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REVIEW ARTICLE

# Analysing the Health of Queer Muslims Through the 4M Framework: A Scoping Literature Review

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## Abstract

The health and wellbeing of queer Muslims, a group positioned at the intersection of multiple marginalised identities, remains underexplored in academic literature. This scoping literature review critically analyses existing research on queer Muslim health using the 4M framework (Mega, Macro, Meso, Micro) to identify structural and individual determinants impacting health outcomes. The study highlights the profound influence of intersecting factors such as race, ethnicity, gender, sexuality, geographic location, and socioeconomic status on healthcare access and health outcomes. Findings reveal that dominant epistemological assumptions about queerness and Islam perpetuate stigma, discrimination, and minority stress, leading to adverse health outcomes. Key barriers include inadequate funding, homonormative healthcare policies, and exclusionary cultural expectations within healthcare settings. Conversely, supportive familial, peer, and religious networks, along with access to digital resources, are identified as facilitators of better health outcomes. The review calls for culturally competent, strength-based models of care and emphasises the need for future research to address the diverse health experiences of queer Muslims across different regions and identities.

**Keywords** LGBTQ + Muslim health · Intersectionality in healthcare · Culturally competent care · Intersectional health disparities · Minority stress and health

## Introduction

In recent years, the health and wellbeing of culturally and linguistically diverse (CALD) populations, including those with diverse sexualities and genders, has become a focal point of scholarly interest. Yet, little is known about the health experiences of queer Muslims–a group at the intersection of multiple identities. This represents a concerning gap, especially considering that intersections of race, ethnicity, gender, sexuality, geographic region, and socioeconomic status significantly

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influence healthcare access and overall health outcomes (Medina-Martínez et al., 2021).

Current research also suggests that religious affiliation can impede health access for some queer people (Miller et al., 2020). For instance, in religiously conservative environments, individuals may be reticent to disclose their queer identities and sexual practices to healthcare professionals due to the illegality and stigma attached to same-sex sexual relationships in their respective contexts. Additionally, laws against homosexuality have not only eroded Indigenous sexualities but also facilitated the emergence of a Western-centric concept of homosexuality, used to demonise and criminalise queer sexual practices (Coll-Planas et al., 2021; Massad, 2019; Rahman, 2010). While many queer people now adapt Eurocentric identity politics to achieve LGBTQ+rights, this categorisation based on sexual and gender identities continues to serve as a means for surveillance and control of queer expressions, which extends into healthcare environments (Coll-Planas et al., 2021; Massad, 2019; Rahman, 2010).

Extensive research also demonstrates that secular institutions, government policies, sociocultural norms surrounding gender and sexuality, family and community networks can significantly impact healthcare experience, needs, access and outcomes (Chaudhry et al., 2024; Kassa & Grace, 2019). In light of these wide-ranging influences, this review employed the 4M framework (Mega, Macro, Meso, Micro) along with Bourdieu's theory of capital to explore how factors operating at structural and institutional levels cascade down to impact individuals, shaping their health, healthcare access, and experiences (Kassa & Grace, 2019; Noor, 2021). Additionally, this framework also acknowledges the agentive potential of individuals to achieve better health outcomes within the constraints of their respective environments.

In this context, a review of literature on the health of queer Muslims is timely. This scoping review aims to critically analyse the existing research on the health of queer Muslims, with an emphasis on understanding their unique health experiences, needs, and the barriers they face in achieving optimal health and wellbeing. By addressing this critical research gap, the review aims to contribute to the fields of public health, queer studies, and cultural competency in healthcare.

## Method

### Research Questions and Protocol

This review adheres to the PRISMA-ScR checklist and Arksey and O'Malley methodological framework for scoping studies (Arksey & O'Malley, 2005). The protocol for this scoping review was registered in Open Science Framework and includes a detailed explanation of the staged PRISMA-ScR process undertaken. This is available in Supplementary Material S1. The overarching research question, decided upon collaboratively by the team, was: '*What does existing research say about the health experiences and needs of queer Muslims?*' In answering this question, we also sought to understand whether healthcare services are experienced as accessible and relevant for queer Muslims, and what similarities and differences exist in the

health needs and outcomes for sexuality and gender diverse Muslims, considering intersectional differences.

## Search Strategy

We conducted searches in five databases: MEDLINE, EMBASE, PsycINFO, CINAHL and Scopus. Only peer-reviewed research articles (i.e. excluding grey literature) published in English until 2nd November 2023 were included. Search terms, developed by the whole team, were organised under three major concepts: 'queer', 'Muslim' and 'health'. Search strategies for each database (detailed in Supplementary Material S2) were drafted by a team member [SS], reviewed by another team member [BS], then evaluated and further refined using the PRESS 2015 Guideline Evidence-Based Checklist. Consultations were also held with a research librarian, and among the contributing authors, who participated in a consensus-based process of developing the search strategy.

After conducting the database searches, duplicate articles were eliminated in EndNote (Fig. 1). To ensure consistency during the screening process, a team member [HW] devised a flowchart (see Supplementary Material S3) to determine eligible papers. Papers shortlisted following an initial screening process by the first author [SS] were transferred to Covidence for independent title and abstract screening by all team members. Conflicts during this stage were discussed and assessed using the flowchart by two members [SS, BS]. All team members then conducted full-text screening. Conflicts during full-text screening were resolved by three members [BS, HW, SI]. After the final articles were selected, two team members [SS, BS] re-evaluated and cross-checked the articles initially excluded in EndNote.

## Eligibility Criteria

### Inclusion Criteria

Theoretical and empirical papers published in indexed journals were included in this review. Theoretical studies had to primarily focus on queer Muslim health, while empirical studies required either a queer Muslim sample of at least 25% or attend to specific findings related to queer Muslim health. Given the profound shifts in media, foreign and military policy, government surveillance, and global perceptions of Muslims following the September 11 attacks in 2001, the team decided to limit literature inclusion to those published between September 2001 and November 2023.

### Exclusion Criteria

The search strategy resulted in 1393 articles. During the screening process 796 articles were excluded. Of these excluded papers, 255 papers had a limited health focus (e.g. homonationalist policies, identity construction with no or tangential references to health outcomes), and 252 were either irrelevant or included a queer Muslim sample of less than 25%. 103 papers were excluded on the basis that they focused on

