



Raising standards of health care
service provision for LGBTIQ people

TRAINING SESSION FOR HEALTHCARE PRACTITIONERS



Co-funded by the Rights, Equality and Citizenship (REC) Programme of the European Union

INTRODUCTION

While Malta has one of the best legal frameworks worldwide with respect to the recognition and protection of LGBTIQ (lesbian, gay, bisexual, trans, intersex and queer) persons, the process of mainstreaming these legal provisions across all public services is still ongoing.

When LGB people access health services, practitioners often assume heterosexuality and use language, accordingly, meaning LGB people experience exclusion and invisibility. For trans and intersex people, health professionals using pathologising language and misgendering can result in avoidance of healthcare, as well as other problems.

For this reason, the Human Rights Directorate within the Ministry for Justice, Equality and Governance submitted an application under the Rights, Equality and Citizenship Programme of the European Union to tap into funds in order to ensure that LGBTIQ persons enjoy equal and non-discriminatory access to health services by enhancing the awareness and capacity of those involved in mainstream healthcare provision to meet their needs. The project **TRANSFORM: Raising standards of health care service provision for LGBTIQ people** has been awarded successfully and will run until October 2021.

It aims to do so primarily by enhancing the capacity of a range of health practitioners to address the health needs of LGBTIQ patients in a sensitive manner that acknowledges the specific challenges often encountered by LGBTIQ persons in their everyday life which impact on their health and wellbeing and by making practitioners more aware of heteronormative assumptions that result in inequalities in access to healthcare of LGBTIQ persons.

The project will also conduct awareness raising activities and provide resources that can assist healthcare providers in communicating their services as safe and inclusive spaces for LGBTIQ patients needing their care. A number of resources are aimed at the LGBTIQ community, based on the increased likelihood of experiencing a number of health-related conditions such as mental health; sexual health; substance misuse; as well as inform on existing health services and how to access them.

The project aims to benefit from the exchange of good practices through partnership with the Ghent University Hospital Trans Info-Point (TIP) and Gender Team. Through this partnership, it aims to build the knowledge base of GPs who are often the first point of call for all persons, including LGBTIQ persons suffering from generic ailments or requiring medical advice or referral to a specialist healthcare provider. Specialised training will also be provided to emergency services personnel. These trainings would be complimented by a website to which medical practitioners could refer for information on trans patient healthcare as well as signposting to specialist services such as those provided through the Gender Wellbeing Clinic where required.

Other training sessions are organised in collaboration with the Office of the Deputy Prime Minister and Ministry for Health, the Malta Union of Midwives and Nurses (MUMN) and the Malta College of Family Doctors (MCFD) as well as Steward Health Care. These sessions are aimed at various healthcare practitioners, managers and practice nurses, and front office staff who are the first point of contact for healthcare provision.

ILGA Europe and Transgender Europe are also involved in the project as associate partners which will increase outreach and dissemination of project results in European and international platforms. The project also enjoys the support of the Council of Europe SOGI Unit.

ABOUT THIS TRAINING

There is substantial evidence demonstrating that Lesbian, Gay, Bisexual, Trans, Intersex and Queer (LGBTIQ) people experience health inequalities. The social determinants of health, namely the discrimination, social exclusion and stigmatisation faced by LGBTIQ people are well-recognised root causes of such inequalities.

There is also evidence to suggest that direct and indirect discrimination against LGBTIQ people along with a lack of specific knowledge and sensitivity also exists within the health sector contributing to, and reinforcing LGBTIQ health inequalities.

This training course has been developed as part of the Health4LGBTI project by a consortium of 5 European partners, namely: EuroHealthNet (European Partnership for Improving Health, Equity and Wellbeing, Europe - Belgium), Verona University Hospital (AOUI-VR-Italy), National Institute of Public Health – National Institute of Hygiene (NIZP-PZH-Poland), University of Brighton (UoB-UK) and the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA-Europe-Belgium), working on behalf of the European Commission following a call for tenders (SANTE/2015/C4/035). It has been adapted to the Maltese context by the Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics Unit within the Ministry for Justice, Equality and Governance.

Who is this training course for?

This training course has been designed for Health Care Professionals (medical doctors – GPs and Specialists – nurses, psychologists, social workers, others) across all disciplines of healthcare and can be implemented at any stage of the education and working life, from undergraduate level to continuing professional education.

It is suitable also for support staff working in healthcare environments (e.g. secretaries, administrative staff) who come into contact with patients/clients on a regular basis.

What is the objective of this training course?

The overall objective of this training course is to raise awareness about the health inequalities experienced by LGBTIQ people and to provide Health Care Professionals (HCPs) with specific tools to ensure they have the right skills and knowledge to overcome the identified barriers to care provision for LGBTIQ people.

Specifically, the objectives of this training course are:

- To increase knowledge about LGBTIQ persons' health needs;
- To improve inclusive attitudes towards LGBTIQ persons; and
- To increase LGBTIQ-inclusive skills in providing healthcare for LGBTIQ people.

STRUCTURE OF MODULES

Module 1:

Introduction, awareness raising, concepts & terms

- Training overview
- Terminology & concepts

Module 2:

Health & health inequalities

- Health inequalities & root causes
- LGBTIQ health & healthcare provision
- Intersectionality

Module 3:

Communication & practice

- Inclusive & non-judgmental language
- Inclusive environment & practice

Module 4:

Trans & intersex health

- Myths on trans & intersex people
- Trans health
- Intersex health

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CONFIDENTIALITY AND PROTECTION

Regulation (EC) 45/2001¹ lays down the rules for data protection in the EU Institutions and is distinct from Directive 95/46/EC² (soon to be replaced by Regulation (EU) 2016/679)³ which applies at the level of the individual Member States.

Similarly, to Health4LGBTI project, TRANSFORM is a European Commission funded project and as the project involves the processing of personal data, it is subject to data protection rules as established by Regulation (EC) 45/2001.

As the training foresees the use of interactive training methods (e.g. practical exercises, discussion on case studies, guided brainstorming sessions) where the trainees are asked to contribute their views and possibly share their work experience in the context of a given activity, all participants are asked to sign a **Confidentiality Declaration** whereby they commit to **not refer** to any personal data of patients or service users during the training sessions.

Personal data shall mean any information relating to an identified or identifiable natural person hereinafter referred to as “data subject”; an identifiable person is one who can be identified, directly or indirectly, in particular by reference to an identification number or to one or more factors specific to ~~his or her~~ physical, physiological, mental, economic, cultural or social identity.

¹ Regulation (EC) 45/2001 of the European Parliament and of the Council of 18 December 2000 on the protection of individuals with regard to the processing of personal data by the Community institutions and bodies and on the free movement of such data

² DIRECTIVE 95/46/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data

³ Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation) (Text with EEA relevance)

MODULE 1

Introduction, awareness raising, concepts & terms

Learning objectives

After this module, participants will have a better understanding of:

- ▶ the overall aims, background and contents of the project and of the training course;
- ▶ terms and concepts in the field;
- ▶ sexual orientation, gender identity, gender expression and sex characteristics;
- ▶ how to go about discussing LGBTIQ issues; and
- ▶ the correct use of the relevant terminology.

Activity 1: Introduce yourself

This is an icebreaker activity. We ask you all to take turns and answer the following questions:

- Your name & the pronoun you use to describe yourself;
- Your professional background;
- Your previous experience on this topic; and
- One or two things you expect from the training course.

Video: Experience of healthcare settings: LGBTI people tell their stories



Think about the following question:

Do you think these could be stories of patients/clients accessing health services in Malta?

Observations:

Terms and Concepts

LGBTIQ

LGBTIQ:

LGBTIQ is an acronym for lesbian, gay, bisexual, trans, intersex and queer people. It is commonly used within the LGBTIQ movement itself.

