic hardship + average age + openness + minority religion | X | - | X | X | - | X | - | X | - | X | 45.9% | 183.6 |
| H – Highly vulnerable (all factors present) | X | X | X | X | X | X | X | X | X | X | 96.1% | 384.4 |
| H.1 – Highly vulnerable (all factors present) except trans | - | X | X | X | X | X | X | X | X | X | 70.0% | 280 |

Finally, regarding experiences in healthcare, the Survey asked respondents about in which kinds of healthcare (mental, sexual, emergency, other) they experienced difficulties, displayed in Figure 3; respondents could choose more than one answer. It is remarkable how different various groups are in their exposures across healthcare sectors, and also quite notable that more than 10% of cis men, trans and non-binary people, and intersex people all experienced difficulties even in emergency care, which points to serious structural issues across healthcare systems that make LGBTI people less likely to seek care even in emergency situations for fear of discrimination.

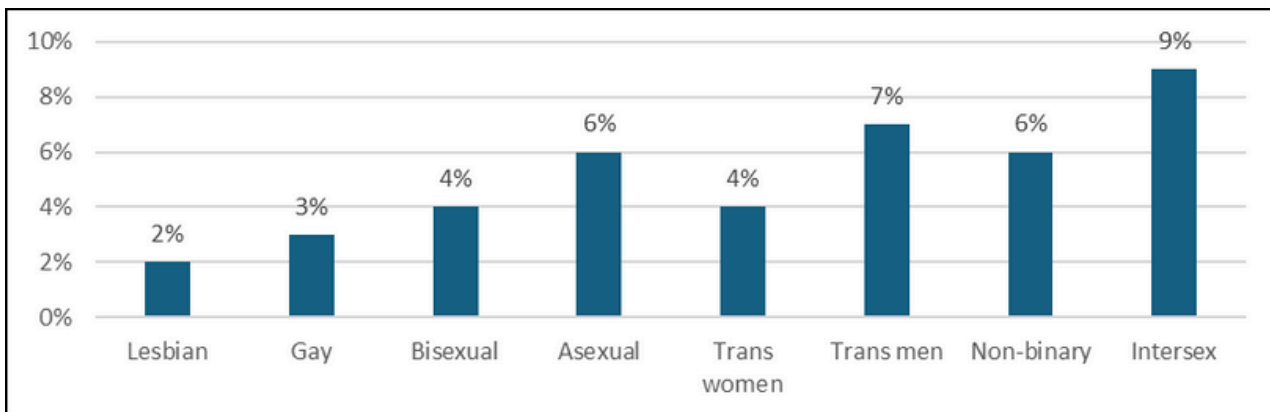
FIGURE 3 TYPES OF HEALTHCARE WHERE DIFFICULTIES WERE EXPERIENCED (C15) BY GENDER IDENTITY AND SEX CHARACTERISTICS



PERCEIVED HEALTH STATUS AND ACTIVITY LIMITATIONS

Respondents were asked to rank their health status from very bad to very good; while 0% of all cis respondents across various sexual orientations chose “very bad”, 1% of trans women and non-binary people, 2% of trans men, and 3% of intersex people chose this option. However, factoring in socioeconomic status has a large impact, as Figure 4 shows, with respondents across all sexual orientations, gender identities, and sex characteristics who make ends meet only with “great difficulty” having notable percentages who describe their health in general as “very bad”.

FIGURE 4. PERCEIVED HEALTH STATUS “VERY BAD” (G16) OF RESPONDENTS WHO HAVE “GREAT DIFFICULTY” MAKING ENDS MEET (G19)



Alarming, 47% of trans women, 48% of asexual people, 49% of trans men, 52% of non-binary people, and 55% of intersex people report having a longstanding illness or health problems (G17).

SUICIDAL IDEATION & ATTEMPTS

The Survey asked respondents about their current mental health via 4 questions, 2 of which are explored in this report – one asking if respondents had thought of committing suicide in the past year (H3) and another if respondents had ever attempted suicide (H4).

Figure 5 and Figure 6 display suicidal ideation and attempts, respectively, by sexual orientation among cis respondents – notably, asexual men and women both had much higher suicidal ideation in the past year than gay, lesbian, or bisexual respondents; however, bisexual women had the highest suicide attempts.

