transform | Raising standards of health care service provision for LGBTIQ people

TRAIN THE TRAINER SESSION

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) 45/2001[1] lays down the rules for data protection in the EU Institutions and is distinct from Directive 95/46/EC[2] (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 their 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):

The classification of a person as male or female.

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.

A person's sex, however, is actually a combination of bodily characteristics including chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics.

The sex assigned at birth usually becomes the legal sex after being written in the birth certificate and transposed to identification documents.

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 2: 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 identity 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

Guidance Notes

Introduction
Slide 1-6

Guidance for trainer

Welcome participants to the training course. Briefly describe the TRANSFORM project and explain the main aims and contents of the training packs.

Ground rules
Flipchart

Guidance for trainer

You can explain the relevance of establishing some ground rules (e.g. the conversation can be difficult; different and contrasting viewpoints can emerge during the training course a positive atmosphere can support learning).

You may write on a flipchart the following ground rules, explaining the meaning of each rule. Having the ground rules on the flipchart will enable you to refer back to them in case of difficulties during the training course. As the pages will be turned, when the list is completed tear off the page with the ground rules and stick it to the wall, so it is always visible to all participants.
The following are three essential rules:

- **Confidentiality/safe space.** All participants, the trainers and evaluators have signed a confidentiality form which assures that no personal data of the participants involved in the training course will be reported outside of it. This rule serves the purpose of encouraging the participants to speak freely;
- **Mutual respect of participants**' contributions and potential disagreement. Participants may feel vulnerable and/or uncomfortable with this style of training and/or with these topics. For this reason, it is important to emphasise mutual respect and acceptance of all participants' contributions and to remember that there are no correct or incorrect answers and that all the opinions are useful to enrich the discussion. For this reason, you will ask participants not to have a judgmental attitude toward the opinion of participants expressed during the training course; and
- **Participation.** During the different training sessions, you will encourage the active participation of all participants and their contribution to the discussion. At the same time there is no obligation to participate and participants should contribute only if they feel comfortable doing so.

Once agreement has been reached on the ground rules, you can suggest the participants to add rules that have not been covered but that participants would like to add based on their previous experience. It is important to obtain participants' approval for all suggested rules before adding them into the list.

Activity 1: Introduce Yourself
Slide 7

Guidance for trainer

Introduce yourselves and invite all participants to introduce themselves using the icebreaker activity.

Video experience of healthcare settings: LGBTI people tell their story
Slide 8

Guidance for trainer

Introduce the video to the participants and explain how this video will be presenting real experiences of LGBTIQ persons in accessing health care.

Terms and Concepts
Slide 9-29

Guidance for trainer

You can highlight that this section is aimed at promoting the participants' knowledge on the most relevant terms and concepts related to LGBTIQ topics. During this section it is recommended to give the participants a space for questions and comments to make the contents clearer. It may be useful to use the flipchart to take notes, write keywords, explain a particular concept using figures or diagrams, etc. If you use them place them in visible place for the rest of the training course to provide participants the opportunity to refer back to them when necessary.

This section is particularly important because it lays the groundwork for the rest of the training course. It provides participants with key terminology that will enable them to gather knowledge throughout the training course.

Participants might have heard the LGBTIQ acronym before, or other acronyms. Some may find 'confusing' that different acronyms and terminology exist. Therefore, it is important that trainers explain the acronym and what it stands for, but also provide some background information on its history, as well as its relevance for this particular training course.

Slide 13

You can explain that LGBTIQ is an acronym for lesbian, gay, bisexual, trans, intersex and queer people. Most people have heard this acronym and globally understand this meaning, but fewer know the distinction between the groups that each letter designates.

The abbreviation "LGBTIQ" is commonly used within the LGBTIQ movement itself.

You should then explain how the LGBTIQ acronym will be used during the training course

- The LGBTIQ acronym is the one that will be used throughout this training course. However, we might also use variations of the acronym. For example, when some data only relates to lesbian, gay and bisexual people: in this case, we might only use the acronym LGB; if some data related to L, G, B, T but not intersex people, we might use the acronym LGBT;
- Here it is used as pedagogical tool to raise awareness on the experiences of LGBTIQ people in healthcare settings and is relevant for use in this training course. The intent is not to create a series of rigid requirements, but to provide the participant with a guide, to create a reflection about a correct terminology to use when talking about LGBTIQ issues in healthcare settings;
- The acronym refers to a great variety of people. It is important to recognise the diversity within the LGBTIQ community in order to distinguish the different issues and needs that could be masked when lumping together all the categories;
- Furthermore, participants should be aware that not all people might want to be categorised in this way. Therefore, it is important to always ask people how they want to be referred to and stick to their choice of vocabulary when addressing them.
- Therefore, varying use of these terms is neither comprehensive nor inviolable but a work in progress.