The LGBTIQ acronym refers to different groups of people who have been historically marginalised because they do not fit norms around gender and sexuality;

Even though like all acronyms, it both includes and excludes people, it enables to shed light on situations and experiences that are often invisible in society, including in healthcare settings;

The acronym has changed over time, and varies across countries, regions and communities. However, the LGBTIQ acronym was chosen for this project because it is widely used by the LGBTIQ community, and is inclusive of realities that need to be taken into account in healthcare settings;

While several acronyms can be used, participants should be aware that they are not interchangeable. Each letter represents a specific group. Therefore, when using a specific acronym, we are including/excluding certain people, which should always be justified.

Terms and cultures regarding sexual orientation, gender identity, gender expression and sex characteristics are constantly evolving and can vary in different countries. The important thing is to listen to people and reflect on the terminology they use to identify themselves.

Sexual Orientation

Sexual Orientation (noun):

Refers to each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, persons of a different gender, the same gender or more than one gender. The most visible sexual orientations include, but are not limited to, homosexuality, bisexuality or heterosexuality.

Lesbian (adjective):

A woman emotionally and/or sexually attracted to other women.

Example: Marta identifies as a woman. She is only sexually and emotionally attracted to people of the same gender. Marta is a lesbian.

Gay (adjective):

A person who is emotionally and/or sexually attracted to people of the same gender. Traditionally, it refers to men, but other people who are attracted to the same gender or multiple genders may also define themselves as gay. So 'gay' is sometimes also used as a blanket term to cover lesbians and bisexual people as well as gay men.

Example: John identifies as a man. He is only sexually and emotionally attracted to people of the same gender. John is gay.

Bisexual
(adjective): A person who is emotionally and/or sexually attracted to people of more than one gender.

Example: Juliana identifies as a woman. She is sexually and emotionally attracted to people of the same gender as her, but also to people of another gender. Juliana is bisexual.

Homosexual: A term used to describe someone who has an emotional, romantic and/or sexual attraction towards someone of the same gender. The term 'gay' is now more generally used.

Gender Identity and Gender Expression

Gender
(noun): Refers to the socially constructed roles, expectations, activities, behaviours and attributes that society at any given time associates with a person of any sex, assuming any form of gender identity or gender expression.

Gender Identity
(noun): Refers to each person's internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance and, or functions by medical, surgical or other means) and other expressions of gender, including name, dress, speech and mannerisms.

Gender Expression
(noun): Refers to each person's manifestation of their gender identity, and, or the one that is perceived by others.

Trans
(adjective): This is an inclusive umbrella term referring to people whose gender identity and/or gender expression differ from the sex/gender they were assigned at birth. It may include, but is not limited to: people who identify as transsexual, transgender, transvestite/cross-dressing, androgyne, polygender, genderqueer, agender, gender variant, gender non-conforming, or with any other gender identity and/or expression which does not meet the societal and cultural expectations placed on gender identity.

Trans man: A term used to identify a person assigned a female gender at birth (or who is female-bodied) and who identifies as a male, lives as a man, or identifies as masculine.

Example: Alex identifies as a man and his gender identity is male. However at birth, his assigned sex was female: Alex is a trans man.

Trans woman: A term used to identify a person assigned a male gender at birth (or who is male-bodied) and who identifies as a female, lives as a woman, or identifies as feminine.

Example: Maria identifies as a woman: her gender identity is female. However, at birth, her assigned sex was male: Maria is a trans woman.

Transsexual
(adjective): An older and medicalised term used to refer to people who identify and live in a different gender. The term is still preferred by some people who intend to undergo, are undergoing or have undergone gender affirmation treatment (which may or may not involve hormone therapy or surgery).

Cisgender
(adjective): A term referring to those people whose gender identity matches the sex they were assigned at birth.

Non-binary: Describes a person whose gender identity falls outside the traditional gender binary. Other terms for people whose gender identity falls outside the gender binary include gender variant, gender expansive, gender fluid gender queer, etc. Gender expression may or may not differ from a society's norms for males and females.

Example: Dylan identifies as non-binary. However, at birth, their assigned sex was female: Dylan is a trans person.

Specific terms on Gender Identity

Cross-dresser: A person who occasionally wears clothing considered typical for another gender, but who does not necessarily desire to change gender. Cross-dressers can be of any sexual orientation.

**Drag King/
Drag Queen:** A person who wears the clothing of another gender, often involving presentation of exaggerated, stereotypical gender characteristics. Individuals may identify as drag kings or drag queens when performing gender as parody, art or entertainment.

**Cross-gender
hormonal therapy**
(noun): The administration of hormone therapy in order to match a person's physical characteristics to their gender identity.

Gender fluid
(adjective): Describes a person whose gender identity is not fixed. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more one gender some days, and another gender on other days.

**Gender
non-conforming**
(adjective): Describes gender expression that differs from a given society's norms for males and females.

Genderqueer
(adjective): Describes a person whose gender identity falls outside the traditional gender binary.

Gender variant
(adjective): Can refer to someone whose gender identity differs from normative gender identity and the gender roles/norms assigned at birth.

**Gender affirmation
process**
(Transition) (noun): Refers to a series of steps people may take to live in the gender they identify with. Transition can be social and/or medical. Steps may include coming out to family, friends and colleagues; dressing and acting according to one's gender; changing one's name and/or sex/gender on legal documents; medical treatments including hormone therapies and possibly one or more types of surgery.

Gender dysphoria (noun):	Distress experienced by some individuals whose gender identity does not correspond with their assigned sex at birth. Manifests itself as clinically significant distress or impairment in social, occupational, or other important areas of functioning. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes gender dysphoria as a diagnosis.
Gender reassignment:	Refers to the process through which people re-define the gender in which they live in order to better express their gender identity. This process may, but does not have to, involve medical assistance including hormone therapies and any surgical procedures that trans people undergo to align their body with their gender.
Gender Reassignment Surgery (GRS):	Medical term for what trans people often call gender confirmation/affirmation surgery, which is sometimes (but not always) part of a person's transition.
Gender Recognition:	A process whereby a trans person's gender is recognized in law, or the achievement of the process.
Genderism / Gender binary (noun):	The idea that there are only two genders, male and female, and that a person must strictly fit into one category or the other.
Queer (adjective):	Previously used as a derogatory term to refer to LGBTIQ individuals in the English language, queer has been reclaimed by people who identify beyond traditional gender categories and heteronormative social norms. However, depending on the context, some people may still find it offensive. Also refers to queer theory, an academic field that challenges heteronormative social norms concerning gender and sexuality.

Sex Characteristics

Sex (noun):	<p>The classification of a person as male or female.</p> <p>Sex is assigned at birth and written on a birth certificate, usually based on the appearance of their external anatomy and on a binary vision of sex which excludes intersex people.</p> <p>A person's sex, however, is actually a combination of bodily characteristics including chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics.</p> <p>The sex assigned at birth usually becomes the legal sex after being written in the birth certificate and transposed to identification documents.</p>
Biological male:	A term assigned to a person at birth whose sex produces spermatozoa and refers to traditionally defined anatomy (e.g. penis, scrotum) and chromosomal makeup (XY) of a boy/man.
Biological female:	A term assigned to a person at birth whose sex produces ova and has traditionally defined anatomy (e.g. vagina, uterus) and chromosomal makeup (XX) of a girl/woman.

Intersex
(adjective):

Intersex individuals are born with physical sex characteristics that don't fit medical or social norms for female or male bodies.

These variations in sex characteristics may manifest themselves in primary characteristics (such as the inner and outer genitalia, the chromosomal and hormonal structure) and/or secondary characteristics (such as muscle mass, hair distribution and stature).

People with variations of sex characteristics may use or not the term "intersex" to refer to themselves. Nonetheless, during the training we use the term intersex to refer to all people with variations of sex characteristics.

