

Review of Interventions to Promote Culturally Congruent Care for Sexual and Gender Minorities

Ryan Q. De Torres, MA, RN

College of Nursing, University of the Philippines Manila, Philippines, WHO Collaborating Center for Leadership in Nursing Development, Manila, National Capital Region, Philippines

Gracielle Ruth M. Adajar, MA, RN

College of Nursing, University of the Philippines Manila, Philippines, WHO Collaborating Center for Leadership in Nursing Development, Manila, National Capital Region, Philippines

Lung Center of the Philippines, Manila, Philippines

Alexandra Belle S. Bernal, MOHRE, RN

Jenniffer T. Paguio, PhD, MA, RN, FNYAM

College of Nursing, University of the Philippines Manila, Philippines, WHO Collaborating Center for Leadership in Nursing Development, Manila, National Capital Region, Philippines

Abstract: Sexual and gender minorities (SGMs) are more likely to suffer from healthcare disparities and inequities than heterosexuals. Whittmore and Knafl's method was used in this integrative review to examine interventions to promote culturally congruent care for SGMs. Using online databases and search alerts, 31 articles were searched, appraised, and included. There are universality and diversity in the characteristics of interventions to promote culturally congruent care for SGMs. The findings reveal that culturally congruent care interventions can significantly promote optimal health outcomes and effective care delivery for SGMs. Collaboration, partnership, and advocacy must be observed in conceptualizing culturally congruent care for sexual and gender minorities.

Introduction

Sexual and gender minorities (SGMs) are at greater risk of healthcare disparities and inequities and are more prone to health-related risk behaviors than heterosexuals (Baptiste-Roberts et al., 2017; O'Malley & Holzinger, 2018). SGMs have a higher risk of acquiring human immunodeficiency virus (HIV) and sexually transmitted infections and are also at risk of other chronic health conditions (Baptiste-Roberts et al., 2017; O'Malley & Holzinger, 2018; Tadele & Amde, 2019). Studies have shown that SGMs are more likely to suffer from depression, anxiety, poor mental health, substance abuse, suicidal risk (Baptiste-Roberts et al., 2017; Johns et al., 2018), and lower health-related quality of life than heterosexuals (Austin et al., 2017).

The healthcare concerns and needs of SGMs could have resulted from and been aggravated by varying and interacting individual, social, cultural, structural, and healthcare factors (Haviland et al., 2020). SGMs report stigmatization, discrimination, and physical and psychosocial harm (Johns et al., 2018; Tadele & Amde, 2019). They experience harassment, poor housing support, work insecurity, and physical violence (O'Malley & Holzinger, 2018; Tadele & Amde, 2019). At the healthcare level, the discriminatory, homophobic, non-affirming, and judgmental behaviors and attitudes of health professionals widen the gap in the access and delivery of quality healthcare among SGMs (Lisy et al., 2018). In a review, barriers to cancer screening among SGMs are health professionals' lack of knowledge, poor communication skills, and cultural care incompetence (Haviland et al., 2020). These barriers may be due to a lack of awareness, training, and exposure to SGM care. In a survey of 18 healthcare organizations, more than half of the clinicians reported having rarely or never talked to patients about sexual orientation and gender identity (SOGI; Goldhammer et al., 2018). The clinicians rationalized that the questions were irrelevant to care, made the patient uncomfortable, or lacked experience or knowledge of the appropriate language in talking about the topics.

Culturally Congruent Care

Several papers emphasized the importance of culturally congruent care to holistically address the healthcare needs of SGMs (Lisy et al., 2018; Margolies & Brown, 2018; Tadele & Amde, 2019). Culturally congruent care goes beyond addressing the health concerns of individuals by identifying social, cultural, and environmental factors (McFarland & Wehbe-Alamah, 2019). Pacquiao's (2008) Cultural Competent Care for Vulnerable Groups framework emphasizes social justice, human rights, and compassion to deliver care that respects and values the knowledge, beliefs, and practices of people experiencing oppression, violence, and powerlessness. Culturally congruent care has the potential to promote equitable and transformative healthcare (Pacquiao, 2008). There is a need to determine ways to integrate the concept of culturally congruent care into the healthcare of SGMs.

Study Purpose

This review aims to describe interventions to promote culturally congruent care for SGMs. Specifically, the review presents the aims, developments, contents, deliveries, structures, and outcomes of interventions.