FIGURE 5 SUICIDAL IDEATION (H3) DISAGGREGATED BY SEXUAL ORIENTATION

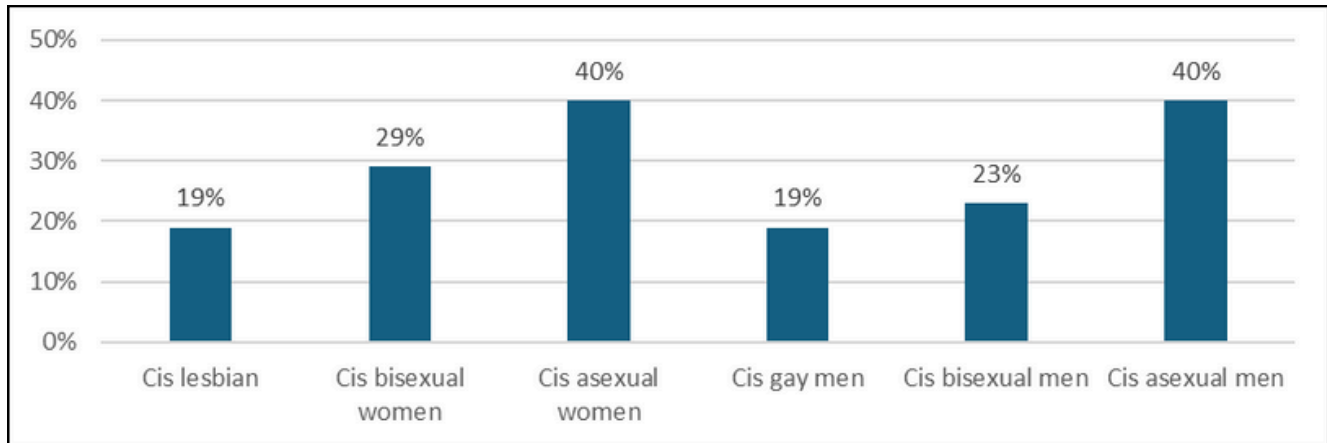


FIGURE 6 SUICIDE ATTEMPTS (H4) DISAGGREGATED BY SEXUAL ORIENTATION

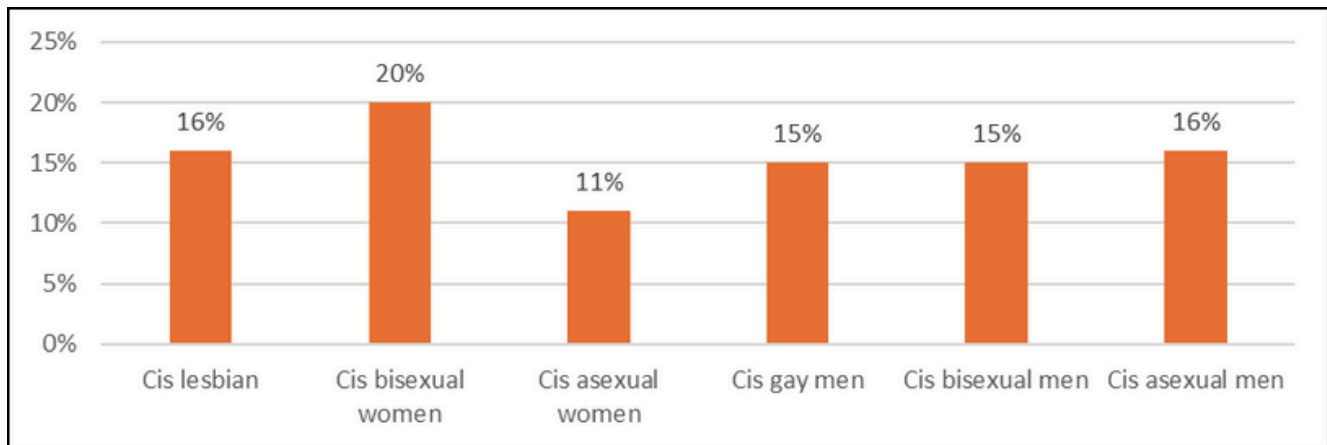


Table 5 displays the factors which have statistically significant impacts on suicidal ideation and/or suicide attempts. Notably, on average all cis men had slightly lower odds of suicidal ideation than cis women (the Reference Profile), where trans women had more than double the odds of suicidal ideation and trans men more than double the odds of suicide attempts.