Example: When he was born, Sam's sex characteristics could not be clearly classified as either male or female. His parents decided to assign him as a female. However, today, Sam identifies as a man.

Example: Lily was assigned male at birth. However, as she got into puberty, she developed sex characteristics traditionally assigned to females. Now Lily identifies as female. Lily is intersex (and trans).

Sexual behaviour

MSM (men-who-have-sex-with-men):

MSM is a term used to refer to men who have sex with other men but do not necessarily identify as gay or bisexual.

WSW (women-who-have-sex-with-women):

WSW is a term used to refer to women who have sex with other women but do not necessarily identify as lesbian or bisexual.

Terms related to the field of discrimination

Discrimination:

Unequal or unfair treatment which can be based on a range of grounds, such as age, religion or belief, race or ethnicity, disability, sexual orientation or gender identity.

Victimisation:

A specific term describing discrimination that a person suffers because they have made a complaint or been a witness in another person's complaint.

Harassment:

Shall be deemed to occur when there is unwanted conduct related to one or a combination of any protected characteristic, which has the purpose or effect of violating the dignity of a person, in particular when creating an intimidating, hostile, degrading, humiliating or offensive environment.

Transphobia:

Refers to negative cultural and personal beliefs, opinions, attitudes and behaviours based on prejudice, disgust, fear and/or hatred of trans people or against variations of gender identity and gender expression.

- Heteronormativity:** Refers to the set of beliefs and practices that gender is an absolute and unquestionable binary, and therefore describes and reinforces heterosexuality as a norm. It implies that people's gender and sex characteristics are by nature and should always be aligned, and therefore heterosexuality is the only conceivable sexuality and the only way of being 'normal'.
- Cisnormativity:** Cisnormativity is the assumption that all, or almost all, individuals are cisgender. It is a combination of the prefix cis-, as in cisgender, and the suffix -normativity, as a complement to heteronormativity.
- Heterosexism:** It is a set of discriminatory attitudes, bias and behaviour relying on gender as a binary to favour heterosexuality and heterosexual relationships.

Activity 3: Let's practice your knowledge

Assign each term to its correct definition and category.

GROUP 1					
	Term	Definition	Category (Mark with an X)		
			Sexual Orientation	Sex and Sex Characteristics	Gender Identity
1		Term used to identify a person assigned a male gender at birth and who identifies as a female.			
2		A term that relates to a range of physical traits or variations that lie between stereotypical ideals of male and female.			
3		Person that is emotionally and/or sexually attracted to people of the same gender.			

Terms: Gay; Transwoman; Intersex

GROUP 2					
	Term	Definition	Category (Mark with an X)		
			Sexual Orientation	Sex and Sex Characteristics	Gender Identity
1		Combination of bodily characteristics including chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics.			
2		Term that refers to people whose gender identity and/or gender expression differs from the sex they were assigned at birth.			
3		Person that is emotionally and/or sexually attracted to people of more than one gender.			

Terms: Bisexual; Sex; Trans

GROUP 3					
	Term	Definition	Category (Mark with an X)		
			Sexual Orientation	Sex and Sex Characteristics	Gender Identity
1		Person at birth whose sex produces spermatozoa and refers to traditionally defined anatomy (e.g. penis and scrotum) and chromosomal makeup (XY).			
2		Each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth.			
3		Person whose partner's gender is the same as the individual's.			

Terms: Homosexual; Biological Male; Gender Identity

GROUP 4					
	Term	Definition	Category (Mark with an X)		
			Sexual Orientation	Sex and Sex Characteristics	Gender Identity
1		Person at birth whose sex produces ova and has traditionally defined anatomy (e.g. vagina, uterus) and chromosomal makeup (XX).			
2		A woman who is sexually and/or emotionally attracted to women.			
3		An older and medicalised term used to refer to people who identify and live in a different gender.			

Terms: Transsexual; Biological female; Lesbian

GROUP 5					
	Term	Definition	Category (Mark with an X)		
			Sexual Orientation	Sex and Sex Characteristics	Gender Identity
1		Term used to identify a person assigned a female gender at birth and who identifies as a male.			
2		Person whose gender identity and assigned sex at birth correspond.			
3		Term refers to each person's capacity for profound affection, emotional and sexual attraction to, and intimate and sexual relations with, someone.			

Terms: Sexual Orientation; Trans man; Cisgender

MODULE 2

Health and health inequalities

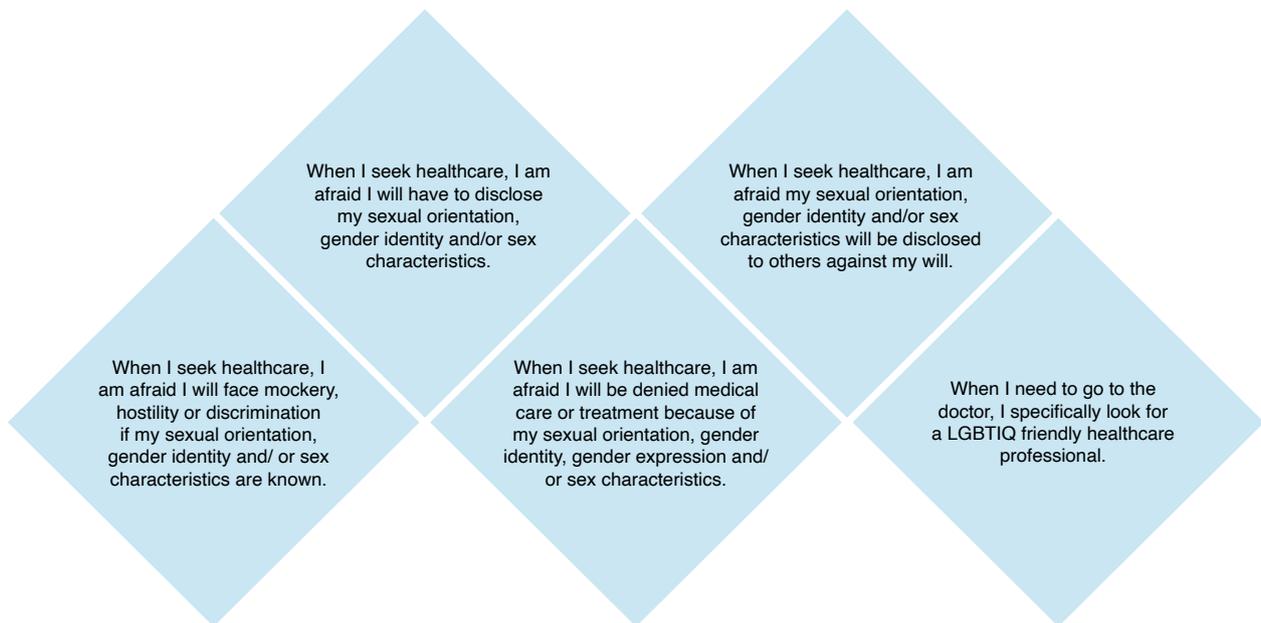
Learning objectives

After this module, participants will have a better understanding of:

- ▶ factors that affect LGBTIQ people's health outcomes;
- ▶ specific health needs of LGBTIQ people;
- ▶ access and barriers to proper care faced by LGBTIQ people;
- ▶ barriers and challenges faced by healthcare professionals in providing care; and
- ▶ the concept of intersectionality

Activity 1: Position & privilege

This is a self-reflection exercise. Take off your hat as a healthcare provider and think of yourself as a patient/client. Reflect on the statements below:



Health inequalities - What are they?