Literature Search

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines (Page et al., 2021) were followed in the conduct of this review. An online literature search was performed through CINAHL Complete and PubMed with the combination of the terms: ("culturally congruent care" OR "culturally competent care" OR "culturally sensitive care" OR "culturally appropriate care") AND ("sexual and gender minorities" OR "non-heterosexuals" OR "LGBT persons" OR "LGBTQ persons" OR "lesbigay persons" OR "men who have sex with men" OR "queers" OR "homosexuals" OR "women who have sex with women" OR "gay" OR "transgender" OR "bisexual" OR "lesbian"). Seven hundred and sixty-six records were retrieved and entered into reference management software.

After removing duplicate records, 672 abstracts were screened for relevance. Four additional records were found relevant through

email search alerts activated for 2 months. For inclusion, papers should be primary studies (quantitative, qualitative, and mixed-methods research) in English that focus on interventions to promote culturally congruent care for SGMs that substantially describe the intervention and study outcomes. Commentaries, opinion papers, editorials, letters to the editor, book reviews, and study protocols were excluded.

Method

Design

This integrative review used Whittemore and Knafl's (2005) method to examine culturally congruent care interventions by integrating studies of diverse methodologies. This method helps to understand the nuances in translating the concept of culturally congruent care into real-world settings by examining the similarities and differences of interventions. The depth and breadth of knowledge from this review can inform practice, research, education, and policy (Whittemore & Knafl, 2005) toward culturally congruent care for SGMs. This review followed the steps of problem identification, literature search, data evaluation, data analysis, and presentation.

Data Evaluation and Analysis

After the full-text screening, 31 articles underwent quality appraisal using the Joanna Briggs Institute's (JBI's) Critical Appraisal Tools (Lockwood et al., 2015; Moola et al., 2017; Tufanaru et al., 2017). These tools assess the studies' methodological rigor by identifying whether specific criteria have been met, not met, unclear, or not applicable. The final analysis included articles that met half or more of JBI's criteria.

Data extraction was initially done by one author (RQDT), including the intervention's purpose, development, content, delivery, structure, outcome measures, and evaluations. An Excel table was used to organize data. Other authors (ABSB, GRMA, and JTP) also read and reviewed assigned papers and double-checked the extracted data. The data were read several times and compared item by item. A constant comparison approach was used to analyze and synthesize data. Similar data were clustered and grouped according to the preliminary categories. Counting was performed to determine the occurrence of the patterns of data.

An iterative process of comparing data to initial categories was done to extract emerging and expanding categories. Finally, categories and subcategories were refined and finalized through discussions among the authors (ABSB, GRMA, JTP, and RQDT). Reviewers resolved inconsistencies through repeated discussions until a consensus was reached.

Results

Table 1 shows the characteristics of the studies included in this review. Most were conducted in the United States ($n = 28$, 90.32%) and in academic institutions ($n = 14$, 45.16%). Most studies employed quantitative design only ($n = 25$, 80.65%). The majority ($n = 20$, 64.52%) used a pretest and posttest evaluation, but only a few ($n = 3$, 9.68%) had control groups. Twelve studies (38.71%) had health professionals as their participants. SGM participants mainly were men who have sex with men (MSM; $n = 4$, 12.90%).

Aims

Most interventions ($n = 22$, 71%) focused on *developing and strengthening the cultural competence of health professionals and students* in the care of SGM. These interventions aimed to enhance the knowledge, skills, attitudes, confidence, and approach to providing care for the general and subgroup SGM populations. Nine interventions (29.03%) focused on *care access, delivery, and services for different SGM subpopulations*. Most of these interventions ($n = 7$, 22.58%) aimed to mitigate HIV risks by providing HIV education, promoting access to HIV prevention services, observing patient-centered approaches, and addressing social determinants of HIV. One (3.22%) intervention focused on HIV treatment adherence (Graham et al., 2015), and one (3.22%) focused on optimal methods of collecting SOGI information from emergency department patients (Haider et al., 2018).