Age at the time of the survey, health, and ability to make ends meet financially had very large impacts as well. With respect to age, both suicidal ideation and suicide attempts were highest for respondents age 15 to 17, with consistent decreases over time; this may indicate the weight of family and peer pressure faced by LGBTIQ youth, amongst other factors, and points to the positive impact of becoming more independent with age. Regarding health, the worse the health at the time of the survey of a respondent, the higher the odds of suicidal ideation and of a history of suicide attempts, with those reporting “very bad health in general” being more than 9 times as likely to contemplate suicide as those with very good health in general (the Reference Profile).

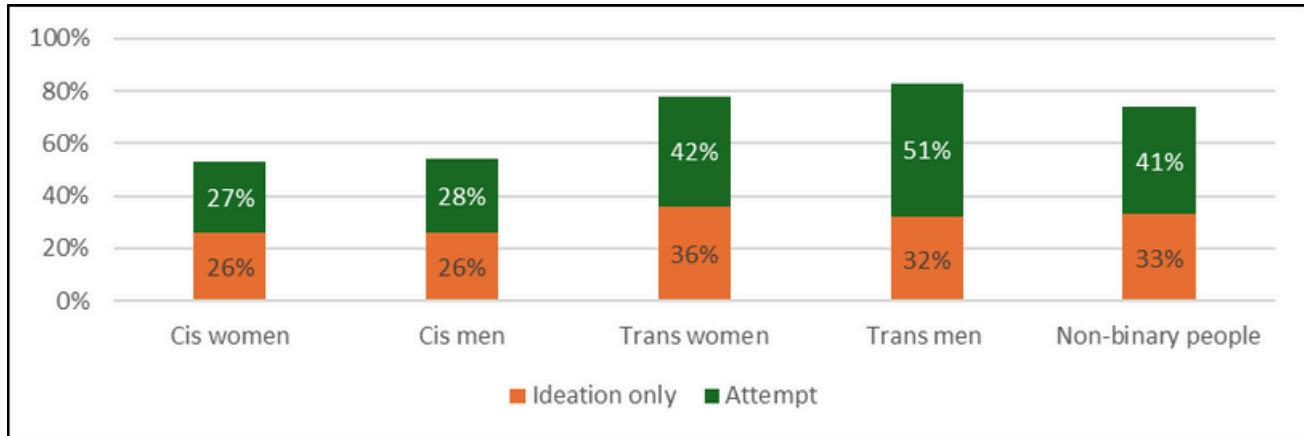
TABLE 5 STATISTICALLY SIGNIFICANT FACTORS¹ CORRELATED WITH CONSENT TO SUICIDAL IDEATION (H3) AND SUICIDE ATTEMPT(S) (H4)

| | Suicidal ideation | | Suicide attempt(s) | |
|--------------------------------|-----------------------------|---------------------------|-----------------------------|---------------------------|
| | Odds ratio (%) [#] | Significance [‡] | Odds ratio (%) [#] | Significance [‡] |
| Cis women (Reference) | - | | - | |
| Cis men | -7% | *** | | |
| Trans women | 136% | *** | 77% | *** |
| Trans men | 64% | *** | 101% | *** |
| Non-binary | 58% | *** | 28% | *** |
| Yes – avoid healthcare | 69% | *** | 37% | *** |
| 15-17 | 746% | *** | 113% | *** |
| 18-24 | 362% | *** | 69% | *** |
| 25-39 | 151% | *** | 23% | *** |
| 40-54 | 62% | *** | 9% | |
| Unemployed | 39% | *** | | |
| Not in work | 8% | *** | -14% | *** |
| Minority in terms of ethnicity | 25% | *** | 16% | *** |
| Asylum seeker or refugee | | | 82% | *** |
| A religious minority | 24% | *** | 41% | *** |
| A person with disability | 8% | * | 45% | *** |
| Good health | 89% | *** | 44% | *** |
| Fair health | 318% | *** | 150% | *** |
| Bad health | 646% | *** | 241% | *** |
| Very bad health | 849% | *** | 343% | *** |
| With great difficulty | 108% | *** | 139% | *** |
| With difficulty | 92% | *** | 101% | *** |
| With some difficulty | 42% | *** | 47% | *** |

[#] Positive odds ratios indicate an increased likelihood of consent; negative indicate a decreased likelihood of consent.
[‡] Significance level indicated by stars; more stars showed higher significance. The table includes only those factors with at least limited statistical significance.