“Health inequalities refer to the avoidable and unfair differences in health that are strongly influenced by the actions of governments, stakeholders, and communities and can be addressed by public policy”⁴



“LGBTIQ people in Europe experience significant health inequalities within heteronormative contexts where heterosexuality based on binary gender is upheld as the social and cultural norm, as well as minority stress associated with sexual orientation, gender identity and sex characteristics, victimisation, discrimination and stigma”⁵

⁴(EC, 2009 ; Gugglberger et al., 2016; Marmot, 2010; NHS Health Scotland, 2015; Sherriff et al., 2014)

⁵Zeeman et al., 2017 - Health4LGBTI Scientific Review

Root causes of health inequalities



Example:

Heteronormativity, heterosexism, victimisation, institutional discrimination, stigma (anticipated, internalised, enacted), minority stress, etc.

Anticipated stigma:	where LGBTIQ people show apprehension due to potential future occurrences of stigmatisation.
Internalised stigma:	where people devalue themselves as a result of their sexual orientation, gender identity, gender expression or sex characteristics.
Enacted stigma:	where people experience real instances of discrimination.
Minority stress:	the leading narrative that explains the health inequalities of LGBTIQ people. Stigma, prejudice and discrimination create a hostile environment where LGBTIQ people are subject to stressful social exchange that may have adverse implications for health-seeking behaviour and health outcomes later in life.

Activity 2: Let's talk about LGBTIQ healthcare

Look at the quotes below and reflect on the following questions:

- Which could be the potential causes of health inequalities in these quotes?
- Which could be the potential barriers faced by health professionals and LGBTIQ patients/clients in this healthcare setting?
- Which potential impact could they have on the healthcare pathways?

1. ***“After experiencing the first symptoms of an illness, I feel huge emotional stress, because I know that after turning to a healthcare facility either I will have to come ‘out’ as lesbian and shock my doctor or I will have to conceal this fact and to face many misguided questions. As long as I have the choice, I will stay at home and will try to treat myself independently. The healthcare sector is alien, unsafe and not understanding my needs.”***

Lesbian woman, Lithuania

2. ***“I went to my doctor with a stress-related illness and mentioned that ‘coming out’ to my family had been a recent source of stress. He responded by telling me that his sister had recently ‘come out’, told me that he was still revolted by it, and said that his family were operating a ‘don’t ask don’t tell’ policy. He didn’t seem to have any awareness that this might have an impact on my reaction to him!”***

Bisexual woman, UK

3. ***“I have contacted 16 doctors from [name] and local towns. Most of them wrote back to me explaining that they do not work with people like me and they have no information [about the options of transitioning in Slovakia]. They know nothing, they are not trained or they simply wrote to me that they are not interested in meeting me.”***

Anonymous 20-year old, Slovakia

4. ***LT LGBTI 2: I feel horrible when they refer to me as ‘she’ only because it is in my documents... There was a situation. I went to see an eye doctor, and they referred to me as ‘she’, ‘she’, ‘she’, ‘she’. I felt horrible, I hate to hear this. Hence, I try not to go there.
LT LGBTI 9: Did you ask them to refer to you as “he“?
LT LGBTI 2: I did. Funnily, when I came they were saying ‘he’, ‘he’, then they read ‘she’ in my documents and that was it. I was referred to as ‘she’ for the rest of my visit.***

Lithuania LGBTI Focus Group

5. ***“They made [asked] me various intimate questions, including on my biology and sexuality. I was so uncomfortable that I left as soon as possible. I was afraid for my well-being.”***

Trans man, 21 years old, Portugal

6. ***“A trans woman went to the pharmacy with a valid receipt. The pharmacist did not fill the prescription and said: ‘You won’t get female hormones; I can see that you are a man’.”***

Trans woman, Austria

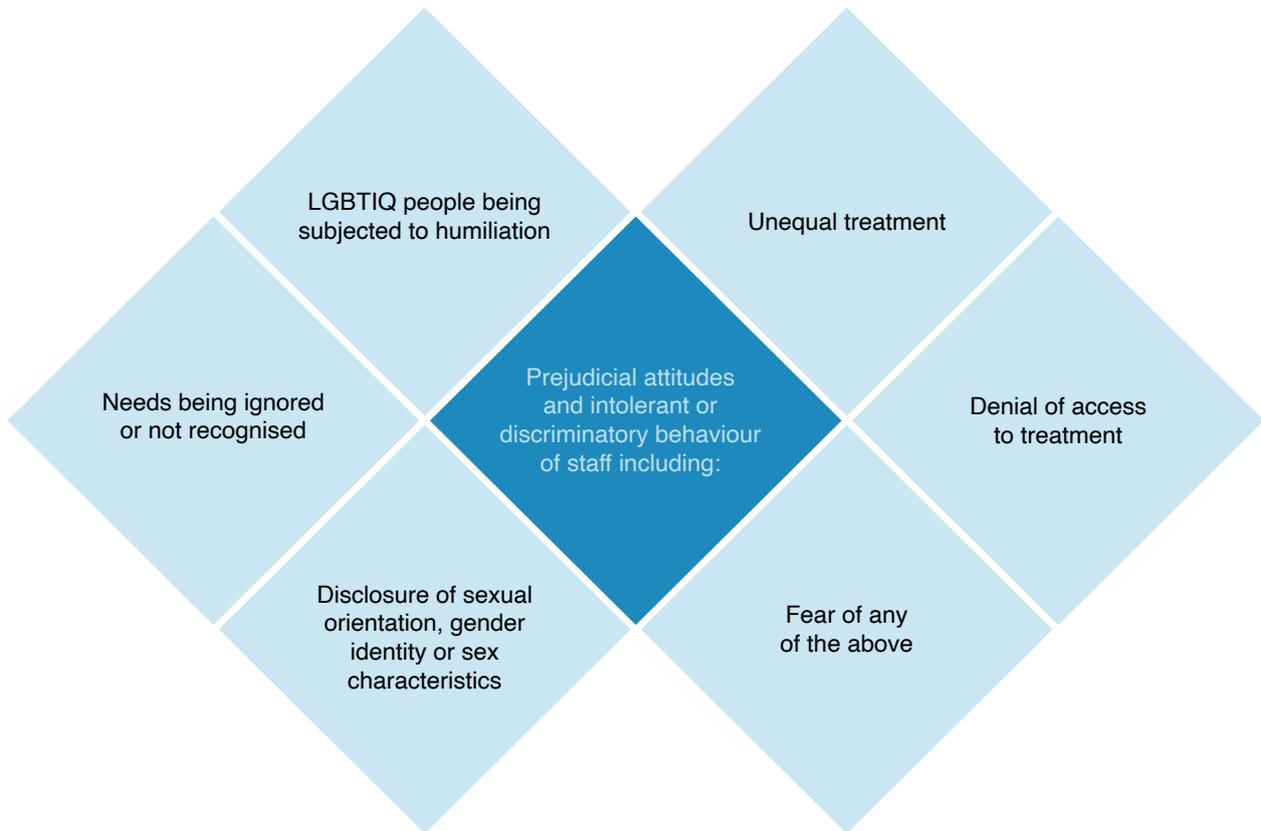


<https://www.youtube.com/watch?v=2asPSMg0HDk>

Potential barriers and challenges faced by health professionals and LGBTIQ people

- 1** Cultural and social norms
- 2** Institutional barriers
- 3** Lack of knowledge and training
- 4** Not using the right language
- 5** “Don’t ask, don’t tell” routine

Examples:



With regards to cultural and social norms, in contexts where gender and sexual norms are upheld (such as heteronormativity), health professionals may (un) knowingly and often (un) intentionally subject LGBTIQ people to heterosexism, homophobia, biphobia, transphobia, or intersexphobia resulting in significant barriers to healthcare.

With regards to language, when LGB people access health services, practitioners often assume heterosexuality and use language accordingly, meaning that LGB people experience exclusion and invisibility. For trans and intersex people, health professionals using pathologising language and incorrect pronouns can (amongst other things) result in avoidance of healthcare.

