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The Need for Affirming Health Care among LGBTQ+ Survivors of Intimate Partner Violence

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The Need for Affirming Health Care among LGBTQ+ Survivors of Intimate Partner Violence

Autumn M. Bermea [α] & Tammy L. Henderson [σ]

Abstract- **Lesbian, gay, bisexual, trans, queer, and others who are not heterosexual and cisgender (LGBTQ+) are a growing population in the United States and globally; however, they are more likely to report health conditions while are simultaneously more likely to struggle attaining patient centered or affirming health care. Struggles to receive care are amplified by the lack of formal policy that views health care as a human right. This population is also more vulnerable to several risk factors, including intimate partner violence (IPV) than cisgender and heterosexual people. Therefore, they are more likely to necessitate medical care due to injuries (e.g., broken bones, vaginal trauma, lost teeth). In the absence of macro-level policy protections, we make the case for patient-centered and affirming health care that addresses health inequities and the negative health outcomes for IPV survivors. We provide recommendations for providers in primary care, emergency rooms, obstetrics and gynecology, and dentistry.**

Keywords: abuse, bisexual, constitutional rights, domestic violence, fourteenth amendment, gay, lesbian, medicine, sexual minority, transgender.

I. Introduction

Lesbian, gay, bisexual, trans, queer, and others who are not heterosexual and cisgender (LGBTQ+) comprise a growing population globally (Conron, 2020; Ipsos, 2023). However, they face health disparities wherein LGBTQ+ people report more health conditions than their cisgender (i.e., one whose physiological sex characteristics matches their gender identity) and heterosexual counterparts (Committee on Community-Based Solutions to Promote Health Equity in the United States, 2017). Health equity refers to the nondiscriminatory and just ability to obtain quality health care that counters historical and current injustices, dismantles economic, social, and other hinderances to health and health care; and eradicates avoidable health inequalities (Centers for Disease Control and Prevention, 2022). Despite disproportionate health conditions, LGBTQ+ people often report both implicit (i.e., a bias against a group of people of which one is unaware that they hold and/or are acting on) and explicit (biases of which a person is aware and/or acts on intentionally) biases against them in health care settings (Dean et al., 2016; McNeill et al., 2023; Sabin et al., 2015), which might prevent them from accessing care. Another possible explanation is that, in the United States, this population is less likely to have adequate insurance coverage (Nguyen et al., 2018). There have been international calls to provide affirming health care for LBGTQ+ people (Coleman et al., 2022; Fredriksen-Goldsen et al., 2017; Mulé et al., 2009; Narah & Sonam, 2023; Pillay et al., 2022) and some trainings do exist to improve health care providers' ability to providing affirming care, although their findings are mixed (Lelutiu-Weinberger et al., 2023; Morris et al., 2019; Prasad et al., 2023). Some scholars have therefore called for policy that protects the rights of LGBTQ+ people globally to have access to affirming health care (Dean et al., 2016).

The purpose of this paper will be to argue for health equity for LGBTQ+ adults using the Civil Rights Act, the Equal Protection of the U. S. Constitution (Schweikart, 2021), the Article 25 of the Universal Declaration of Human Rights (United Nations, 2018), and the principle of equity of access to health services as a feature of universal health coverage as established by the World Health Organization (2023). We will highlight the importance of moving from access to care for members of the LGBTQ+ community to affirming the access and health needs of people with diverse sexual and gender identities (Bhatt et al., 2022; Cooper et al., 2023) and patient-centered care (Hascher et al., 2024; McEwing et al., 2022). We will also provide recommendations for medical professionals.

II. LGBTQ+ Population Estimates

a) Global Estimates

Global estimates of the number of people who are LGBTQ+ are difficult to ascertain. According to a survey administered by Ipsos (2023) in 30 countries, around 9% of the world's population holds a non-heterosexual sexual identity, with Brazil reporting up to 14% of the national population identifying as lesbian, gay, bisexual, pansexual or omnisexual, and asexual. Brazil is followed closely by Spain (12%), the Netherlands (11%), and Great Britain (11%). Related to gender identity, the same survey found that about 3% of the global population identifies as transgender; gender non-binary, gender non-conforming, gender fluid, or otherwise outside the male/female gender binary (Ipsos, 2023). Switzerland holds the largest estimated population of gender minorities (6%), followed closely by Thailand (5%), Italy (4%), Sweden (4%), Germany (4%), and Spain (4%).