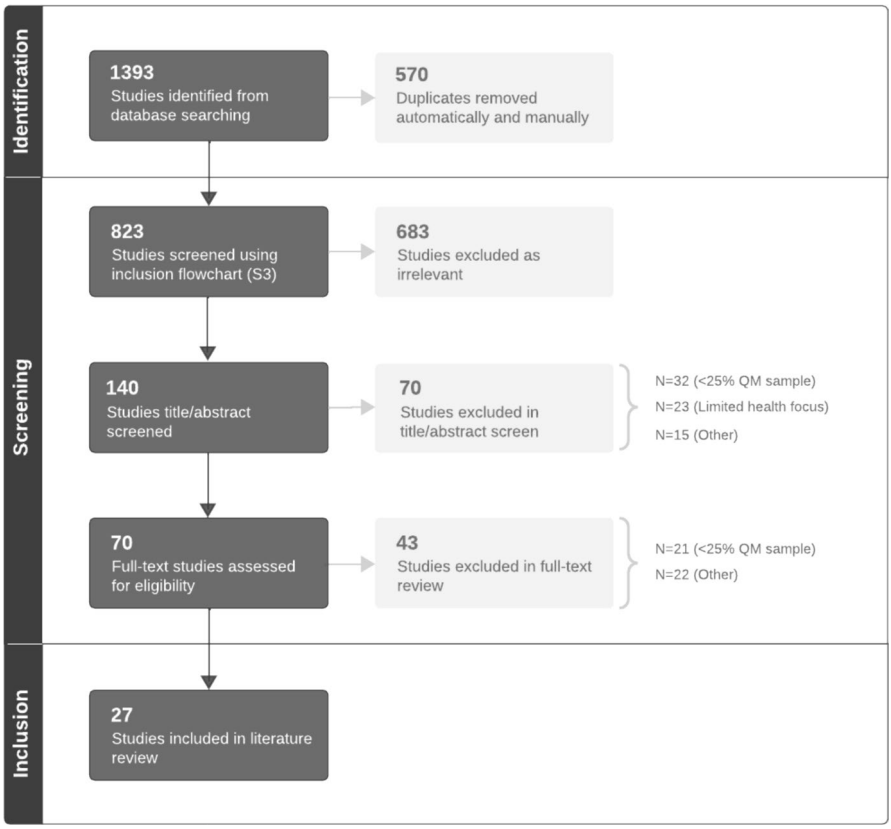


**Fig. 1** PRISMA Flowchart

societal attitudes towards or between queer and Muslim populations, or the attitudes of Muslim healthcare workers/educators toward queer clients whose religious backgrounds were not specified. Other papers were excluded on the basis that they were not journal articles (N = 63), did not specify their participants' religious beliefs or conflated Islam with ethnicity (N = 53), were theology-based (N = 43), or were published before 2001 (N = 18). The remaining 9 papers were excluded because their either non-queer or non-Muslim authors presented reductive or stereotypical analyses of homosexuality and transgenderism, or framed Muslims and Islam through a singular, monolithic lens. These essentialist perspectives limited their ability to critically engage with the diversity of queer Muslim identities and experiences, perpetuating stigma rather than providing nuanced insights.

## Data Extraction and Synthesis

The shortlisted papers were distributed among all team members for extraction. The extracted information was then cross-checked by another team member. The

extracted information included publication details (e.g., authors, study design, country, and publication year); the specific subpopulation of queer Muslims under examination (including sample number and percentage of queer Muslim participants for empirical studies); the specific health focus, key findings and study limitations (see summary of this information in Supplementary Material S4).

We used an inductive and iterative approach to identify themes. The main findings identified during data extraction and full-text readings were coded, synthesised, and organised hierarchically by a team member [SS]. These codes were reviewed by another team member [SKP] before discussion with the rest of the team. Given that many papers discussed structural issues relating to health, we adapted a multilevel sociological systems framework, known as 4M (Mega, Macro, Meso, Micro), to interpret and present the findings (Kassa & Grace, 2019). This model helps explain the complex interplay between mega, macro, meso and micro level factors (Fig. 2).

## Findings

A total of 27 papers were included in this review. For clarity, given the linearity of the text format, findings from these papers are presented as individual themes. However, we recognise that these themes often intersect and overlap, reflecting the complex nature of the subject matter.

### Overview of Included Articles

The studies spanned fourteen countries: Australia, Canada, France, Germany, United Kingdom, United States, Turkey, Lebanon, Kuwait, Pakistan, Bangladesh, Malaysia, Nigeria, and Senegal. Two empirical papers included multi-country samples. There was a range of study designs: the majority were qualitative (52%), then quantitative (22%), theoretical (15%), and mixed methods (11%). Participants in empirical studies were overwhelmingly gay men, men who have sex with men (MSM), men who have sex with men and women (MSMW), and trans women. Lesbians, bisexuals, trans men, non-binary or genderfluid individuals constituted a smaller proportion of the studies. Additionally, we would like to highlight that the health experiences of queer Muslim individuals in the reviewed literature are all shaped by varying geographic, legal, cultural, and religious contexts. For instance, in some Muslim-majority countries, accessing healthcare is fraught with legal and social risks. Conversely, queer Muslims in some secular societies often contend with intersecting stigmas related to both Islamophobia and homophobia, influencing their healthcare experiences differently.

### Mega: Epistemological Assumptions

Epistemologies are foundational beliefs that underpin ways of knowing, perceiving and being in the world. Conflicts can arise when individuals, groups or institutions