Findings from the research revealed that many health practitioners are not always aware of the LGBTIQ status of their patients/ clients nor that their patients/clients could be LGBTIQ. Reasons for non-disclosure include perceptions of irrelevancy to treatment and care, concerns over the negative attitudes of health professionals including fear of impact on healthcare.

When it comes to institutional barriers, research showed that documentation and protocols used by practitioners had clearly been developed around assumed heterosexuality and were therefore not geared towards the needs of LGB people. Moreover, there is a lack of relevant documentation like leaflets, flyers, information, marketing materials and processes for recording patient information and care pathways that are appropriate for lesbian and gay patients.

Although no research was evident for trans or intersex people in this respect, it is important to acknowledge that trans and intersex people may have very particular needs with regards to the recording of demographic information and health records which need to be addressed.

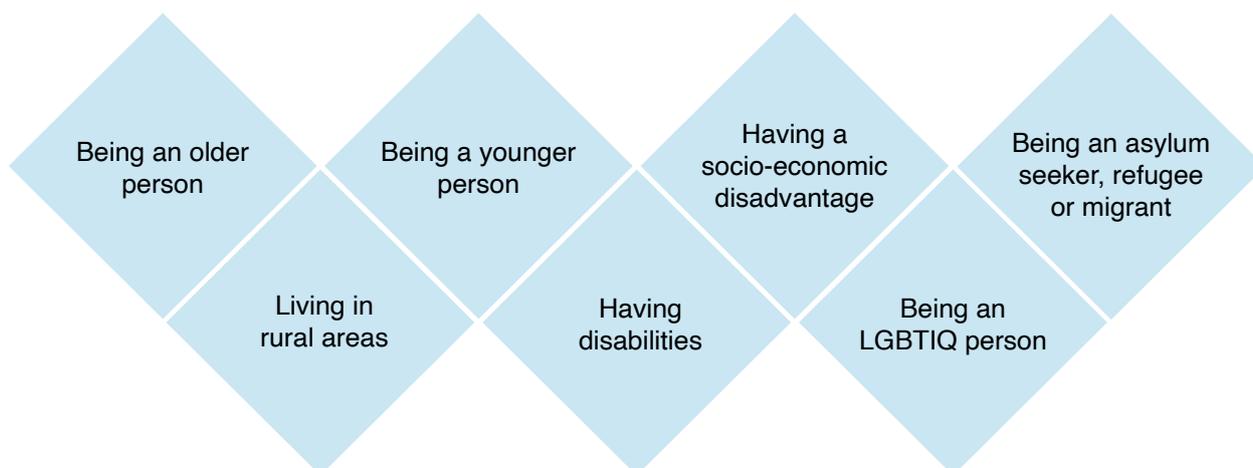
With respect to knowledge and training, the research is overwhelmingly clear; many generic and specialist health professionals lack the appropriate knowledge regarding the lives and related healthcare needs of LGBTIQ people as well as lack the appropriate culturally competent skills necessary to meet their needs. Appropriate training is required to redress these key gaps in the knowledge of health professionals.

Activity 3: Quiz on health inequalities experienced by LGBTI people

Look at the following statements and mark with an **X** whether they are true or false.

	STATEMENT	TRUE	FALSE
1	Lesbian women are at increased rates of polycystic ovaries and polycystic ovary syndrome.		
2	Only half of lesbian and bisexual women in one sample attended cervical screening.		
3	More than one fifth of gay and bisexual men are depressed and more than half of them experience anxiety.		
4	One fifth of lesbian and bisexual women had deliberately self-harmed (in the year before the study was conducted).		
5	More than half of trans women suffer of depressive symptoms		
6	Almost two-thirds of intersex people have considered suicide (compared to 3% of the general population).		
7	Gay and bisexual men are more than at twice the risk of developing drug dependence than their heterosexual counterparts.		
8	Almost nine out of ten HIV-positive gay men carry the human papilloma virus.		

Intersectionality



In general, there appears to be very little research exploring intersectionality for LGBTIQ people, but particularly so for trans and intersex people. Intersections of LGBT(I)Q identities were found to contribute to LGBTIQ health inequalities.

“Actually, so far, I haven’t thought there could be a LGBT senior. I thought that only the young ones are ...”

Manager of a health and social care institution, Czech Republic

LT LGBTI 4: “I believe that everything should start with a GP because if you don’t trust your GP then you have to choose private services...”

LT LGBTI 6: “Only if you have money. Some people, most of the people, especially young students do not have money to spare for private hospitals and they have no other possibilities.”

Lithuania LGBTI Focus Group

“It is so much harder to access the healthcare services that are friendly to LGBT communities especially from smaller places that have a worse contact with the community. Sometimes they have to travel, can’t afford it, they can’t explain the travel to the family because they don’t know. Because they haven’t come out so they don’t receive any help.”

Poland LGBTI HCP Interview

Key findings on intersectionality

- **Living in rural areas** appears to contribute to health inequalities and have implications for access to services.
- **Older LGB** people can experience both physical and mental health difficulties as they age; social support can act as a protective factor.
- Many **young LGBT** people experience mental health difficulties and substance misuse.
- Mental health practitioners will benefit from increased awareness of the psychosocial impact of abuse experiences on **LGBT(I)Q migrants**.
- LGBT(I)Q people on **lower incomes** may be at a higher risk of mental health problems and smoking (data limited).
- LGBT(I)Q people with **disabilities** due to chronic health conditions or poor physical or mental health are more likely to be disabled at a younger age.

MODULE 3

Communication and practice

Learning objectives

After this module, participants will have a better understanding of:

- ▶ the relevance of using inclusive language taking into account sexual orientation, gender identity, gender expression and sex characteristics;
- ▶ how to approach LGBTIQ people in an inclusive and non-judgmental way; and
- ▶ how to make their practice/ the healthcare setting more welcoming for LGBTIQ people by respecting privacy and ensuring trust and comfort.

Introduction: Language and communication

“I feel horrible when they refer to me as ‘she’ only because it is in my documents... There was a situation. I went to see an eye doctor, and they referred to me as ‘she’, ‘she’, ‘she’, ‘she’. I felt horrible, I hate to hear this. Hence, I try not to go there.”

Trans Man Lithuania LGBTI Focus Group

Language is often seen as a potential barrier for transgender persons in accessing health care services. Health practitioners often approach their patients assuming everyone is heterosexual, cisgender and non-intersex. This is reflected in the language that is used, which may not always be inclusive. Such assumptions reinforce the invisibility of LGBTIQ people and create certain barriers in communication.

Practitioners sometimes use pathologizing language with LGBTIQ people and incorrect pronouns for trans identities and intersex people.

Practitioners sometimes express inappropriate curiosity towards the LGBTIQ identity of patients, by asking questions or making comments not related to the health concern that the patient sought help for.

Activity 1: ‘Cuál es la diferencia?’ (2nd part)



<https://www.youtube.com/watch?v=2asPSMg0HDk>

- Observe language (both verbal and non-verbal) used by the healthcare provider and take notes of the relevant communication aspects (i.e. questions, non-verbal, terminology used) noticed.
- Consider the impact of the two different kinds of communication on the clinician – patient interaction.
- Consider the potential impact on the care pathways.

Observations:

Inclusive Communication

	
<p>Are you married?</p>	<p>Do you have a partner?</p>
<p>Do you have a girlfriend? (If with a male patient) Do you have a boyfriend? (If with a female patient)</p>	<p>Are you in a relationship? Do you have a girlfriend or a boyfriend? Are you in one or more relationships?</p>
<p>What is your wife's name? (If with a male patient) What is your husband's name? (If with a female patient)</p>	<p>What is your partner's name?</p>
<p>Are you having sex change treatments?</p>	<p>Are you accessing gender-affirming healthcare/ transition-related healthcare?</p>
<p>Using the wrong pronouns and name with trans people.</p>	<p>What name and pronoun should I use?</p>

Health professionals should never assume the sexual orientation, gender identity, gender expression or sex characteristics of any of their patients. It is advisable to always use the terminology and pronouns used by the patients themselves, as these are most likely to be the ones that they mostly feel reflect their identities and prefer to be referred to as.