Development

There are four main strategies employed in intervention development mainly applied in combination, including (a) identification of service delivery gaps, (b) use of a conceptual framework, (c) expert collaboration and stakeholder consultation, and (d) training on culturally congruent care. *Recognizing service delivery gaps* served as a triggering point for

TABLE 1. Characteristics of Studies Included in the Review

Author, year, and country	Study design	Sample	Study setting
1. Bakhai et al. (2016a) United States	Posttraining survey	First-year medical students ($n = 121$)	Medical school
2. Bakhai et al., (2016b) United States	Pre- and post-survey	Third- and fourth-year medical students ($n = 40$)	Medical school
3. Braun et al. (2017) United States	Forum evaluation	Health profession students ($n = 550$)	University
4. Bristol et al. (2018) United States	Pre- and post-intervention	Emergency department health professionals ($n = 135$)	Hospital
5. Burch (2008) United States	Evaluative, cross-sectional	Health professionals ($n = 402$)	Hospital
6. Burns et al. (2020) United States	Mixed-method, multi-unit, embedded case study	Black MSM	Community
7. Desrosiers et al. (2019) United States	Pilot randomized controlled study	HIV-negative young Black MSM ($n = 50$)	Clinic
8. Donaldson et al. (2019) United States	Pilot pre- and post-intervention	Interdisciplinary long-term care staff ($n = 26$)	Hospital
9. Englund et al. (2019) United States	Pilot nonexperimental descriptive pretest–posttest survey	Nursing students ($n = 76$)	University
10. Gao & Wang (2007) China	Pretest, posttest	Gay men, men who have sex with men, and money-boy commercial sex workers ($n = 160$)	Gay venues, networks, and events
11. Garbers et al. (2016) United States	Project evaluation	Black and Latino SGM youth	Mobile van and clinic testing sites
12. Graham et al. (2015) Kenya	Pilot test	Men having sex with men ($n = 10$)	Clinic
13. Haider et al. (2018). United States	Matched cohort study	SGM and non-SGM emergency department patients ($n = 540$)	Hospital
14. Hanssmann et al. (2010) United States	Pre-experimental one group pretest, posttest	Healthcare or social service providers ($n = 55$)	Mixed of public school, non-profit clinics, and university-based clinic
15. Hardacker et al. (2014) United States	Pretest, posttest	Health professionals ($n = 849$)	Academic settings, community-based health centers, and long-term care facilities
16. Hickerson et al. (2018) United States	Pilot study	Nursing students ($n = 230$)	University

(Continued)

TABLE 1. Characteristics of Studies Included in the Review (*Continued*)

Author, year, and country	Study design	Sample	Study setting
17. Hughto et al. (2017) United States	Mixed-methods, pre-post, longitudinal	Correctional healthcare providers ($n = 34$)	Correctional facilities
18. Ingraham et al. (2016) United States	Pilot pretest, posttest	Healthcare providers and medical students ($n = 92$)	Universities and community health center
19. Kaplan et al. (2019) Lebanon	Pilot mixed methods	Transgender women ($n = 16$)	Nongovernment organization
20. Knockel et al. (2019) United States	Pre- and post-survey	Student pharmacists ($n = 85$)	University
21. Maruca et al. (2018) United States	Pretest, posttest, nonexperimental research	Student nurses ($n = 47$)	Universities
22. Muckler et al. (2019) United States	Pilot study with pre- and post-simulation survey	Nurse anesthesia students ($n = 30$)	Nursing school
23. Ostroff et al. (2018) United States	Online survey	Pharmacy students ($n = 108$)	University
24. Ozkara San et al. (2019) United States	Pilot post-simulation survey	Student nurse ($n = 32$)	Nursing school
25. Perucho et al. (2020) United States	Pretest posttest survey	Medical students ($n = 43$)	Medical school and cancer hospital
26. Reback et al. (2012) United States	Pretest, posttest longitudinal	Transgender women ($n = 60$)	Community
27. Seay et al. (2020) United States	Pilot pretest, posttest survey	Oncologists ($n = 44$)	Cancer centers
28. Stephenson et al. (2019) United States	Pilot randomized controlled study	Binary and nonbinary transgender youth ($n = 201$)	Participants' home
29. Traister (2020) United States	Descriptive correlational pretest, posttest	Registered nurses ($n = 111$)	Hospitals
30. Ufomata et al. (2020) United States	Pretest, posttest	Internal residents ($n = 100$) and faculty preceptors ($n = 29$)	Medical center
31. Walia et al. (2019) United States	Pretest, posttest	Pediatric perioperative care providers ($n = 169$)	Children's hospital

Note. MSM = men who have sex with men; SGM = sexual and gender minorities.