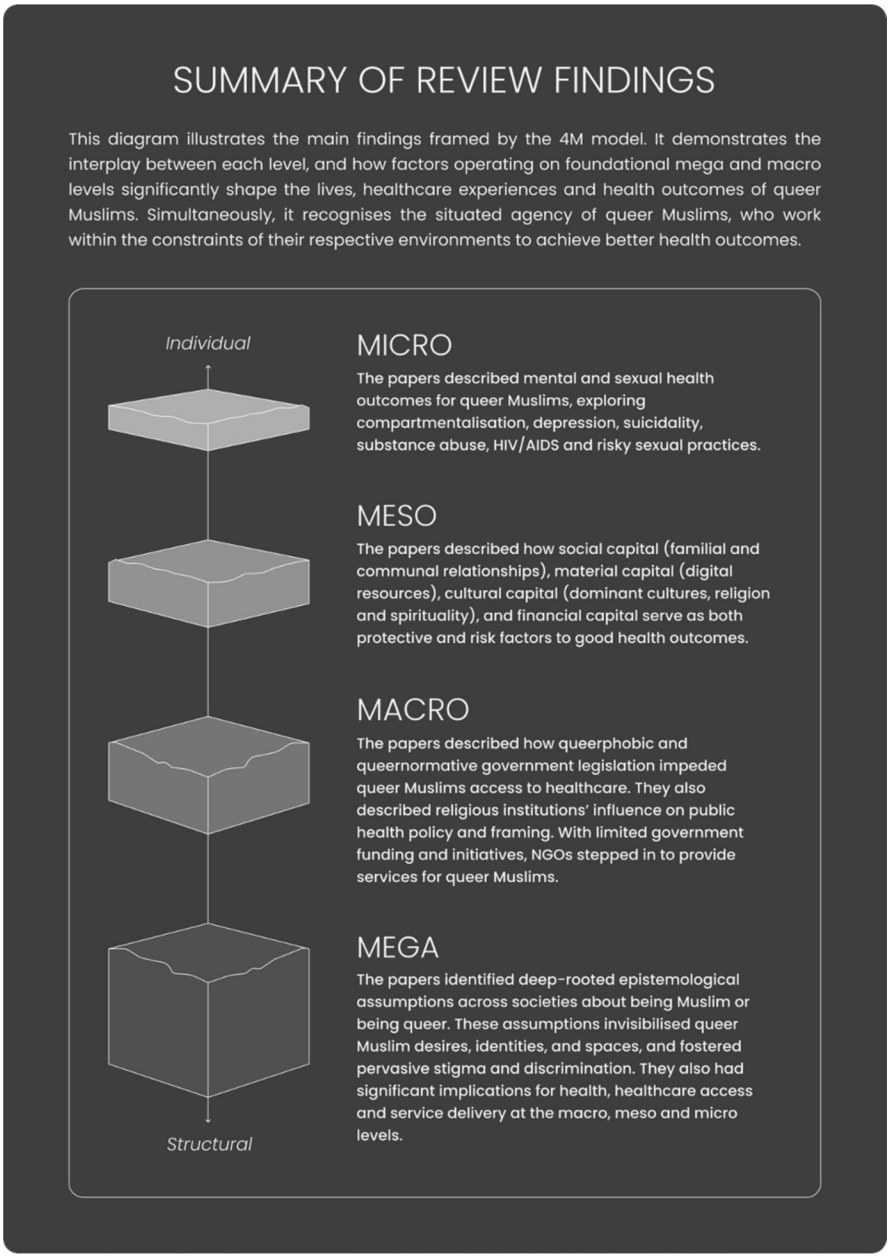


**Fig. 2** Summary of Review Findings

hold different epistemological assumptions that lead to contrasting perspectives on truth and ethics.

Authors of the papers surveyed discussed a range of epistemological assumptions about sexuality, gender and religion. Notably, they identified several dominant, conflicting (and often essentialist) narratives about what it means to be Muslim or to be queer. These mega-level assumptions not only overshadowed diversities within and across communities but also invisibilised queer Muslim desires, identities, and spaces, resulting in significant implications for health, healthcare access and service delivery at the macro, meso and micro levels.

#### Assumptions About "Being" Queer

Fourteen papers discussed rigid epistemological assumptions regarding the notion of being queer (Akolo et al., 2014; Altay et al., 2021; Alvi & Zaidi, 2021; Askari & Doolittle, 2022; Barmania & Aljunid, 2016; Etengoff & Rodriguez, 2021; Farhadi Langroudi & Skinta, 2019; Hammoud-Beckett, 2022; Kumpasoğlu et al., 2022; Lim et al., 2020; Pallotta-Chiarolli et al., 2022; Scull & Mousa, 2017; Semlyen et al., 2018; Vaughan et al., 2021). The authors highlighted dominant cultures within LGBTQ+, Muslim and wider communities that construct the hegemonic queer identity as Westernised, white, urban and secular (or a combination thereof) and that this ideal is antithetical to (their construction of) being Muslim. The literature also highlighted how there were implicit expectations of how to "be queer" and prescribed scripts to follow, such as sexual non-monogamy, public displays of affection and coming out. Three papers interrogated the concept of coming out, describing it as a Western construct that can be limiting for some queer Muslims as it can create an added pressure to perform a prescribed identity (Farhadi Langroudi & Skinta, 2019; Hammoud-Beckett, 2022; Vaughan et al., 2021). Hammoud-Beckett introduces the concept of 'coming in' (i.e. consciously inviting select people into their life to share their gender and sexuality with) as another legitimate, more appropriate pathway for some queer Muslims to affirm and honour both their familial and intimate relationships (Hammoud-Beckett, 2022).

#### Assumptions About "Being" Muslim

There were also dominant epistemological assumptions about being Muslim. Almost all papers noted that most Qur'anic interpretations consider queer sexual behaviour sinful and are cisnormative in that they assume that everyone will 'naturally' embrace and perform roles associated with the gender they were assigned at birth. Six papers from the USA, Australia, Germany, Canada, Turkey and France also discussed gendered stereotypes about Muslims that arise from legacies of colonialism, nationhood and migration, such as discriminatory ideas that Muslims as 'feudal', 'uncivilised', 'backwards', 'dangerous', 'alien', 'invaders' who contaminate host nations and require assimilation (Altay et al., 2021; Alvi & Zaidi, 2021; Farhadi Langroudi & Skinta, 2019; Khan & Cailhol, 2020; Pallotta-Chiarolli et al., 2022; Vaughan et al., 2021).

### Consequences of These Assumptions

The aforementioned epistemological assumptions were found to have profound implications for health, manifesting in pervasive stigma and discrimination, heightened experiences of minority stress, and the erosion of Indigenous genders and sexualities.

**Stigma and Discrimination** The dominance of these assumptions has resulted in pervasive stigma and discrimination, which was discussed in every paper. Stigma and discrimination manifested across structural, institutional and legislative levels, community and network levels, as well as familial and individual levels. Due to its extensive impact, this issue is explored throughout the findings, rather than in isolation.

**Multiple Minority Stress and Internalisation** Almost all papers linked the mega to the micro, emphasising how stigma and discrimination caused adverse health outcomes among queer Muslims. Ten papers discussed queer Muslims experiencing multiple minority stress and used minority stress theory to guide their research (Etengoff & Rodriguez, 2021, 2022; Farhadi Langroudi & Skinta, 2019; Kumpasoğlu et al., 2022; Maatouk & Jaspal, 2022; Ogunbajo et al., 2022; Pallotta-Chiarolli et al., 2022; Stuhlsatz et al., 2021; Usman et al., 2018; Vaughan et al., 2021). Three papers described how many queer Muslims experienced adverse mental health outcomes (e.g., suicidality, depression, anxiety) because they internalised Islamophobic and queerphobic beliefs (Farhadi Langroudi & Skinta, 2019; Hammoud-Beckett, 2022; Ogunbajo et al., 2022). In fact, in order to counter this, one clinician promoted 'externalisation' (i.e. exposing sociopolitical discourses that queer Muslims have internalised as their fault) as a therapeutic technique to help queer Muslims deconstruct dominant assumptions and construct their own narratives of empowerment (Hammoud-Beckett, 2022).

These findings caution against adopting the reductionist view that the challenges faced by queer Muslims is an internal clash between an individual's religion and sexuality. Pallotta-Chiarolli and colleagues emphasise how this neoliberal position diminishes 'structural and institutional responsibility and culpability', while shifting the burden onto individuals (Pallotta-Chiarolli et al., 2022). It ignores legacies of colonialism, histories of migrations and other drivers of Islamophobia and queerphobia. Moreover, it fails to recognise that for some queer Muslims, Islam serves not as a source of conflict but as a strength-giving force.

**Erasure of Indigenous Genders, Sexualities and Ways of Being** Globally, cultures exhibit a vast array of understandings and expressions of gender and sexuality, many of which challenge or outright reject Western binary norms. Ten articles described some or all queer Muslims in their studies resisting Western LGBTQ + identities. Since discrete forms of male-male sexual intimacy are common and practiced in Muslim-majority countries, many participants rejected LGBTQ + identities as

they did not perceive themselves to be outside of normative communities (Khan & Cailhol, 2020; Khan et al., 2005; Sheehy et al., 2014). Some participants also embraced Indigenous identities specific to their cultural contexts, such as socio-sexual hijra identities like *zanana, narban* and *khusra* in Pakistan (Usman et al., 2018)*;* overlapping MSM identities like *kothi, panthi, giriya* and *doparata* in Bangladesh (Khan et al., 2005)*;* and *two-spirit*, *in the life*, and *macha/o* identities in the US (Stuhlsatz et al., 2021). Several papers depict healthcare systems and institutions not only as perpetuators of dominant Western epistemologies but also as entities that systematically fail to recognise or accommodate the healthcare needs of individuals with these Indigenous identities (Altay et al., 2021; Pallotta-Chiarolli et al., 2022).