Experiencing discrimination in healthcare settings has a clear correlation with suicidal ideation and attempts as well, though the correlation is not consistent across various groups as Figure 7 reveals. Notably, suicidal ideation and attempts are higher among those who experienced healthcare discrimination regardless of gender compared to all respondents (24% ideation only for all respondents and 18% attempts).

FIGURE 7 RESPONDENTS WHO HAVE EXPERIENCED DISCRIMINATION IN HEALTHCARE SETTINGS, DISAGGREGATED BY GENDER AND HISTORY OF SUICIDAL IDEATION AND/OR SUICIDE ATTEMPT, COMPARED TO ALL RESPONDENTS



Finally, when building intersectional profiles, increased axes of marginalisation had large effects on suicidal ideation and attempts regardless of gender identity, with all complex intersectional profiles (e.g. where a respondent avoids healthcare settings, is young (aged 15 to 17 at the time of the survey), is unemployed, is of an ethnic minority or with a refugee background, has very bad health in general, and makes ends meet only with great difficulty) having nearly 100% estimated probability of suicidal ideation or attempt (97% for cis men and women of this profile, 98% for trans men and non-binary people, and 99% for trans women).

CONTACT WITH SPECIFIC HEALTH SERVICES

The Survey asked respondents about their contact with health services related to cancer and HIV (H5, H6). Specifically, H5 asked about cancer diagnoses and treatments, and H6 about screenings for cancers and HIV. While most groups of respondents had a cancer diagnosis rate of less than 1% in the previous year, this was 1.3% for trans men and 1.6% for intersex people; these groups also had elevated cancer treatment in the last year (1.1% and 1.8%, respectively). These results were not impacted by intersectional marginalisation.

However, when it comes to screenings (H6), there are larger disparities, as while 36% of lesbian women and 41% of bisexual women and pansexual or asexual women had never had a cervical smear test, 57% of trans men had never had one. With respect to HIV, notably while 19% of gay men had never had an HIV test,^[2] 40% of bisexual men had never had one, along with 49% of gay trans men and 20% of heterosexual or straight trans women. While the survey does not allow for assessing the need of these respondents compared to their access to and uptake of various screenings, there remains a clear need to increase both advertising of and access to free or low-cost screenings for cancers and HIV among LGBTI people, with some groups needing potentially targeted efforts to reach sufficient coverage.

[2] The Survey does provide the option for respondents to select “Does not apply to me” on each of the screenings; it is not clear, however, how participants decided if a test applied to them or not and data were not collected to this end.

RECOMMENDATIONS

The data presented in this report yet again confirm^[3] that LGBTI people - and in particular trans, non-binary, and intersex people - experience serious and complex marginalisation in healthcare settings and with respect to their health status. This is further exacerbated for LGBTI people experiencing intersectional marginalisation. As such, it is recommended that:

- 1.** The European Union mainstream LGBTI issues in all health and public policy and ensure that programmes targeting specific conditions account for the needs of LGBTI people.
- 2.** The EU and its member States fund education and training programmes for healthcare professionals to decrease the exposure of LGBTI people to discrimination and other negative experiences in healthcare settings.
- 3.** States support the creation of targeted mental health support services for LGBTI people, including with suicide prevention programmes such as LGBTI-sensitive hotlines.
- 4.** States increase targeted outreach to LGBTI people for cancer screenings based on their specific needs rather than linked only to their gender marker, and ensure that these screenings are available in LGBTI friendly settings.
- 5.** States support community-based and community-led HIV and cancer support programming, including in the frame of combination prevention programmes.
- 6.** States collect and the EU promote the collection and centralisation of disaggregated health data on the grounds of SOGIESC and use these data to build public health policy at the EU and national levels.

[3] Myriad health marginalisations are well-documented, including by the EC-funded Health4LGBTI project; see: https://health.ec.europa.eu/system/files/2020-02/stateofart_report_en_0.pdf

ILGA-Europe is the European and Central Asia Region of the International Lesbian, Gay, Bisexual, Trans & Intersex Association. ILGA-Europe is a membership-based organisation bringing together over 700 organisations from 54 European and Central Asian countries, making it an excellent platform for joint advocacy and movement development. As part of its mandate, ILGA-Europe both advocates for human rights and equality for LGBTI people in Europe and Central Asia and strengthens the LGBTI movement throughout its capacity building programme. www.ilga-europe.org