intervention conceptualization (Bakhai et al., 2016a; Braun et al., 2017; Burns et al., 2020; Donaldson et al., 2019; Hardacker et al., 2014; Hickerson et al., 2018; Knockel et al., 2019; Maruca et al., 2018; Muckler et al., 2019; Ostroff et al., 2018; Perucho et al., 2020; Reback et al., 2012; Traister, 2020; Walia et al., 2019). Gaps were identified through program review, evidence review, and

results of previous studies. Second, *conceptual frameworks* guided the conceptualization and selection of the target recipients, contents, activities, and evaluation methods of interventions (Burns et al., 2020; Desrosiers et al., 2019; Gao & Wang, 2007; Graham et al., 2015; Hughto et al., 2017; Ingraham et al., 2016; Maruca et al., 2018; Ozkara San et al., 2019; Perucho et al., 2020; Seay et al., 2020; Ufomata

et al., 2020). These frameworks focused on health promotion and education, human behavior, curriculum, and simulation development, socioecology, and stigma and discrimination. *Expert collaboration and stakeholder consultations* were performed among organizations, healthcare providers, SGM populations, and other stakeholders (Bakhai et al., 2016a, 2016b; Braun et al., 2017; Burch, 2008; Burns et al., 2020; Englund et al., 2019; Gao & Wang, 2007; Garbers et al., 2016; Graham et al., 2015; Haider et al., 2018; Hanssmann et al., 2010; Hardacker et al., 2014; Hickerson et al., 2018; Hughto et al., 2017; Ingraham et al., 2016; Kaplan et al., 2019; Maruca et al., 2018; Muckler et al., 2019; Ozkara San et al., 2019; Perucho et al., 2020; Seay et al., 2020; Stephenson et al., 2019; Ufomata et al., 2020). This process involved surveys, needs assessment, in-depth interviews, focus group discussions, community participation, and expert review. SGM groups, organizational leaders, and educational institutions provided support, guidance, and feedback to develop some interventions. Finally, facilitators and implementers received *culturally congruent care training*. They were selected based on their education, experience, and representation of SGMs (Bristol et al., 2018; Graham et al., 2015; Stephenson et al., 2019).

Contents

Most ($n = 17$, 54.84%) intervention content focused on the *foundational concepts of SGMs and their health* including gender, diversity, key terms, and language (Bakhai et al., 2016a, 2016b; Braun et al., 2017; Bristol et al., 2018; Donaldson et al., 2019; Hanssmann et al., 2010; Hardacker et al., 2014; Hickerson et al., 2018; Hughto et al., 2017; Ingraham et al., 2016; Kaplan et al., 2019; Knockel et al., 2019; Ostroff et al., 2018; Seay et al., 2020; Traister, 2020; Ufomata et al., 2020; Walia et al., 2019). The inclusion of these contents aims to reduce gender-based bias, promote individual validation, and demonstrate sensitivity toward the population. Other intervention contents ($n = 13$, 41.94%) included information about the population's general and specific state of health, prevalent health issues, health-related challenges, healthcare barriers, and healthcare experiences (Braun et al., 2017; Bristol et al., 2018; Burns et al., 2020; Desrosiers et al., 2019; Donaldson et al., 2019; Englund et al., 2019; Hardacker et al., 2014;

Hughto et al., 2017; Ingraham et al., 2016; Kaplan et al., 2019; Seay et al., 2020; Traister, 2020; Walia et al., 2019).

The content also focused on the *strategies to improve care delivery for SGMs* ($n = 19$, 61.29%) that emphasized communication and interaction with SGMs, creating inclusive environments, and responsiveness to care needs. These included patient assessment, communication and interviewing skills, best practices in patient care, an inclusive environment, and an interdisciplinary approach (Bakhai et al., 2016b; Braun et al., 2017; Bristol et al., 2018; Englund et al., 2019; Gao & Wang, 2007; Haider et al., 2018; Hanssmann et al., 2010; Hickerson et al., 2018; Hughto et al., 2017; Ingraham et al., 2016; Knockel et al., 2019; Maruca et al., 2018; Muckler et al., 2019; Ozkara San et al., 2019; Seay et al., 2020; Stephenson et al., 2019; Traister, 2020; Ufomata et al., 2020; Walia et al., 2019). Other strategies ($n = 16$, 51.61%) were health promotion, disease prevention, clinical management, stigma and discrimination reduction, and patient safety (Burns et al., 2020; Desrosiers et al., 2019; Gao & Wang, 2007; Garbers et al., 2016; Graham et al., 2015; Kaplan et al., 2019; Knockel et al., 2019; Maruca et al., 2018; Muckler et al., 2019; Ostroff et al., 2018; Ozkara San et al., 2019; Perucho et al., 2020; Reback et al., 2012; Seay et al., 2020; Stephenson et al., 2019; Ufomata et al., 2020).