### Macro: Healthcare Systems

This section focuses on findings relating to the influence of government legislation, NGOs, and religious institutions on healthcare delivery, funding, and framing for queer Muslims. It examines the epistemic assumptions perpetuated by these entities and the systemic barriers to achieving good health outcomes.

#### Government Legislation and Healthcare

Several studies highlighted that the criminalisation of homosexuality and/or transgenderism in some Muslim-majority countries posed significant healthcare challenges for organisations supporting queer Muslims. In one study, an NGO advocating for trans women needed to register under the guise of "other activities" due to government pressure (Rashid & Afiqah, 2023). An absence of protective legislation also resulted in limited access and uptake of essential health services (Ogunbajo et al., 2022; Rashid & Afiqah, 2023). Five papers described how punitive laws in Nigeria, Senegal, Pakistan and Malaysia–even if rarely enforced–challenged effective HIV prevention, treatment, and support (Akolo et al., 2014; Alio et al., 2022; Barmania & Aljunid, 2016; Sheehy et al., 2014; Usman et al., 2018). Moreover, stigma on a legislative level also emboldened some healthcare workers to discriminate against queer Muslims accessing healthcare (Akolo et al., 2014).

The literature addressed how legislation in non-Muslim majority countries also marginalised queer Muslims. Two main forms of legislative marginalisation were identified. The first form is evident in laborious bureaucratic procedures. Two papers highlighted how undocumented Pakistani migrants and transgender-immigrant Muslim sex workers in Europe were unable to access state medical aid or employment as they lacked a valid place of residency, passport, insurance, and tax number (Altay et al., 2021; Khan & Cailhol, 2020). Consequently, many participants sought unsafe and informal healthcare or were forced into survival sex work in dangerous and unregulated conditions. These 'labyrinthine

bureaucracies' served as significant barriers for vulnerable queer Muslim populations who lacked the cultural capital to navigate through state systems, procedures, and paperwork (Altay et al., 2021).

The second form of legislative marginalisation related to homonormative policies that were reinforced by medicolegal institutions within society. Altay and colleagues described how many general practitioners in Germany only prescribed hormone replacement therapy (HRT) and gender confirming surgery (GCS) if their client demonstrated to a psychological counsellor that they met the criteria outlined in the American Psychological Association's definition of gender identity disorder (Altay et al., 2021). However, some participants expressed expansive, fluid gender identities, which fell outside trans definitions recognised by state and medical authorities. Consequently, participants who failed to perform an idealised trans identity that aligned with Western binary logics of gender were disqualified from receiving gender-affirming care (Altay et al., 2021).

### Funding, NGOs, and Healthcare

The literature underscored glaring deficiencies in funding allocation. For instance, in 2011, only 1% of the HIV budget in Malaysia was allocated to MSM prevention programs compared to 58% earmarked for intravenous drug users (Lim et al., 2020). By 2016, only 0.2% of the total Malaysian HIV prevention budget was allocated to MSM programming (Barmania & Aljunid, 2016). This is concerning given that five papers described concentrated HIV/AIDS epidemics among MSM, hijra, and trans populations in Muslim-majority countries like Malaysia, Nigeria, Senegal and Pakistan (Akolo et al., 2014; Alio et al., 2022; Barmania & Aljunid, 2016; Sheehy et al., 2014; Usman et al., 2018).

While none of the papers focused on government-driven initiatives, eleven papers described NGO involvement (Afiqah et al., 2022; Akolo et al., 2014; Altay et al., 2021; Barmania & Aljunid, 2016; Khan & Cailhol, 2020; Khan et al., 2005; Kumpasoğlu et al., 2022; Lim et al., 2020; Rashid & Afiqah, 2023; Usman et al., 2018; Zainal-Abidin et al., 2022). NGOs undertook a range of roles including providing free, confidential medical consultations and treatments; assisting with housing and access to social welfare; and hosting social events for queer Muslims. In the absence of government funding, resources, and initiatives to ensure health, NGOs offered models of service delivery for queer Muslims.

### Religious Influence and Healthcare

Religious groups can exert significant influence over public health policy and funding (Barmania & Aljunid, 2016; Lim et al., 2020; Rashid & Afiqah, 2023; Zainal-Abidin et al., 2022). One paper described how Ministry of Health officials and NGOs in Malaysia had to covertly implement harm reduction strategies for MSM. To ensure funding and placate religious stakeholders, they carefully framed initiatives in language that prioritised health outcomes (e.g. "disease prevention") over rights-based approaches (Barmania & Aljunid, 2016).

Ten papers also described queer Muslims being coerced into conversion therapy, often by family-of-origin or by religious leaders (Alvi & Zaidi, 2021; Barmania & Aljunid, 2016; Farhadi Langroudi & Skinta, 2019; Hammoud-Beckett, 2022; Kumpasoğlu et al., 2022; Lim et al., 2020; Maatouk & Jaspal, 2022; Ogunbajo et al., 2022; Semlyen et al., 2018; Vaughan et al., 2021). These forced conversions involve referrals to Muslim or Christian therapists with the aim of 'returning an individual to a hypothesised heterosexual self' or, as a last resort, to practice celibacy (Farhadi Langroudi & Skinta, 2019). Several papers noted that some queer Muslims actively sought out conversion therapies to suppress their same-sex desires, with some even relocating to USA or Europe for 'treatment' (Farhadi Langroudi & Skinta, 2019). In a Nigerian study, Muslim participants were slightly more likely to be forced into conversion therapy than Christian participants (Ogunbajo et al., 2022).

## Meso: Capital and Health

This section provides an overview of the literature in relation to capital and its influence on queer Muslim health.