Whenever the topic of both sexual and romantic partners is brought up between a professional and a new patient, gender neutral language should be used not to assume heterosexuality.

Remember that each encounter is individual and culturally specific. Language should therefore be fluid and reflect openness and sensitivity to create space for plurality and diversity.

It is an undeniable fact that disclosure of sexual orientation, gender identity and/or sex characteristics can bring health benefits and greater levels of satisfaction with care due to better patient-doctor communication. In some instances LGBTIQ people may not want to disclose their sexual orientation, gender identity or sex characteristics due to safety concerns, fear of discrimination or the need for privacy and confidentiality (Fish & Bewley, 2010). It is the professional's duty to facilitate disclosure where appropriate and if it is deemed necessary for the medical care provided.

LGBTIQ people are more likely to come out where:

They feel supported and know that they will be accepted by others

They know health professionals would uphold their confidentiality and privacy

Activity 2: Creating an inclusive practice

It is very important that all medical and health professionals look and reflect upon the practice and environment that they work in and try to find ways in order to improve it and better cater for the needs of its patients including LGBTIQ persons.

Think what aspects of your practice or the environment that you operate in would you deem to be inclusive and which not. Use the below questions to stimulate your thought.

1

How do patients/clients first come into contact with your practice?

2

How, through the current documentation or protocol, do you record the legal name or preferred name?

3

Do the intake forms in documentation include only binary gender markers or also other possibilities?

4

How do the intake forms ask about marital status? Are civil unions or same-sex marriages considered?

5

Are there some areas of documentation and protocols that should be developed to specifically target the health needs of LGBTIQ people?

6

And what about physical spaces? Is there anything that suggest to LGBTIQ people they are in a friendly and open-minded service (flag, poster, pamphlet, LGBTIQ specific scientific newsletter)?

7

Is there one universal gender-neutral bathroom at your workplace?

Reducing barriers in your practice

“If health workers made it obvious, for example, through posters or direct contact with me, that patient’s sexuality was not an issue for them and that lesbians were welcome, I might feel easier about visiting the GP for things like smears”

Lesbian Woman

Guidelines – Ashworth, A. 2012 Sexual orientation:
A guide for the NHS Stonewall UK

There are various initiatives one can take to try and eliminate this inequality that still exists within our services. Some initiatives cost us little money and time while others might require a little more effort. The below are some recommendations some may wish to adopt within their facility.

- Provide training in all settings to develop LGBTIQ awareness and cultural competence;
- Develop or re-design services to address LGBTIQ persons’ needs;
- Promote connectedness of LGBTIQ people to the broader LGBTIQ community;
- Promote visibility of LGBTIQ staff to create a comfortable atmosphere facilitating people to come out;
- Provide information in health settings which features LGBTIQ people (e.g. leaflets, posters) to help promote the visibility of LGBTIQ people;
- Include same-sex partners in decision-making about care pathways and treatment options;
- LGBTIQ people – like any other patients - should be included in decision-making about healthcare

MODULE 4

Trans and intersex health

Learning objectives

After this module, participants will have a better understanding of:

- ▶ concepts in the field of gender identity, gender expression and sex characteristics;
- ▶ the health needs of trans and intersex people; and
- ▶ the standard of care and human rights of trans and intersex people.

Trans Healthcare and Health Inequalities

Trans persons face a range of specific and particularly difficult obstacles when trying to access or accessing health services (TGEU, 2017). According to the FRA EU LGBTI II survey, 46% are not out to any medical staff /healthcare provider and a further 24% are only out to a few. On average one in 6 LGBTI respondents (16%) who accessed healthcare services in the 12 months before the survey felt personally discriminated against by healthcare personnel.

Among trans participants the level of discrimination was twice as high: almost one in 3 (34%) say they were discriminated against by healthcare personnel in the year before the survey. Notably, 52 % of respondents who assess their general health as 'very bad', and 36 % of those who assess this as 'bad', felt discriminated against in healthcare settings. Fewer who assessed their health as 'very good' or 'good' did so (11 % and 14 %, respectively).

“I was refused medical care from a nurse at a general practice due to being [Trans] and thus making her uncomfortable. I then had to be assigned to another general practice to receive my injections.”

(United Kingdom, Trans woman, Bisexual, 22) FRA LGBTI Survey II (2020)

Most trans people encounter stigma in the form of social rejection and transphobia. For this reason, they are more likely to leave healthcare prematurely due to feeling isolated. In contrast, those who experienced trans friendly and inclusive treatment recount more constructive care pathways and positive treatment outcomes (Lyons T.et al., 2015).

Trans people were more likely to:

- have difficulties in gaining access to healthcare (TGEU, 2017);
- have to change a specialist on account of their negative reaction;
- receive unequal treatment when dealing with medical staff;
- forgo treatment for fear of discrimination;
- have specific needs ignored or inappropriate curiosity; and
- feel pressure or being forced to undergo any medical or psychological test (FRA, 2014).

Research undertaken globally indicates considerably higher rates of mental distress amongst trans people when compared to the general population. This is related to stressors such as discrimination, stigma and also violence (Zeeman, 2017). Studies show that trans people have:

- Higher rates of depression and anxiety;
- Significantly increased levels of suicidal ideation and suicide attempts; and
- Higher rates of substance misuse.

Research supports the requirement for training to educate healthcare practitioners, to challenge prejudice in practice settings, and to increase knowledge and competence on trans specific health needs (Lyons et al., 2015; FRA, 2014).

Gatekeeping

“A disorder is a description of something with which a person might struggle, not a description of the person or the person’s identity.”

W. Path, 2011

Gatekeeping is the practice of imposing requirements which controls access to resources for trans people. It is often used in regard to medical transition, where there are formal requirements one must fulfil in order to access hormonal or surgical treatments. The healthcare provider’s role in guarding access to medical treatments, such as hormone therapy and surgery can be a challenge for both providers and patients (Bess & Stabb, 200931; Bockting et al., 200432). Gatekeeping may be, in fact, a significant barrier in the access to medical treatments.

Harry Benjamin (one of the first physicians to work with trans persons, in the 1960s) did acknowledge that there was a large variation among trans people in terms of their wanting to temporarily, partially, or completely transition to another gender, and whether that transition would be of a social, hormonal and/or surgical nature. But, as trans people gained more attention, those health professionals who acted as gatekeepers enacted an approach different from the one Benjamin initially advocated: one that would regulate the availability of hormones and surgeries only to those people who would be able to successfully blend into society as “regular” women and men by completely transitioning to the so-called other sex.

By 1975, the diagnosis of “trans-sexualism” (sic) was included for the first time in the ICD (International Classification of Diseases of the WHO), within the sexual deviations category. In 1980 the diagnosis of “trans-sexualism” appeared in the third edition of the DSM (Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association), within psychosexual disorders. Since their first appearances, these diagnostic classifications have changed various times (Drescher, 2012), not only their names but also their criteria and placement within the two diagnostic guides (ICD and DSM). Despite the various revisions that occurred during the last decades the distress about one’s assigned sex has remained the core feature of the diagnosis (Cohen-Kettenis & Pfäfflin, 2010). However, most new diagnoses were used as if they were identical with the initial diagnosis of trans-sexualism – which was often used as little else than a search for the “true transsexual” (Cohen-Kettenis & Pfäfflin, 2010). “True transsexuals” were understood – and in many cases still are – as those trans people able to successfully blend into society as “regular” women and men by completely transitioning to the so-called “other sex” (e.g., those with the intention to undergo genital surgeries, adopt the expected gender expressions, be heterosexual).