Although a promising start in estimating the global population of LGBTQ+ people, this study does

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not show the full picture. Known as the "global closet," one study estimated that about 83% of the global LGBTQ+ population conceals their sexual identity (Pachankis & Bränström, 2019). This might be due in part to the varying legal contexts by country that would discourage, or even prohibit, people from reporting their sexual and/or gender identities. Countries such as Egypt, Jamaica, and Syria criminalize same-sex sexual activity (known as "debauchery," "buggary," or "unnatural/indecent act" laws, respectively) with penalties ranging from fines, hard labor, lashings, and up to life in prison (Human Rights Watch, n.d.). In Brunei, Iran, Mauritania, Qatar, Saudi Arabia, Uganda, and Yemen, same-sex sexual activity can carry up to the death penalty (Human Rights Watch, n.d.). Brunei, Malawi, Malaysia, Oman, Saudi Arabia, South Sudan, Tonga, and United Arab Emirates contain laws that prohibit non-cisgender gender expression, effectively targeting transgender people's ability to live openly (Human Rights Watch, n.d.).

b) United States Estimates

Although considered vulnerable and marginalized populations, the number of LGBTQ+ people in the United States is not small. Despite there being a sizeable number of youth under the age of 18 who are LGBTQ+ (Conron, 2020), this article will be focused exclusively on adults given youth have unique developmental experiences and face unique access to health care than adults (Chong et al., 2021; Diana & Esposito, 2022). In the United States, about 7.2% of the adult population is LGTBQ+. Bisexual people make up the largest proportion of the LBGTQ+ community, with 58% of this population identifying as bisexual, which is about 4.2% of the entire U.S. population (Jones, 2023). Gay men make up about 1.4% of the entire U.S. population followed by lesbian women, who make up about 1% (Jones, 2023). Related to gender, about .6% of the U.S. population is transgender (Jones, 2023). Given the sizable number of the LGBTQ+ population globally and in the United States, as well as the continued discrimination they face in the policy arena, it is critical to evaluate the status of their health care accessibility.

III. Human Rights and Health Care Accessibility for LGBTQ+ People

a) Global Contexts

Most think of policies that support or discriminate against persons in this community as it relates to marriage and parenting. Ipsos (2023) surveyed 30 countries where 9% of 22,514 adults between 16 and 74 self-identified as LGBTQ+. For example, participants in 20 of the 30 countries supported same-sex marriage with less support in Western countries, and two-thirds believed that, as with heterosexual couples, same-sex couples could successfully rear children. Furthermore, 67% of survey participants agreed that transgender people faced discrimination and should be protected from said discrimination in the areas of housing, work, and access to businesses (Ipsos, 2023). Inequities faced by members of the LGBTQ+ community include challenges accessing food, housing, education, employment, services, receiving asylum, and migrating between countries (Gerber et al., 2020; ILGA World).

One key form of policy impacting LGBTQ+ people is access to quality and affirming health care; however, it remains a challenge across the globe. This is troubling as various Articles of the Universal Declaration of Human Rights (UDHR) that outline equality, freedom from discrimination, life, liberty, and personal security; freedom from torture and debasing treatment; the humane recognition of a person; and the right to marry and family (Marks, 2006). There have been, in recent years, calls by medical providers internationally to provide affirming health care for LGBTQ+ people (e.g., Coleman et al., 2022; Fredriksen-Goldsen et al., 2017; Mulé et al., 2009; Narah & Sonam, 2023; Pillay et al., 2022), yet the actual application of these calls remains limited. For instance, although the World Professional Association for Transgender Health (WPATH) has released its eighth version of standards of care for trans people internationally (Coleman et al., 2022), many trans people globally still report struggling to access care that is affirming to their gender and experiences for numerous reasons, including restrictive policies (Koch et al., 2020). Given the criminalization of same-sex sexual activity as well as to diverse genders and gender expression in some countries (Human Rights Watch, n.d.), it is further likely that many citizens of these countries also decline to seek health care that would require them to disclose their sexual and/or gender identity thus limiting their access to affirming care.

b) United States Contexts

Similar to restrictions to affirming health care for LGBTQ+ people globally, there are many discrepancies in the United States. In the U.S., every human being has the right to life, liberty, and the pursuit of happiness; however, these principles have not been extended to health care (Gerisch, 2018; Holtzman & Schwartzstein, 2020). A lack of health equity for persons in the LGBTQ+ community will likely continue due to (a) access to quality health care not being a constitutional right, (b) the incomplete and incremental set of rights assigned to health care (Ruger, et al., 2015), and (c) the challenges implementing health equity policies. Despite the formal lack of protections in access to health care, liberty principles are woven into the definitions of health equity policies. The latest Executive Order by the White House requires fair, just, and impartial access to services and benefits (Exec. Order No. 13985, 2021) but it is unclear how this order will be implemented, making

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it a symbolic law much like the Family and Medical Leave Act that does not guarantee job security and paid benefits.