### Social Capital

**Family-of-origin** Family-of-origin as a determinant of health was a major theme, explored in fourteen papers (Afiqah et al., 2022; Alio et al., 2022; Alvi & Zaidi, 2021; Askari & Doolittle, 2022; Etengoff & Rodriguez, 2021, 2022; Hammoud-Beckett, 2022; Khan et al., 2005; Lim et al., 2020; Maatouk & Jaspal, 2022; Rashid & Afiqah, 2023; Scull & Mousa, 2017; Stuhlsatz et al., 2021; Zainal-Abidin et al., 2022). Studies showed that levels of familial acceptance are strongly associated with depression and suicidality scores (Etengoff & Rodriguez, 2021; Rashid & Afiqah, 2023). Participants across studies had varying relationships with their families. These included concealing their queerness to preserve their relationships with family or to safeguard their family's reputation within their communities (Afiqah et al., 2022); distancing themselves from their families or leading double lives to balance familial expectations with their desire to live authentically (Afiqah et al., 2022; Alio et al., 2022; Khan & Cailhol, 2020); being disowned by their families (Afiqah et al., 2022; Etengoff & Rodriguez, 2021; Scull & Mousa, 2017; Usman et al., 2018); being abused or forced into conversion therapy by family post disclosure (Afiqah et al., 2022; Alio et al., 2022; Etengoff & Rodriguez, 2021; Hammoud-Beckett, 2022; Khan & Cailhol, 2020; Pallotta-Chiarolli et al., 2022; Rashid & Afiqah, 2023; Scull & Mousa, 2017); and experiencing no changes or having an improved relationship with family post disclosure (Afiqah et al., 2022; Etengoff & Rodriguez, 2021). Some participants noted that their families became more accepting over time (Afiqah et al., 2022).

**Community and Chosen Family** Peer networks also had a significant influence on health outcomes. When they lacked family support, queer Muslim participants often relied on friends and chosen families. For instance, papers described undocumented Muslim migrants and sex workers in Europe, trans women in Malaysia and hijra in

Pakistan forming tightly knit homosocial communities (Altay et al., 2021; Khan & Cailhol, 2020; Usman et al., 2018). Several studies demonstrated that participants with robust peer networks had lower levels of depression compared to those who were marginalised by their peers (Etengoff & Rodriguez, 2021; Rashid & Afiqah, 2023; Usman et al., 2018). The literature also highlighted the importance of dedicated queer Muslim spaces, given that participants across studies felt excluded from both Muslim communities and queer communities (see Compartmentalisation) (Askari & Doolittle, 2022; Etengoff & Rodriguez, 2022; Hammoud-Beckett, 2022; Kumpasoğlu et al., 2022; Lim et al., 2020; Pallotta-Chiarolli et al., 2022; Semlyen et al., 2018).

### Material Capital

**Digital and Online Resources** Digital capital refers to one's ability to transform online resources into social resources. Ten papers explored this concept to varying degrees (Etengoff & Rodriguez, 2021, 2022; Kumpasoğlu et al., 2022; Lim et al., 2020; Ogunbajo et al., 2022; Pallotta-Chiarolli et al., 2022; Rashid & Afiqah, 2023; Scull & Mousa, 2017; Stuhlsatz et al., 2021; Vaughan et al., 2021). They emphasised that online platforms empowered queer Muslims to express their gender or sexuality in ways they were unable to do in offline settings (Stuhlsatz et al., 2021), and connected them to local queer Muslim communities and/or to resources and networks inaccessible locally (Scull & Mousa, 2017). A global study revealed that while 73% of participants had never attended queer Muslim events in person, 60% belonged to online queer Muslim networks (Etengoff & Rodriguez, 2022). Moreover, three studies found that engaging in online queer Muslim communities fostered self-acceptance, reduced depression, and promoted resilience when navigating minority stress (Etengoff & Rodriguez, 2021, 2022; Scull & Mousa, 2017). However, two papers noted the risks of digital spaces: one detailed how popular dating apps like Grindr, Hornet, and Jack'd increased the likelihood of unsafe sexual practices, while the other discussed participants' experience of transphobic cyberbullying (Lim et al., 2020; Rashid & Afiqah, 2023).

### Cultural Capital

**Dominant and Non-dominant Cultures** Cultural capital refers to an individual's capacity to leverage the values, resources, knowledge, and dominant culture of a society, institution, or organisation. Doing so enables upward mobility and the ability to navigate complex systems such as healthcare. The literature showed that queer Muslims' cultural capital (or lack thereof) affected their access to healthcare in various ways. One paper showed that only two trans Muslim participants qualified for HRT and GCS because they had the cultural and educational tools (e.g. fluent German, state education, ability to leverage NGO support) to align their cases with local medicolegal standards (Altay et al., 2021). The remaining participants, who did not embody trans identities recognised by the German system, were denied gender affirming care (Altay et al., 2021). Other studies from South Asia and Africa revealed a cultural disconnect in HIV/AIDS organisations and their clientele. Specifically, organisations that used identity-based strategies aimed at MSM, gay and bisexual men failed to

reach clients who also engaged in sexual activity with cisgender women (Khan et al., 2005; Sheehy et al., 2014). Studies from Australia and the UK also highlighted queer Muslim anxieties around disclosing their sexual practices (or lack thereof) to healthcare providers. While some feared for their privacy, others felt embarrassed that their limited sexual experience/knowledge diverged from dominant cultural expectations of being sexually active/literate (Pallotta-Chiarolli et al., 2022; Semlyen et al., 2018).

**Religion and Spirituality** For queer Muslims, religion can be both a protective and risk factor for mental health, depending on their relationship with Islam, and their religious and/or queer communities. Research indicated that being part of a *supportive* religious community boosts wellbeing and resilience. A North American study found that participants born into a Muslim faith had higher levels of psychological wellbeing than Muslim converts – potentially because the former may have more religio-social capital (Stuhlsatz et al., 2021). Another study found that gay and bisexual Lebanese men who regularly attended religious services had lower rates of depression and distress (Maatouk & Jaspal, 2022). However, one study described how queer Muslims who internalised religious anti-gay messages and frequently attended religious services exhibited higher levels of depressive symptoms and were more likely to undergo conversion therapy (Ogunbajo et al., 2022).

We identified three main identity-based coping strategies in the literature reviewed. First were participants who rejected their Muslim identities to embrace their queer identities. Second were participants who embraced their Muslim identities to reject their queer identities. Third were participants who embraced both their Muslim and queer identities. Research indicated that participants who embraced both identities reported the highest life satisfaction, suggesting that if these identities are not in conflict, religiosity might be an important factor for emotional wellbeing (Kirac, 2016). Four studies also described queer Muslims using Islam as a strength-giving force and how religious engagement reduced distress and depression (Etengoff & Rodriguez, 2022; Maatouk & Jaspal, 2022; Vaughan et al., 2021; Zainal-Abidin et al., 2022). While many of these participants used religious coping strategies to embrace gender and sexuality, others used it to practice abstinence and celibacy (Etengoff & Rodriguez, 2022; Vaughan et al., 2021; Zainal-Abidin et al., 2022).

### Financial Capital

Two studies from Nigeria and the United States showed that queer Muslims with higher income levels had better mental health and resilience (Ogunbajo et al., 2022; Stuhlsatz et al., 2021). In contrast, queer Muslims who experienced economic discrimination were less likely to maintain good health. Economic exclusion identified in literature included being prematurely forced out of school or home thereby lacking income-generating skills; engaging in survival sex work in exchange for accommodation or food; experiencing sexual and economic exploitation by employers (Alio et al., 2022; Khan & Cailhol, 2020); and being denied work due to HIV status (Lim et al., 2020; Zainal-Abidin et al., 2022). Economic instability hindered access to healthcare. One paper described how only 50% of people with HIV in Malaysia

sought HIV treatment: due to economic discrimination, many struggled with the financial burden of frequent hospital visits (Zainal-Abidin et al., 2022). Many trans people also relied primarily on their own resources to access gender-affirming care. Self-funding their own care placed many trans sex workers in a double-bind as many defined these medical procedures as essential to their profession (Altay et al., 2021). In a French study, lack of financial capital resulted in Pakistani asylum seekers resorting to informal, unregulated healthcare from unregistered clinicians in impoverished areas of urban Paris (Khan & Cailhol, 2020).