Delivery and Structure

Interventions varied in terms of activities, duration, and facilitators. The majority ($n = 25$, 80.65%) employed a varied combination of approaches. Interventions were commonly offered for 2 hours or less (Bakhai et al., 2016a, 2016b; Burch, 2008; Donaldson et al., 2019; Englund et al., 2019; Hughto et al., 2017; Ingraham et al., 2016; Knockel et al., 2019; Muckler et al., 2019; Ostroff et al., 2018; Perucho et al., 2020; Seay et al., 2020). Others range from 2–6 hours (Bristol et al., 2018; Hanssmann et al., 2010; Hardacker et al., 2014; Hickerson et al., 2018; Ufomata et al., 2020), in weekly sessions totaling 10 (Reback et al., 2012) to 18 hours (Kaplan et al., 2019), or in a 1-day forum (Braun et al., 2017).

The activities were either learning-centered or care-centered, promoting care engagement, positive learning, and participant retention. *Learning-centered activities* aimed to educate participants on the care and needs of SGM through audiovisual presentations and interactive

discussions that applied safe space learning, case scenarios, clinical simulation, and learning assessment (Bakhai et al., 2016a, 2016b; Braun et al., 2017; Bristol et al., 2018; Burch, 2008; Donaldson et al., 2019; Englund et al., 2019; Hanssmann et al., 2010; Hardacker et al., 2014; Hickerson et al., 2018; Hughto et al., 2017; Ingraham et al., 2016; Knockel et al., 2019; Maruca et al., 2018; Muckler et al., 2019; Ostroff et al., 2018; Ozkara San et al., 2019; Perucho et al., 2020; Seay et al., 2020; Traister, 2020; Ufomata et al., 2020; Walia et al., 2019). In contrast, *care-centered activities* aimed to provide care services and promote care engagement directly to SGMs ($n = 9$, 29.03%). Care-centered activities involved creating an affirmative environment, doing care collaborations, performing community outreach, reducing disease-related risks, and providing health education (Burns et al., 2020; Desrosiers et al., 2019; Gao & Wang, 2007; Garbers et al., 2016; Graham et al., 2015; Haider et al., 2018; Kaplan et al., 2019; Reback et al., 2012; Stephenson et al., 2019).

Outcomes Measured

Outcomes measured can be categorized into healthcare provider outcomes, patient health outcomes, and intervention acceptability and feasibility. The instruments used for quantitative studies varied extensively in terms of type and validity. The *healthcare providers' cultural competence* was the most assessed outcome ($n = 22$, 70.97 %) based on knowledge, skills, attitudes, confidence, and comfort in the care of SGM populations (Bakhai et al., 2016a, 2016b; Braun et al., 2017; Bristol et al., 2018; Burch, 2008; Donaldson et al., 2019; Englund et al., 2019; Hanssmann et al., 2010; Hardacker et al., 2014; Hickerson et al., 2018; Hughto et al., 2017; Ingraham et al., 2016; Knockel et al., 2019; Maruca et al., 2018; Muckler et al., 2019; Ostroff et al., 2018; Ozkara San et al., 2019; Perucho et al., 2020; Seay et al., 2020; Traister, 2020; Ufomata et al., 2020; Walia et al., 2019).

Patient health outcomes included SGMs' health knowledge and behaviors ($n = 2$, 6.45 %) and healthcare utilization and experiences ($n = 7$, 22.58%). Among them, five (16.13%) evaluated the utilization of HIV education and prevention services among high-risk SGM groups (Burns et al., 2020; Desrosiers et al., 2019; Gao & Wang, 2007; Garbers et al., 2016; Stephenson et al., 2019). Three studies (9.68%) evaluated *intervention*

acceptability and feasibility through qualitative reports (Graham et al., 2015; Kaplan et al., 2019; Stephenson et al., 2019).