Scholars report the need to advance access to health services for persons with diverse sexual and gender identities through the adoption of inclusive and holistic views (Alencar Albuquerque et al., 2016; Dean et al., 2016), enhancing the number of trained professionals who provide affirming care (Alencar Albuquerque et al., 2016; Bhatt et al., 2022; Fredriksen-Goldsen et al., 2017; Hudson & Bruce-Miller, 2023), and understanding the health services needs of members of LGBTQ+ communities (Alencar Albuquerque, et al., 2016). In a systematic review examining research published between 2004 to 2016, authors reported people who were not heterosexual faced more challenges accessing health care (Alencar Albuquerque, et al., 2016). Indeed, 12.7% of LGB people were uninsured compared to 11.4% for persons who were cisgender and heterosexual in 2019, including Market place and Medicare enrollment. Lesbian, gay, and bisexual (LGB) people are also more likely than heterosexual people to have insurance though Medicaid coverage at 17.2% and 10.3% respectively (Bosworth et al., 2021). Even among those insured, more LGB adults in 31 states reported having individually purchased insurance, which suggests that the repeal of the ACA's individual mandate may create challenges in the affordability of necessary care (Nguyen et al., 2018).

Outside of insurance coverage, LGBTQ+ people often struggle to access providers. One study found that LGB people reported not being able to afford common health services more often than heterosexual people (Heslin & Alfier, 2022). Likewise, compared to heterosexual adults, more LGB adults in the three-wave Behavioral Risk Factor Surveillance System reported avoiding necessary care they needed due to its cost (Nguyen et al., 2018). Even the coverage insurance provides might not be enough to meet their needs or they might have trouble finding an affirming medical provider (Nguyen et al., 2018).

One potential reason for LGBTQ+ peoples' decreased access to health care compared to those who are cisgender and heterosexual is the role of some health care providers' implicit biases that favor cisgender and heterosexual people (Dean et al., 2016; Sabin et al., 2015). Implicit biases many LGBTQ+ people encounter globally in health care settings include providers being uneducated about how to treat LGBTQ+ patients, being visibly uncomfortable around LGBTQ+ patients, invalidating same-gender families during family health care visits, holding a lack of understanding around specific health care needs (e.g., providing condoms but not dental dams or gloves to lesbian women for safer sex practices), or making assumptions that patients were cisgender and/or heterosexual (Dean et al., 2016; McNeill et al., 2023). In other cases, biases against LGBTQ+ patients are made explicit, such as spending less time with LGBTQ+ patients and refusing to perform specific procedures (e.g., artificial insemination for women in same-gender couples). Explicit biases also include verbally expressing being "horrified" around LGBTQ+ people, comparing LGBTQ+ and "regular" patients, and drawing on religious beliefs that "God created Adam and Eve…" (McNeill et al., 2023, pp. 269-270). LGBTQ+ people can also internalize these biases in a way that might reduce access to health care because they fear discrimination, hold distrust medical providers, or experience stereotype threat (Dean et al., 2016; Fingerhut et al., 2022; McNeill et al., 2023).