### Micro: Individual Health Outcomes

The two main individual health outcomes identified in the literature related to mental and sexual health.

#### Mental Health

**Compartmentalisation** Nine papers discussed queer Muslims "packaging" their identities to fit into different contexts (Afiqah et al., 2022; Altay et al., 2021; Etengoff & Rodriguez, 2022; Hammoud-Beckett, 2022; Kumpasoğlu et al., 2022; Lim et al., 2020; Pallotta-Chiarolli et al., 2022; Semlyen et al., 2018). Most often, this involved downplaying their queer identity in Muslim spaces while amplifying their Muslim identity; and downplaying their Muslim and/or racial identities in queer spaces while amplifying their queer identity. Two papers described queer Muslims compartmentalising in healthcare settings. In one study, participants deliberated on how to self-present before British Muslim healthcare practitioners, who could not comprehend their dual queer and Muslim identities (Semlyen et al., 2018). In the other study, participants felt that Australian LGBTQ + specific health services pressured them to abandon their religious and cultural backgrounds and conform to white LGBTIQ + norms (Pallotta-Chiarolli et al., 2022). Another paper described how compartmentalisation can be a strength as it allows queer Muslims to honour the multiplicity of their identities in different spaces (Hammoud-Beckett, 2022).

**Depression** Nineteen papers discussed depression, with some studies suggesting a higher prevalence within queer Muslim populations (Afiqah et al., 2022; Alio et al., 2022; Alvi & Zaidi, 2021; Askari & Doolittle, 2022; Etengoff & Rodriguez, 2021, 2022; Farhadi Langroudi & Skinta, 2019; Kirac, 2016; Kumpasoğlu et al., 2022; Lim et al., 2020; Maatouk & Jaspal, 2022; Ogunbajo et al., 2022; Rashid & Afiqah, 2023; Scull & Mousa, 2017; Semlyen et al., 2018; Stuhlsatz et al., 2021; Usman et al., 2018; Vaughan et al., 2021; Zainal-Abidin et al., 2022). One study found that 50% of British Muslim lesbians scored from mildly to severely depressed, compared to 11–30% of general lesbian populations (Etengoff & Rodriguez, 2021). Other studies showed that trans Muslim participants exceeded the clinical depression threshold (Etengoff & Rodriguez, 2022; Rashid & Afiqah, 2023). Mattock and Jaspal found that gay and bisexual men in Lebanon with no religious affiliation exhibited the highest rates of depression, followed by Muslims, then Christians

(Maatouk & Jaspal, 2022). Ogunbajo and colleagues' study also observed that Nigerian Muslim men had increased risk factors for depression when compared to Nigerian Christian men (Ogunbajo et al., 2022). Risk factors for depression included: strained familial relationships due to sexuality or gender, an absence of families of choice, ostracisation by peers, being a new convert to Islam, difficulties finding employment, lower incomes, a history of physical abuse and a history of forced conversion therapy. Interestingly, studies presented conflicting findings on whether disclosure/outness is a risk or protective factor for depression. One study found that higher disclosure/outness is associated with lower psychological distress (Stuhlsatz et al., 2021), while another showed that it correlated with higher rates of depression (Maatouk & Jaspal, 2022).

**Suicidality** Thirteen papers noted the presence of suicidality in queer Muslim populations, with five of these papers directly observing their participants having suicidal thoughts (Etengoff & Rodriguez, 2021; Khan & Cailhol, 2020; Ogunbajo et al., 2022; Rashid & Afiqah, 2023; Scull & Mousa, 2017). Among British Muslim lesbians surveyed in Etengoff and Rodriguez's study, 44% reported experiencing suicidal ideation, with 16% expressing active desires to commit suicide, and one participant disclosing a suicide attempt leading to hospitalisation (Etengoff & Rodriguez, 2021). Additionally, participants in three other studies, focusing on Pakistani migrants in Europe (Khan & Cailhol, 2020), Malaysian trans women (Rashid & Afiqah, 2023), and LGB Kuwaitis (Scull & Mousa, 2017), also revealed their struggles with suicidal thoughts during interviews with researchers. Furthermore, one study found that while conversion therapy increased the risk of suicidal thoughts, frequent attendance at religious services was associated with a lower history of suicidal ideation (Ogunbajo et al., 2022).

**Substance Use** Fourteen papers discussed the heightened risk of substance misuse among queer Muslims. Among these studies, four directly documented participants engaging in drug use (Alio et al., 2022; Altay et al., 2021; Alvi & Zaidi, 2021; Usman et al., 2018). In one study, 88% of hijra sex workers turned to drug use to cope with extreme ostracisation and isolation, with some succumbing to addiction (Usman et al., 2018). A social worker in another study also described trans Muslim sex workers in Europe developing drug addictions and dying at an early age (Altay et al., 2021). Second generation university students in Canada also relied on illicit substances to cope with mental illness and the challenges of navigating their queer and Muslim identities. (Alvi & Zaidi, 2021). While these participants recognised its harm, it was a normalised coping mechanism.

### Sexual Health

**HIV/AIDS** Eight papers described concentrated HIV epidemics amongst MSM in Malaysia, Senegal, Nigeria, Bangladesh and Pakistan (Akolo et al., 2014; Alio et al., 2022; Barmania & Aljunid, 2016; Khan & Cailhol, 2020; Lim et al., 2020;

Sheehy et al., 2014; Usman et al., 2018; Zainal-Abidin et al., 2022). Many papers discussed the emotional impact of HIV diagnoses, with participants experiencing shame, blame, self-hatred, suicidality, and feelings of worthlessness due to the stigma associated with HIV (Alio et al., 2022; Khan & Cailhol, 2020; Ogunbajo et al., 2022; Rashid & Afiqah, 2023; Usman et al., 2018). Stigma led some queer Muslims to deny their HIV status or avoid testing altogether (Akolo et al., 2014; Alio et al., 2022; Khan & Cailhol, 2020; Usman et al., 2018; Zainal-Abidin et al., 2022). Participants who were less likely to disclose their HIV status also struggled with medication adherence (Akolo et al., 2014; Khan & Cailhol, 2020; Zainal-Abidin et al., 2022). In fact, one study found that, compared to Christian participants, Muslim participants were less likely to adhere to antiretroviral therapy or disclose to their families and healthcare providers that they were MSM (Zainal-Abidin et al., 2022). Moreover, HIV prevention strategies focusing on MSM often failed to reach MSMW. This is significant given that many MSM (100% in Khan and colleagues' study, and 48% in Sheehy and colleagues' study) also engaged in casual sex with women (Khan et al., 2005; Sheehy et al., 2014). Furthermore, participants across studies exhibited knowledge gaps concerning HIV, HPV, and hepatitis (Khan & Cailhol, 2020). Finally, HIV risks were heightened among Muslim asylum seekers, sex workers and individuals with a history of forced conversion therapy (Khan & Cailhol, 2020; Ogunbajo et al., 2022; Usman et al., 2018).