In ICD 11 which was adopted by the WHO in 2019 and will come into effect over the coming years, trans-related categories have been removed from the Chapter on Mental and Behavioral Disorders and now fall under the category of Conditions related to sexual health (Chapter 17), **which means that trans identities are formally de-psycho-pathologized in the ICD-11.**

Malta depathologised sexual orientation, gender identity and gender expression through ACT LVI of 2015 which amended the Gender Identity, Gender Expression and Sex Characteristics Act (CAP 540).

It is clear that social and cultural biases have significantly influenced – and still do – diagnostic criteria and the access to hormonal and surgical treatments for trans people. Current visions of trans and gender nonconforming people are significantly different from the ones in the past.

Today, Gender **nonconformity** refers to the extent to which a person’s gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex. **Gender dysphoria** refers to discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).

Only some gender nonconforming people experience gender dysphoria at some point in their lives. On the other hand, those who do experience gender dysphoria may reach such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatisation or for the deprivation of civil and human rights.

Treatment is available to assist people who are experiencing gender dysphoria in exploring their gender identity and finding a gender role that is comfortable for them.

All treatment is individualized. What helps one person alleviate gender dysphoria might be very different from what helps another person. Hormones and surgery are just two of many options available to assist people with achieving comfort with self and accept their identity.

Standards of Care

“The WMA [World Medical Association] emphasises that everyone has the right to determine one’s own gender and recognises the diversity of possibilities in this respect. The WMA calls for physicians to uphold each individual’s right to self-identification with regards to gender.”

World Medical Association

The World Professional Association for Transgender Health (WPATH) is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health.

The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transgender, and gender nonconforming people in all cultural settings. One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of Standards of Care (SOC) for the Health of Transgender, and Gender Nonconforming People.

The SOC are based on the best available science and expert professional consensus. Most of the research and experience in this field comes from a North American and Western European perspective. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the SOC.

The overall goal of the SOC is to provide clinical guidance for health professionals to assist transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfilment. This assistance may include primary care, gynaecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g. assessment, counselling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the SOC may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

EPATH, is the European Professional Association for Transgender Health, which aims to promote mental, physical and social health of transgender people, to increase the quality of life among transgender people and to ensure transgender people's rights for healthy development and well-being in Europe. Its goals are to foster the European knowledge and skills in transgender care, to facilitate and extend the bonds between European countries, to spread the results of research and experiences by publishing reports, organising scientific conferences and meetings and to collaborate with international organisations with the same or related aims.

The Gender Wellbeing Clinic

The Gender Wellbeing Clinic aims to offer transgender inclusive healthcare and access to safe therapy, through a multidisciplinary, person-centred and holistic approach to care. The team is clinically lead by the endocrinologist and comprises of the clinic nurse; social worker; psychologists; family therapist; speech and language pathologist; psychiatrist; gynaecologist; urologist and plastic surgeon.

Any transgender persons seeking gender affirmative health care, may be referred to this clinic by the medical doctor, a psychologist or a social worker using a specific referral form which may be accessed online via this link:

www.transhealth.gov.mt

The duly filled referral form may be either scanned and emailed to: **transhealthcare.health@gov.mt**, or else delivered by hand to Mater Dei Hospital Reception.

More information on transgender services can be found at:

www.transhealth.gov.mt

Contact Details

Gender Wellbeing Clinic

Address: Mtarfa Health Clinic, Triq ir Regimenti Maltin, Mtarfa

Tel no: 21456750 - 21454917

Mob no: 79500299

Email: transhealthcare.health@gov.mt

Legal situation in Europe

Legislation varies between countries, and also within the European context. All countries have different degrees of trans-friendly legislation.

In some EU MS, rapid-reviews reported on literature show that legal limitations exist in policy, law and social norms and they differ between EU MS: for example, in some countries, trans people need to undergo sterilisation before they can have access to legal gender recognition while in other countries, legal gender recognition is based on self-determination and no medical intervention nor sterilisation whatsoever are required.

In 2020, 13 countries in Europe and Central Asia require sterilisation for legal gender recognition. In April 2017, the European Court of Human Rights ruled that requiring sterilisation for legal gender recognition violates human rights.

In 2020, 31 countries in Europe and Central Asia required a mental health diagnosis for legal gender recognition. A mandatory mental health diagnosis for legal gender recognition violates trans people's human rights and dignity. It promotes stigma, social exclusion and discrimination. Moreover, and as mentioned before, gender incongruence is not in itself a mental disorder.

Malta's legal framework

Malta has a robust legal and policy framework in relation to equality and non-discrimination of LGBTIQ persons, equal recognition in family life, hate crime and hate speech provisions, legal gender recognition and bodily integrity and asylum.

Equality and non-discrimination

In 2014 Malta amended the Constitution to include sexual orientation and gender identity as protected characteristics. Through different pieces of legislation Malta also introduced anti-discrimination equality provisions on the grounds of sexual orientation, gender identity, gender expression and sex characteristics in employment.

Recognition of couples

Malta has three forms of recognition for couples: Marriage, Civil Unions and Cohabitation. All three are equally available to couples irrespective of gender. Marriage and Civil Unions also provide for parenting rights of all couples. This includes access to fostering, adoption and to IVF services. Surrogacy remains unavailable although it is possible to access surrogacy abroad and register the child in Malta.

Legal Gender Recognition and bodily integrity

Malta's Gender Identity, Gender Expression and Sex Characteristics Act regulates access to legal gender recognition. With this legislation Malta adopted a self-determination model which fully respects the human rights of trans and gender variant individuals. The legislation also places obligations on public and private entities to address discriminatory practices and to respect the right to gender identity of trans persons who may access their services.

This legislation also criminalises normalising treatments and surgeries on intersex children without their informed consent.

In February of 2018, A legal notice introduced 'gender identity and sex characteristics related conditions' in the entitlement schedule relative to the National Health Service (NHS) (LN 44 of 2018).

A consultation to ensure the best healthcare services on these grounds was subsequently launched. The Gender Wellbeing Clinic became operational in November 2018 providing services through a multi-disciplinary team to trans and gender variant individuals.

The Gender Wellbeing Clinic provides prescriptions for hormone treatments, assessments for surgical interventions, psychosocial support, and voice therapy. It also provides reproductive health services in collaboration with the ART Clinic at Mater Dei.

Conversion practices

In 2016 Malta banned conversion practices through the Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act (CAP 567). This affirms that all persons have a sexual orientation, a gender identity and a gender expression, and that no particular combination of these three characteristics constitutes a disorder, disease, illness, deficiency, disability and/or shortcoming. The law prohibits conversion practices as deceptive and harmful acts or interventions against a person's sexual orientation, gender identity and, or gender expression.

Mental health

The Mental Health Act (CAP 525) affirms the rights of mental healthcare users and bans discrimination on the ground of sexual orientation.

Blood donation

Following a risk assessment conducted by the National Blood Transfusion Service in 2018, which took into account the introduction of Nucleic Acid Testing (NAT) in 2019 as well as the current HIV infection rate among MSM's, a shift in policy from a lifetime deferral to a one year deferral for MSM's was introduced. This addressed the previous lifetime ban on men who have sex with men.

Intersex health

Intersex individuals are born with physical sex characteristics that don't fit medical or social norms for female or male bodies. These variations in sex characteristics may manifest themselves in primary characteristics (such as the inner and outer genitalia, the chromosomal and hormonal structure) and/or secondary characteristics (such as muscle mass, hair distribution and stature).

What is the main problem faced by intersex children today?

In many countries, healthy intersex bodies are considered to be a 'medical problem' and a "psycho-social emergency" that needs to be fixed by surgical, hormonal, other medical treatments and sometimes psychological means.