Recognizing challenges the role of bias toward LGBTQ+ people in the training of health care providers, there are some interventions in place to address and reduce such biases. However, findings on their efficacy are mixed (Dean et al., 2016). Prasad et al. (2023) found a case-based and active learning approach advanced the cultural competence of 111 health care professional students who completed the pre-post test survey for an interprofessional education (IPE) course in 2016. Lelutiu-Weinberger and colleagues (2023) found statistically significant reductions in both explicit and implicit biases following both online and in-person trainings as well as increases in LGBTQ+ affirming beliefs, clinical skills, and behaviors. However, participants' intention to use affirming behaviors did not show a statistically significant reduction. Although changes in both explicit and implicit biases were no longer statistically significant beyond a 15-month follow up, those who participated in supervision did show greater reductions in explicit biases than those who did not suggesting that participants might benefit from assistance in interventions. In their review, Morris and colleagues (2019) found that although some interventions might improve medical providers' knowledge of treating LGBTQ+ patients, their attitudes towards them, and their level of comfort working with them, they did not find any interventions that measured for the presence of implicit biases, which might still persist. Many trainings target individual health care providers and do not address policy issues that affect health care access, which can limit their impact on the lived experiences of LGBTQ+ patients (Dean et al., 2016). Although such interventions do appear to hold promise, their mixed efficacy in reducing bias necessities policies that guarantee access to health care (Mulé et al., 2009).

IV. Intimate Partner Violence and the Need for Health Care in the LGBTQ+ Community

Examining the contexts related to LGBTQ+ peoples' health and wellbeing is critical because, even in countries that do not explicitly criminalize same-sex

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sexual activity and relationships, such as stigma and discrimination in the U.S., can lead to violence that further necessitates access to health care, including, intimate partner violence (IPV) (Decker et al., 2018; Edwards et al., 2015). By Therefore, it is also critical to highlight not only the risks the LGBTQ+ population face, but also ways to support their access to quality and affirming care. To address the risk factors of this community, we use IPV as the context.

Access to affirming health care is critical for LGBTQ+ people. In addition to the health care needs that span across all groups (e.g., annual physicals, preventative screenings, dental care, oncological care, cardiovascular care, chronic illness support), LGBTQ+ people face contexts that further necessitate access to affirming health care. Although highlighting every context is out of the scope of the current paper, we will focus on the particular case of the increased exposure to violence victimization LGBTQ+ people often face (Chen et al., 2023). It should be noted that although many of the studies cited in this section rely on samples from a single country or region, the literature reviewed is from multiple countries globally.

LGBTQ+ people are generally more likely than heterosexual (Chen et al., 2023) and cisgender (Peitzmeier et al., 2020) people to experience IPV victimization. Although there are forms of victimization that are not physical, such as psychological or coercive controlling violence, physical and sexual IPV exist within these relationships. As defined by the CDC (Chen et al., 2023), some physical IPV involves acts like slapping, shoving, or pushing. There are also "severe" forms of IPV that include acts such as hitting hard enough to leave a mark, burning, using a weapon, or slamming. Although a separate form of IPV from physical violence, sexual IPV is also physical in nature and involves acts such as unwanted sexual contact, coerced or forcible rape, being forced to touch or penetrate a partner, or being unable to consent to a sexual act due to incapacitation (e.g., being asleep, intoxicated, or drugged) (Basile et al., 2014).

It is then unsurprising that being an IPV survivor has long lasting health consequences and requires affirming health care across many domains of medicine. Although some injuries do not require medical care, such as bruising, victimization often necessitates emergency health care due to acute injury sustained during an assault (Doyle, 2020). Importantly, bisexual and lesbian women are more likely than heterosexual women to report attaining an injury or needing medical care. Similarly, gay men are more likely than heterosexual men to report injury or needing medical care (Chen et al., 2023). Injuries might include broken or fractured bones (Doyle, 2020; Kavak et al., 2022), often noses or ribs (Kavak et al., 2022), burning (Singhal et al., 2021), or wounds from weapons (Doyle, 2020). Survivors also sometimes necessitate dental care for oral maxillofacial trauma and traumatic dental injury (da Nóbrega et al., 2017; de Souza Cantão et al., 2024; Levin & Bhatti, 2024). Emerging research is also uncovering the long-lasting effects of traumatic brain injury (TBI), which is when a person experiences a heavy bump, jolt, or blow to their head or else suffers penetration to their head (Centers for Disease Control and Prevention, 2017), and can result from the above injuries, namely head and face injuries as well as strangulation. These symptoms include memory loss and issues with concentration, experiencing blackouts, ringing ears, and problems with vision (Campbell et al., 2018). However, it is important to note that these studies rely on the presence of TBI symptoms, given that a TBI is not formally diagnosable until after death.