**Risky Sexual Practices** Risky sexual practices identified in the literature included low condom use, sex work and chemsex (sexual activity under the influence of drugs). Eight papers discussed low condom use (Akolo et al., 2014; Barmania & Aljunid, 2016; Khan & Cailhol, 2020; Khan et al., 2005; Lim et al., 2020; Sheehy et al., 2014; Usman et al., 2018; Zainal-Abidin et al., 2022). Reasons for low condom use included abstinence-based strategies, succumbing to the 'heat of the moment', relying on luck or fate in casual sex encounters, lacking knowledge about HIV transmission, placing trust in sexual partners, and not negotiating condom use with partners. Eleven papers described queer Muslims who engaged in sex work, either as a worker or client (Afiqah et al., 2022; Alio et al., 2022; Altay et al., 2021; Barmania & Aljunid, 2016; Etengoff & Rodriguez, 2022; Khan & Cailhol, 2020; Lim et al., 2020; Pallotta-Chiarolli et al., 2022; Rashid & Afiqah, 2023; Sheehy et al., 2014; Usman et al., 2018). Many of these papers described queer Muslims resorting to survival sex work in exchange for shelter, food and/or accommodation, often without access to safe sex resources. In Usman and colleagues study, 88% of hijra participants living with HIV in Pakistan were forced to continue sex work to survive (Usman et al., 2018). Two papers noted that chemsex was increasing in MSM populations, including in Muslim-majority countries and in countries with growing Muslim MSM migrant communities (Barmania & Aljunid, 2016; Khan & Cailhol, 2020).

## Discussion

The aim of this study was to review literature on queer Muslim health outcomes, experiences and access to healthcare, taking into account intersectional differences. Our findings identified a range of factors that impacted health outcomes and accessibility.

On a mega-level, dominant epistemological assumptions about being queer and being Muslim resulted in stigma and intersectional discrimination, multiple minority stress and the erosion of Indigenous genders and sexualities. On a macro-level, government legislation, religious influence and funding significantly impacted the ability of queer Muslims to access healthcare. On a meso-level, participants' levels of social, cultural, financial and material capital were identified as both protective and risk factors to good health outcomes. On a micro-level, many queer Muslims experienced the impact of Islamophobia and queerphobia, which led to poor mental and sexual health outcomes.

### Health Accessibility

This review identified a range of facilitators and barriers to accessing and achieving optimal health for queer Muslims.

#### Facilitators

Facilitators identified in the literature occurred mainly at the meso and micro levels. They included individuals embracing both their queer and Muslim identities, having supportive familial, peer and religious networks, being connected to online and offline queer Muslim communities and resources, and having financial capital.

#### Barriers

Barriers to good health were identified across all 4M levels, but were especially prevalent at mega and macro levels and outside the control of queer Muslim individuals. Various barriers were identified on a governmental and legislative level. Firstly, punitive laws exist that criminalise homosexuality and/or transgenderism and deter queer Muslims from seeking healthcare. Secondly, inadequate government funding and support result in a scarcity of public health initiatives aimed at mitigating health disparities within queer populations. Thirdly, homonormative laws and healthcare policies, which are rooted in narrow LGBTQ+identity-based models, exclude some queer Muslims whose experience of sexuality and gender transcend Western frameworks.

Another barrier occurring at the healthcare provider level involved the dominance of certain epistemic assumptions extending into healthcare environments. Specifically, some healthcare providers perpetuate dominant narratives that conflate being queer with being secular and sexually active/literate, and being Muslim with being cisgender, heterosexual and sexually inactive (outside the boundary of heterosexual marriage), which results in queer Muslims feeling judged and excluded from healthcare spaces.

### Health Outcomes

Given the structural discrimination against queer and Muslim communities, studies highlighted that queer Muslims were at high risk of experiencing multiple minority stress. The literature showed that queer Muslims were also more likely to experience depression compared to general populations. Additionally, suicidal ideation,

substance use, and risky sexual practices were identified amongst queer Muslim participants in the reviewed empirical studies. Various papers also described concentrated HIV epidemics amongst gay and bisexual men, MSM and MSMW in Muslim-majority countries.

### Intersectional Differences

Several intersectional differences were identified in the literature. Economically vulnerable queer Muslims experienced poorer health outcomes. These included Muslims who were expelled from home or school; lacked income-generating skill; were refused work; were abused by their employers; were HIV positive; were sex workers; or were asylum seeker and migrants with limited cultural capital. Additionally, converts to Islam limited religious support networks also had poorer mental health outcomes.

Although the reviewed papers primarily focused on gay men and MSM, there were several findings that suggest intersectional differences. A Lebanese and Nigerian study found that bisexual men had higher levels of internalised homophobia, were more likely to conceal their sexuality from their family and were also more likely to face familial pressure to have heterosexual marriage than gay men (Maatouk & Jaspal, 2022; Ogunbajo et al., 2022). The Nigerian study also demonstrated gay men were more likely to be forced to participate in conversion therapy compared to bisexual men.

While only one paper exclusively examined the experiences of Muslim lesbians (Etengoff & Rodriguez, 2021), several studies suggested that lesbian, bisexual and queer Muslim women may experience the compounded challenge of both their gender and sexuality being invalidated, dismissed or pathologised within the heteropatriarchal frameworks of Muslim and wider societies (Pallotta-Chiarolli et al., 2022). These papers stressed the intersectional impact of sexism, highlighting how women may experience disproportionate repercussions for rejecting heterosexuality (Etengoff & Rodriguez, 2021; Pallotta-Chiarolli et al., 2022; Vaughan et al., 2021).

Nine papers included transgender or hijra participants, three of which exclusively focused on the experiences of trans women (Afiqah et al., 2022; Altay et al., 2021; Rashid & Afiqah, 2023). These studies described transgender Muslim experiencing more overt socioreligious persecution and a higher prevalence of depression, anxiety and stress compared to cisgender populations (Etengoff & Rodriguez, 2022; Rashid & Afiqah, 2023).

## Implications for Policy Makers, Researchers, and Health Clinicians

### Cultural Humility and Self-reflexivity

Given the dominant epistemological narratives discussed above, it is easy to get caught in an intersecting monologue that reduces the complexities of queer Muslim health to simplistic binaries of religion vs. sexuality, Muslim vs. non-Muslim, Global South vs. Global North, and East vs. West.

In this context, cultural humility and self-reflexivity become essential for policy makers, researchers, and health clinicians (Pallotta-Chiarolli et al., 2022; Vaughan et al., 2021). This involves being cognisant of dominant epistemologies and bodies of knowledge, and continually questioning: whose way of seeing and being is being validated? Who is defining sexuality, gender and what it means to be queer? Who is defining Islam and what it means to be Muslim? Who is defining health? Whose views are reflected in the dominant epistemological culture?