Components of Effective Interventions

Interventions that showed statistically significant improvement ($p < .05$) from the baseline or comparator group were considered effective interventions. Among the 25 studies that employed a quantitative approach only, 17 (68.00%) interventions achieved statistically significant positive effects on the set of outcomes measured (Bakhai et al., 2016b; Braun et al., 2017; Bristol et al., 2018; Desrosiers et al., 2019; Donaldson et al., 2019; Englund et al., 2019; Gao & Wang, 2007; Haider et al., 2018; Hardacker et al., 2014; Ingraham et al., 2016; Knockel et al., 2019; Maruca et al., 2018; Ostroff et al., 2018; Perucho et al., 2020; Reback et al., 2012; Seay et al., 2020; Traister, 2020). The common characteristics of effective interventions include (a) the use of combined approaches to developing the interventions, (b) the inclusion of critical concepts and strategies, and (c) delivering the intervention for a longer period. An example of intervention (Gao & Wang, 2007) exemplified the combination of these components through peer-led health education that positively impacted MSM's HIV prevention knowledge and behavior.

On the other hand, one study used a qualitative approach only and described favorable effects on participants, patient health outcomes, and intervention acceptability and feasibility (Graham et al., 2015). Finally, studies that used a mixed-methods approach showed complementary findings (Burns et al., 2020; Garbers et al., 2016; Hanssmann et al., 2010; Hughto et al., 2017; Kaplan et al., 2019). Qualitative descriptions supported quantitative findings and presented the strengths and points for improvement of interventions.

Discussion

This review provides evidence that culturally congruent care interventions can positively transform healthcare access, delivery, and outcomes among SGMs. The purposes of these interventions are to educate healthcare providers, reduce healthcare barriers, promote healthcare access, and improve care services among SGMs. Recognitions of care and educational

gaps trigger the development of these interventions. Systematic, collaborative, and evidence-based approaches were employed to design these interventions, delivered with varying and combined learning-centered and care-centered activities. In general, the more comprehensive, rigorous, and multi-method interventions are more likely to achieve successful outcomes.

Addressing the healthcare needs of SGMs requires extensive effort to understand the complexities of their health and healthcare needs. Pacquiao's (2008) Cultural Competent Care for Vulnerable Groups framework underscores the will to act and stand for SGMs' healthcare by initially having awareness, knowledge, and exposure to the nuances of the population's healthcare needs. Critical components of culturally congruent care interventions for SGMs echo the concepts of social justice and human rights. Fundamental concepts on SGM care, embedded in most interventions, drive healthcare providers to reflect on their biases, beliefs, and practices. Partnership, collaboration, and advocacy were demonstrated in the conduct of the intervention by actively involving stakeholders and SGM representatives. Finally, compassion that requires significant time to practice and develop is emphasized in the effective intervention that was implemented over a longer period, giving participants time to reflect and apply learned concepts and strategies.

Despite intentions to determine quantifiable measures through data pooling, the variability in study designs, instrumentation, and outcome measures only allowed narrative synthesis. Inherently, this study has several limitations. The retrieved studies only reflect those done in English and the majority from the United States limits the generalizability of the findings considering the uniqueness and variances of healthcare patterns of SGMs and the care practices of care providers in other settings. Most studies involved healthcare providers, and there is a limited representation of other SGM groups. However, the available information has allowed the inclusion of studies with acceptable quality to add to the existing evidence on culturally congruent care for SGMs.

Conclusion

This review shows that culturally congruent care interventions promote optimal health

outcomes and effective care delivery for SGMs. The characteristics of interventions demonstrate universality and diversity on how they were conceptualized, implemented, and evaluated. There is no single best-designed intervention that is feasible and acceptable across SGM subpopulations and their settings. To address this issue, collaboration, partnership, and advocacy can make interventions grounded on SGMs' health needs, lifeways, and sociocultural environments.

This review recommends further studies to test the effectiveness of well-designed interventions on a long-term cyclical term on actual healthcare delivery and experience. Culturally congruent care intervention requires greater meaning and extensive efforts to make them effective and sustainable. Interventions targeting healthcare providers require further evaluation on how they impact SGM's health and healthcare. The findings of this review reveal concepts, methods, and ways to manifest cultural care preservation, accommodation, or repatterning toward holistic and equitable care of SGMs.

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Correspondence regarding this article should be directed to Ryan Q. De Torres, MA, RN, College of Nursing, University of the Philippines Manila, Manila, National Capital Region, Philippines. E-mail: rqdetorres@up.edu.ph