Even outside of the direct impacts of IPV, survivors report a host of medical conditions that last a lifetime including diabetes, cardiovascular health, obesity, sexual health concerns (e.g., sexually transmitted infections [STIs] and HIV/AIDS), and other chronic health conditions (e.g., gastrointestinal disorders, respiratory illnesses, urinary and liver problems) (Rivara et al., 2019; Stubbs & Szoeke, 2022). Although still in its infancy, research also documents that some people who have been abused also experience telomere shortening, which accelerates the physical aging process at the genetic level at a rate faster than chronological age (Stubbs & Szoeke, 2022). Given that health care is not a constitutionally protected human right, we will provide recommendations on ameliorating some of the health outcomes associated with IPV by addressing IPV itself through patient centered and affirming care.

V. Implications for Patient-Centered and Affirming Care

In lieu of the lack of a constitutionally protected right to quality health care, patient-centered and affirming care allows for microsystemic access to high-quality, compassionate care.

Patient-centered care (PCC) is a process that encompasses respect between the provider and patient, with the provider being curious about and open to the preferences, needs, and values of their patient and providing care that aligns with the patient's values when rendering health care decisions. PCC is a holistic and empowering lens on health care, encompasses expanding access to personal health information by way of current technologies, creating pathways for active participation, and keeping the patient informed and educated about their health and options (Institute of Medicine, Committee on Quality of Health Care in America, 2001).PCC involves the challenges of training, multiple providers, measurement concerns (Edgeman-Levintan & Schoenbaum, 2021), and the need for enhanced and sustainable alterations in clinical, administrative, and organizational practices to promote

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holistic and respectful quality care (Gartner et al., 2022). Walsh and colleagues (2022) systematically reviewed PCC in emergency departments. They found that PCC's key features were communication, engaging the patient and their family, patient-provider shared decision-making, respect, trust, continuity in care, and consistency. Outcomes of PCC include greater patient satisfaction (Rathert et al., 2013; Walsh et al., 2022), fewer days in the hospital (Walsh et al., 2022), and enhanced patient self-managed care (Rathert et al., 2013).

Providing and intervening with affirming care and using guidelines on standards for offering affirming care can reduce the impacts of the unprotected right to access to quality, comprehensive and respectful care (Poteat et al., 2023). We purposefully use affirming care as an inclusive and respectful practice. Persons who experience affirming care tend to be less stressed, have improved overall and mental health outcomes, and reduce anxiety, depression, and stress (Arquilla, 2022).

Discussions related to providing PCC and LGBTQ+ affirming care and those related to health care for IPV survivors largely remains siloed. There have been global calls to improve affirming care for LGBTQ+ people (Coleman et al., 2022; Fredriksen-Goldsen et al., 2017; Mulé et al., 2009; Narah & Sonam, 2023; Pillay et al., 2022). Elsewhere, medical professionals across a variety of specializations and disciplines have called for need to screen for IPV as part of their best practices (American Medical Association [AMA], 1992), with the U.S. Department of Health and Human Services including this screening as part of free preventative services (Miller et al., 2015). Some of the medical fields calling for the increased need to screen for and address IPV include those likely to encounter survivors, such as primary care providers (Alvarez et al., 2017; AMA, 1992), emergency room workers (AMA, 1992), OB/GYNs (AMA, 1992; American College of Obstetricians and Gynaecologists [ACOG], 2012), and dental professionals (Levin & Bhatti, 2024). We argue medical professionals should be attuned the presence of IPV specific to their areas of specialization (Phares et al., 2019).

a) Primary Care

Primary care physicians and other medical professionals are paramount to aiding IPV survivors and providing PCC (Langhinrichsen-Rohling et al., 2020). This is because they are central to survivors' care given that they can build relationships with their patients, often have a better understanding of their relationships (e.g., who is an important family member), and are able to make referrals to other health care providers (Langhinrichsen-Rohling et al., 2020).

Primary care professionals are poised to be culturally affirming of their patients, given their ability to form more meaningful relationships (Langhinrichsen-Rohling et al., 2020). In their article related to addressing IPV among LGBTQ+ patients in primary care settings, Bermea and colleagues (2021) suggest incorporated screenings using tools that are designed specifically to capture IPV in this population are part of routine care, including the sexual and gender minorities–specific IPV Conflicts Tactics Scale (Dyar et al., 2021) and the transgender-related IPV Tool (Peitzmeier et al., 2019). Primary care clinics and practices should have protocols in place that all employees who interact with patients are trained in that encompass receiving standardized questions related to IPV that all patients receive, recognizing signs of abuse, and being able to identify local affirming resources (Alvarez et al., 2017). It is important to learn about this population's unique needs, such as not assuming patients' sexuality and/or gender, not making assumptions about the presence of IPV because of patients' relationships configuration (e.g., assuming there is no IPV because both partners are women), and creating physical spaces that signal being LGBTQ+ affirming (e.g., pride flag decals in lobby spaces, inclusive pronouns on intake and other forms, artwork featuring same-gender couples) (Bermea et al., 2021).