In turn, it is necessary to cast this critical eye upon the research and policies being produced, and the healthcare being provided: what are the epistemological assumptions embedded within them? Who are these policies serving? Who are they excluding? Are organisations that deliver healthcare perpetuating dominant worldviews? What are the dangers of this? How can this be addressed?

### Two-eyed Seeing

In a healthcare context, "two-eyed seeing" is one avenue to bridge diverging knowledge systems. Originating from First Nations Elders in Canada, it involves viewing the world through a dominant epistemological lens with one eye, while the other eye sees through a non-dominant epistemological lens (Jeffery et al., 2021). Effective two eyed seeing requires an equal power balance between the two lenses. In some of the literature reviewed, we see some healthcare professionals striving to engage in something akin to it. For example, Hammoud-Beckett's concept of "coming in" provides an equally valid way of perceiving self-disclosure for some queer Muslims, rather than being constrained to a singular lens of the queer individual whose sole path to liberation is to escape the closet by publicly proclaiming an identity (Hammoud-Beckett, 2022).

Similarly, several therapists blended Western modalities like acceptance and commitment therapy, compassion-focused therapy and narrative therapy with religious coping mechanisms used by their queer Muslim clients. For example, some healthcare providers integrate 'two-eyed seeing' by combining these Western therapeutic practices with Islamic practices such as *salaah* (prayer) and *dhikr* (recitation) for mindfulness and a closer connection to God, reclamation of scripture and queer identity via liberation theology, and theological and self-reflections to cope with the substantive stress of living within multiple marginalised identities (Vaughan et al., 2021). Through cultural humility, self-reflexive practice and two-eyed seeing, individuals and organisations can honour the heterogeneity amongst queer Muslims, queer communities and Muslim communities, bridge competing epistemic values, and deliver culturally competent healthcare.

### Strength-Based Models of Care

Strength-based models of care are also important to consider. Effective strength-based models do not ignore or diminish the structural barriers to good health, but rather they recognise that queer Muslims have 'situated agency' in that they work within the constraints of their environments, navigating through oppression and privilege, to achieve better health outcomes (Etengoff & Rodriguez, 2022).

Strength-based approaches include leveraging religious scripture for empowerment through liberation theology or creating safe spaces for queer Muslims to engage in community-building activities that affirm both their faith and sexual/gender identity. Furthermore, the literature identified queer Muslims employing various strength-based strategies including the proliferation of queer-inclusive interpretations of Quran and *sunnah,* the growth of online and offline queer Muslim communities, and development of queer Muslim resources and support groups (Etengoff & Rodriguez, 2022).

### Funding and Framing Healthcare

Funding and framing are also crucial issues to take into account. As discussed earlier, in the absence of government funding and initiatives, NGOs often provided healthcare to queer Muslim populations. However, government outsourcing of care to NGOs presents several dangers. First, it shifts the onus of responsibility to NGOs, many of whom work with scarce financial support on a minimal scale. Second, privatising care for certain groups can deepen siloes within healthcare delivery. Several papers describe how queer Muslims felt excluded from mainstream health services and received fragmented care (Pallotta-Chiarolli et al., 2022; Semlyen et al., 2018). Third, NGOs can inadvertently become vehicles that impose dominant epistemic frameworks (e.g. homonormative, neoliberal, or rights-based) onto populations that may not share the same epistemic values. Given this, it is important NGOs also engage in self-reflexive practice.

The importance of framing was also evident in the Malaysian context, whereby Ministry of Health officials and NGOs had to tactically present HIV strategies using health-focused approaches over rights-based ones in order to safeguard funding from conservative religious stakeholders (Barmania & Aljunid, 2016).. Employing health-focused approaches has also proven useful in the Australian context as it has enabled HIV strategies to reach a broader audience of CALD MSM (Saliba et al., 2024).

### Future Research

Research on queer Muslim health remains in its early stages and is primarily limited to preliminary studies. There is a significant lack of literature addressing the health of lesbian, bisexual, transmasculine, nonbinary, and genderfluid Muslims, as well as those who exist outside Western frameworks of gender and sexuality. Further research is needed to explore these subgroups, as well as regional and cultural differences among queer Muslims and their implications for healthcare access and delivery. Other critical areas that require attention include the impact of government legislation on queer Muslims' access to healthcare, strategies for effectively framing healthcare services to reach this population, and methods for fostering cultural safety in collaborations involving stakeholders with differing epistemic values. Additionally, research should examine how Islamic principles can be integrated into

existing and future healthcare models for queer Muslim clients, as well as strength-based studies that explore resilience pathways and protective health factors.

While cross-sectional studies have shed light on correlations between health outcomes and factors like religiosity, there is an urgent need for experimental and longitudinal studies to establish cause-and-effect relationships. Expanding research variables beyond religiosity to include social capital (e.g., family relationships and access to supportive communities), economic capital, and cultural capital would yield a more nuanced understanding of the lived reality of queer Muslims. Employing more comprehensive measures to assess these variables would also enhance the validity and depth of future research.

## Limitations

We identified several limitations in our study. Although our comprehensive search strategy captured a broad range of relevant publications, it is possible that some literature was overlooked. Restricting the review to English-language publications may have also excluded valuable findings published in other languages. Similarly, the exclusion of grey literature, while maintaining a focus on peer-reviewed research and ensuring rigour, overlooked insights from grassroots-level initiatives and community-based studies. Future reviews could address this gap by incorporating grey literature to provide a more inclusive perspective.

A significant limitation is the presence of data gaps, particularly regarding underrepresented subpopulations such as queer Muslim women, trans men, and nonbinary individuals. Moreover, the predominance of studies conducted in urban contexts or the Global North limits the applicability of findings. Due to the limited research available on the health of queer Muslims, our study had to adopt a broad scope, including diverse regions, health topics, and identities. While this approach was necessary, it created challenges in creating clear demographic distinctions within our findings. This difficulty was compounded by the variability in conceptions of gender and sexuality across sociocultural and economic contexts.

The selection of studies as well as the methodologies of studies reviewed introduces potential biases that could result in incomplete or skewed findings. Geographically, only a few regions were represented in the literature we reviewed. This uneven representation fails to reflect the diversity of queer Muslim health experiences, particularly in rural or less-studied regions. Methodologically, the reliance on qualitative interviews and surveys with small, specific populations (e.g., trans women in Malaysia or MSM in Nigeria) provides rich localised insights but limits generalisability. Additionally, studies that rely on self-identified LGBTQ+ participants inadvertently exclude individuals who do not adopt Western identity labels yet experience similar health challenges.

Finally, theoretical studies and research conducted in the Global North, or by scholars from the Global North, often draw on epistemological frameworks that may not align with the lived realities of participants from the Global South. This misalignment risks overlooking Indigenous understandings of gender and sexuality. These factors underscore the need for more diverse, inclusive, and representative

research by researchers with lived experience to more accurately understand the health needs and experiences of queer Muslims worldwide.

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## Declarations

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