In most cases, 'normalising' surgeries are not medically necessary and can have extremely negative consequences on intersex children. In at least 21 EU Member States, sex 'normalising' surgery is carried out on intersex children. Such surgeries are banned in Malta, unless not having an intervention can develop into life-threatening risks.

Variations in sex characteristics of intersex people are currently codified in medical classifications as pathologies or disorders, usually referred to as 'disorders of sex development'. Normalising interventions can result in self-harm and suicidal behaviour later in the infant's life.

Although parents of intersex children around the world are asked to provide their proxy consent to the treatment, they are often ill-informed and impressionable, and are not given adequate time or options necessary to provide a fully informed and conscious consent.

Disbelief, prejudices and unnecessary curiosity expressed by health care personnel can lead intersex people to avoid seeking healthcare. In extreme instances it can also lead health professionals to deny intersex people access to health services, or to commit psychological and physical abuse.

It has been felt that there is a need for large-scale research into the psychological and emotional wellbeing of intersex people, as well as the long-term impact of 'normalising' treatments for older intersex persons.

Younger intersex people report experiencing isolation due to stigma, bullying, discrimination or rejection from family or peers. (Jones, 2016)

Specialist long-term follow up services for intersex people should include psychological support to address psychosexual, emotional and social wellbeing. Isolation may impact negatively on mental health. It is important for practitioners to advise intersex persons and their families to reach out to support groups and/or associations.



Activity 1: Case studies

In small group, discuss “Situation A” or “Situation B”.

“Situation A” is an extract of the first appointment Alex, a trans man, had with a clinical psychologist.
“Situation B” is an extract of a conversation that a doctor had with Maria, the mother of an intersex baby.
Each situation includes some questions to guide the group discussion.

Situation A – Trans man

Alex is a trans man. He is 19 years old, and he lives socially according to his identity since he was 15. Most of his colleagues and teachers at the university, and also his friends and family, recognise him as a man. Nevertheless, and although his gender expression is noticeably “masculine”, he didn’t undergo any gender affirmation treatment (e.g. hormones, surgeries...). Only now is he sure about the changes in his body he wants to accomplish. Moreover, for years he avoided health professionals because of what he read online and heard from other trans people, on the lack of competence and the prejudices of some practitioners. This is an extract of the conversation he had in the first appointment with a clinical psychologist expert on trans health, recommended by an online friend, John.

Psychologist: Hello, good morning. First, let me introduce you to Doctor Peter. He is a psychiatrist. I asked him to be here in the first appointment with you.

Alex: Ok, good morning. But... why?

Psychologist: Because you were referred by John, who’s also my patient. I figured out you are transsexual.

Psychiatrist: I’m here to help you, Alex.

Alex: Oh, ok. Yes, I’m trans. I was born a girl...

Psychologist: Yes, we can see that.

Alex: ...and I knew I was male since I was a child. Everyone recognises me as male, my family, my friends, and also in the university. And now I’m sure I want to do a mastectomy. I was not sure before, but now...

Psychologist: What’s your real name?

Alex: It’s Alex. It’s my name.

Psychologist: Yes, sure. But I need to know your real name, your legal name.

Alex: I don’t like to say it. Or even to remember... It’s... Alexandria.

Psychologist: Ok, just let me write it, A-le-xan-dria [while writing].

Psychiatrist: How can we help you, Alex?

Alex: I’m not happy in my body, I need a mastectomy. I’m ready. And I know I need to go through a mental health practitioner first. I guess I need an authorization from you.

Psychiatrist: We are not here to assess you. We can help you in various ways.

Psychologist: Yes, you need, but it will take time. We need to be sure that you are a transsexual.

Alex: I’m a man.

Psychologist: Yes, but it’s not that simple.

Psychiatrist: May you tell us more about these strong feelings related to your body?

Alex: I was never comfortable in my body. This is not my body; this is not me. Three years ago I started to search the internet about being trans. And I discovered that it’s possible to do a mastectomy. But I’m afraid of doctors, and surgeries and hospitals. Since I discovered, I’m always thinking about this, but I was so afraid and scared. Now I know. I’m ready.

Psychologist: If you truly are a transsexual, how do you have doubts?

Alex: I don't have anymore, now I...

Psychologist: And what about genital surgery?

Alex: I don't know... For now, I really need a mastectomy, I'm not happy.

Psychologist: But if you say you are a man...

Psychiatrist: Alex, to help you we need to understand your story, your feelings. You said you are not happy. May you talk more about that?

Alex: I felt sad for many years. I feel sad every time someone figures out I have breasts and talks to me as if I was a girl. And it affects my relationships. I don't go to the beach. I hate summer, because I have to wear less clothes... I don't go to the gym and I don't do sports. And, it's really difficult for me to have sexual intimacy with someone...

Psychologist: Do you have a girlfriend?

Alex: Yes, but...

Psychologist: So, you like girls. That's good! But, let's talk about your hair: why do you still keep it that long?

Alex: I like it this way.

Psychologist: You said you don't like when other people realise you are a girl. Maybe you should have short hair, as a boy.

Alex: [Silence]

Psychiatrist: I'm interested in your feelings, and worried about your well-being. We can help you.

Alex: What should I do to get your recommendation letter for the surgery?

Observations:

- What are the problems in both healthcare practitioners' performances? Give specific examples.
- In this example, how did the healthcare provision comply – or not – with international standards of care? Give specific examples.
- How do you think Alex felt during this medical appointment?
- As a health professional, what would you do differently?

Situation B – Intersex baby

Maria is 36 years old. For many years she dreamed about being a mother. She is single and does not expect to be in a relationship soon. Maria decided to be a single mother, with the use of medically assisted procreation techniques. Her decision was supported by her family. The pregnancy went well, and the doctors said that she was going to have a daughter. Bianca was the name that Maria chose for her baby. When Bianca was born the doctors immediately noticed that the baby's genitalia were not common. This is an extract of a conversation that a doctor had with Maria and her parents – Bianca's grandparents – the day Bianca was born.

Doctor: How are you, Maria?

Maria: I'm ok, doctor, thank you. I'm happy! How's my baby?

Doctor: We need to talk. She is fine; nothing to worry about with respect to her health. But there's a problem.

Grandmother: A problem?

Doctor: Yes. The baby was born with a disorder of sex development.

Maria: I don't understand.

Doctor: She has a congenital condition, which affected the development of her anatomical sex. Her genitals have masculine traits. I wanted to tell you before we bring her to the room.

Maria: I don't understand. You said everything was ok with her health.

Doctor: Yes, she's fine. Don't worry, Maria. But she doesn't have a normal body. We can help! There are solutions, treatments. She can be a perfect girl.

Maria: Which treatments?

Doctor: Well, we need to do more exams. And my expert colleagues will talk to you later about the options for treatment.

Maria: But... can you tell us more? What's wrong with her? Which treatments?

Doctor: Her condition is rare, but we have a very good team expert in these cases. There are options - surgeries, hormones... And we have time. You don't need to make any decision now.

Maria: Decision? I just want the best for her.

Doctor: I know. We also want the best for the baby. There are no reasons to be worried now.

Grandfather: Please help my granddaughter, doctor.

Doctor: We will. In these cases, most patients grow up as normal children. Most people are satisfied with treatment and can have an almost regular life. You will have some time to think.

Grandfather: We trust in you, doctor.

Maria: [Crying] I'm so confused. You said that's she is in good health, but she needs treatment...

Doctor: My colleagues will explain better.

Maria: Can I see my baby now?

Doctor: Of course. We will bring her.

Observations:

- What are the problems in the healthcare practitioner’s performance? Give specific examples.
- How do you think Maria and her parents felt during this conversation?
- As a health professional, what would you do differently?
- What impact do you think this approach by a health professional may have on the rest of Bianca’s life?

Thank you for your participation in this training organised as part of the transform project.