b) Emergency Room Care

Emergency rooms (ER) may be one of the first health care systems with which IPV survivors interact (Langhinrichsen-Rohling et al., 2020). There are often a host of screening procedures in place either for all patients (universal screening) or for when patients present with injuries that indicate they are violence victims (Ahmad et al., 2016). While screening, especially universal screening, in ER settings is especially valuable in addressing IPV, there are a host of contextual factors that influence their efficacy (Ahmad et al., 2016). Some barriers to disclosing IPV in the ER are similar to other medical settings (e.g., shame, feeling unready); however, some factors are unique (Ahmad et al., 2016). One study in a Dutch ER found that some providers viewed IPV as a chronic issue that should be addressed in primary care, as the purpose an ER was to treat acute problems with little opportunity for follow up (Zijlstra et al., 2017). In another study in a Canadian ER, medical professionals described having a lack of time with patients in which to properly screen for IPV or that their partner was present, making it unsafe to screen (Vonkeman et al., 2019). Despite the efficacy of and recommendation for universal screening practices (Ahmad et al., 2016), many ER medical personnel do not screen for IPV unless patients present with injuries that appear to be deliberate. Still others do not ask about IPV at all, potentially due to discomfort, little to no formal education about IPV, or lack of awareness of screening procedures and tools. In other cases, there

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are no local resources for which to refer patients (Vonkeman et al., 2019).

We echo recommendations for increased training in global screening practices, regardless of patients' gender and sexual identities, including using screening tools that can better capture the experiences of IPV for LGBTQ+ people (e.g., Dyar et al., 2021; Peitzmeier et al., 2019). ER professionals should ask about the relationship between the patient and the person accompanying them (when applicable). For instance, should a male patient arrive with another man, providers should not assume they are not partners because they are of the same gender. This is critical because patients should always be screened for IPV privately (Phares et al., 2019). Although there might not be local IPV resources available to which ER providers can refer LGBTQ+ patients, trainings can include increased awareness of affirming resources online. In the U.S., this includes the National Domestic Violence hotline (National Domestic Violence Hotline, 2023).

c) Obstetrics and Gynecological Care

Professionals in obstetrics and gynecology are uniquely poised to identify cases of IPV (ACOG, 2012; Langhinrichsen-Rohling et al., 2020). It is important that providers not assume that only cisgender men commit sexual assault against their cisgender woman partners. Professionals in this field should avoid using gendered language when asking about sexual and partner history (e.g., use of male only pronouns, asking about boyfriends/husbands) (Light & Obedin-Maliver, 2019; Srousma & Wu, 2018). Even if the patient's partner's gender has been assessed, it is critical to not assume that because a partner is of the same gender they are unable to commit a sexual assault (Gambardella et al., 2020). These providers should also recognize that vaginal or anal trauma is not only the result of penile penetration but might also be the result of digital penetration or the use of a foreign object and be able to recognize evidence of those forms of assault. Further, transgender people with diverse identities (e.g., transgender women, transgender men, transmasc people) also often seek gynecological care (Eckstrand et al., 2016; Srousma & Wu, 2018). It is important for professionals in this field to recognize their heightened risk for sexual assault (Kattari et al., 2022), particularly among transgender women (Valentine et al., 2017) and non-binary people (Kattari et al., 2022).

Given that IPV survivors are also at risk for acquiring an STI and/or HIV (McCauley et al., 2015), it is of critical importance to ensure that professionals in obstetrics and gynecology understand that people with vaginas who have sex with exclusively other people with vaginas are still at risk of acquiring an STI and to ask about forms of safer sex protections that are appropriate to this population (e.g., dental dams, female condoms) (Eckstrand et al., 2016).

d) Dental Care

Dental professionals who see cases of maxillofacial trauma (e.g., fracture to the zygoma, nose, and/or jaw, dentoalveolar trauma) (Benassi et al., 2024; Yari et al., 2024) should ask their patients about IPV regardless of their perceived gender identity. This is critical given the high correlation between these types of injury and IPV (de Souza Cantão et al., 2024). One study from a major trauma center in Iran found that, of their patients presenting with maxillofacial trauma, about a third were IPV survivors (Yari et al., 2024). Benassi et al. (2024) noted a similar pattern in Brazil, where about 28% of over 1,000 patients presenting with maxillofacial trauma were IPV survivors. Their findings were comparable to studies in Italy, Germany, India, and South Korea but lower than in countries such as France, Switzerland, Romania, New Zealand, and the U.S.

Dental professionals should recognize that it is not only traumatic injury that can indicate IPV. IPV survivors are less likely than those who have not experienced IPV to have poorer overall dental health, including more cavities and engaging in fewer dental hygiene behaviors (e.g., tooth brushing) and be missing teeth related to violence (Kundu et al., 2015). Although dental professionals are likely attending to oral care, they work in close proximity to other areas that are subject to physical assault, including the head and neck (Kenny, 2006).

Even when dental professionals do not know the sexual or gender identity of the patient, there are still ways to provide affirming care. Some HIV+ patients, of whom gay men and transgender women are disproportionally vulnerable, receive decreased quality care, or are refused to be seen, once a dental professional learns of their seropositive status (Brondani et al., 2016). HIV has been correlated with IPV victimization among gay men and other men who have sex with men (Kubicek, 2018) and transgender women who have reported IPV are less likely to report viral suppression, potentially due to a lack of access to treatment (Bukowski et al., 2018). Dental professionals should receive trainings on working with HIV+ patients, including dismantling myths around HIV/AIDS. Given that access to health care due to cost is a barrier for many LGBTQ+ people in the United States (Heslin & Alfier, 2022; Nguyen et al., 2018), programming that makes dental care more affordable to survivors is needed. To illustrate, the American Academy of Cosmetic Dentistry (AACD) offers the Give Back a Smile program to provide cosmetic dental repair to front teeth for those who have experienced IPV (AACD, n.d.).

e) Policy and the Limitations of Our Recommendations

Although the provided recommendations are valuable, they are limited by laws and policies that penalize without offering health protection both within the United States and globally. Bermea and colleagues

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(2021) argue that it is important for medical providers to consider the socio-historical context of medical settings for LGBTQ+ people, including the medical pathologization of LGBTQ+ people and historical criminalization of same-sex sexual activity that was only overturned in the United States by the 2003 *Lawrence v Texas* Supreme Court Ruling. It is also important for medical providers consider the banning of gender affirming care in many states that would prohibit affirming care to many transgender people (Hughes et al., 2021). Such contexts are also critical to consider in countries where same-sex sexual activity and living openly as a transgender person are currently outlawed (Human Rights Watch, n.d.). These laws effectively silence survivors from seeking health care. Health care providers in these areas would not be able to ask about sexual or gender identity or screen for IPV that is specific to LGBTQ+ people. However, we urge these providers to not make assumptions about gender, sexuality, or relationship configuration.

Given a lack of constitutional protections in the United States that guarantee health care, along with a similar lack of protections in many places globally, we argue that access to high quality, patient centered, and affirming health care should be a constitutional right (Schweikart, 2021). To provide such health care, it is critical to also be aware of how to work with all patients, including those who are LGBTQ+. Given the lack of policy protections, we urge medical professionals to engage in patient centered and affirming care particularly as it relates to the areas in which LGBTQ+ people disproportionate negative outcomes, in this case IPV (Chen et al., 2023; Peitzmeier et al., 2020).

VI. Concluding Thoughts

Despite the growing population of LGBTQ+ people in the U.S. and globally, there are not civil rights that guarantee access to health care and many LGBTQ+ people face substantial barriers to care. One reason such barriers to care are allowed to continue is due to a lack of constitutional right guaranteeing access to health care. In this paper, we argued that access to high quality and affirming health care should be a constitutional right (Schweikart, 2021). This is important as LGBTQ+ people face contexts that necessitate care, here IPV (Chen et al., 2023). In the interim, it is critical to reduce the barriers to health care this population faces. In place of policy that would guarantee access to care, we have provided recommendations for PCC and affirming care for primary care, emergency room, OB/GYN, and dental providers as a microsystemic intervention in order to promote the high quality for the global LGBTQ+ population.

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