When you describe the terms, focus also on the use of the terms as a noun or as an adjective (e.g. the term "gay" is an adjective and for this reason you have to say "a gay person").

Slide 14

Here you can remind participants of two important concepts:

- 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.

Slide 15

You can explain that it is important to distinguish between:

- sexual orientation;
- gender identity; and
- sex characteristics

as separate concepts. You should remind participants that these concepts concern everyone, and not just LGBTIQ people.

Especially for people who did not hear or do not fully understand the distinction among sex, gender, sexual orientation and sex characteristics, the following could help in explaining the concepts to participants:

1. sex characteristics are used to assign your legal sex and gender at birth
2. but gender identity and gender expression do not necessarily align with your sex characteristics or your assigned sex
3. people can be attracted to people of the same gender as theirs or to people of the opposite gender or to people of more than one gender.

You may wish to use the picture “The Genderbread Person v2.0” as support when explaining this slide.

Slide 15

You can read these slides to describe the main terms and concepts. For some terms, you could give an example of a famous public person who identifies as a member of the LGBTIQ group and/or you can use the example already prepared in the slides. This could help participants better understand the meaning of the terms beyond the written/spoken language.

Slide 16-19

Use these slides to describe and explain what sexual orientation is. You should focus on the following concepts:

- Different people describe their sexual orientation in different ways. For example, some people use terms such as queer, pansexual, same gender loving, or same- sex attracted;
- Others are attracted to and have relationships with people of the same sex but prefer to call themselves heterosexual. This may be because they fear a negative reaction from others, but sometimes it is because in their context the existence of gay, lesbian, or bisexual people is not recognised. Moreover, many heterosexual people do not define themselves since heterosexuality is still considered as the norm.

Slide 20-23

Use these slides to describe and explain what gender identity is. You can use the following concepts:

- Some people identify with the gender they were assigned at birth, other do not. People’s gender identity may or may not align with their sex characteristics.
- We refer to people who identify with the gender they were assigned at birth as cisgender.
- Gender identity is fluid and may change over time.
- Trans is an umbrella term which encompasses very diverse ways that people identify themselves, including people who identify outside of the gender binary (e.g. non-binary people, agender people).
- Gender identity differs from gender expression. Gender identity refers to the internal and individual experience of gender, and therefore if not disclosed, it may be not known by others. Gender expression refers to the way people present themselves to others.
- Gender identity is different from sexual orientation: people can be gay, bisexual, heterosexual, asexual… and this, regardless of their gender identity and whether they are cisgender or trans.

Slide 24-26

Use these slides to describe and explain what sex characteristics are. To help you, use the following concepts:

- People are classified at birth as male or female, i.e. they are assigned a sex based on how they fit one of these two categories

- Most often, this classification is made based on what their external anatomy looks like, and then fit into the binary categories of female or male
- However, sex characteristics are more complex than genitals only: they include primary and secondary characteristics (see definition on slide 24)
- Some people have sex characteristics that are seen as not fitting the binary categories of male or female: intersex people. Some people know from birth they are intersex, others find out later in life or never at all.

If you do not intend to present module 4 to trainees, it may be useful to have a look at it in order to be prepared to answer questions trainees may have on intersex. It is also important to make clear that intersex people's basic human rights are routinely violated due to their non-adherence to sex norms. Even today, intersex people around the world are often subjected to non-consensual medical treatments right after birth and/or during early childhood. This can include unnecessary surgeries and hormonal treatments solely to force intersex people to fit the notion of male and female that persists in our societies as the norm. Treatments often result in emotional and physical trauma, complications after surgery and a lifelong need for treatment. Malta banned normalising surgeries on intersex children in 2015.

Slide 27

Use these slides to describe and explain what sexual behaviour is. You can use the following concepts:

- Some people are attracted to persons of the same gender, but have not acted on this desire, and may want to discuss their feelings; and
- Sometimes health care or research professionals do not use terms like gay or lesbian to describe people but focus instead on their sexual practice. They use terms like men who have sex with men, abbreviated as MSM, or women who have sex with women (WSW). Clarify that MSM is an epidemiological term, not all people that could belong to this category identify as MSM.

Let's Practice your Knowledge
Slide 29

Guidance for trainer

Divide the participants into 5 groups. Each group is assigned terms that have to be matched to their definitions. Every term and definition are then categorized choosing from 'sexual orientation', 'sex and sex characteristics' and 'gender identity'.

MODULE 2

Health and health inequalities

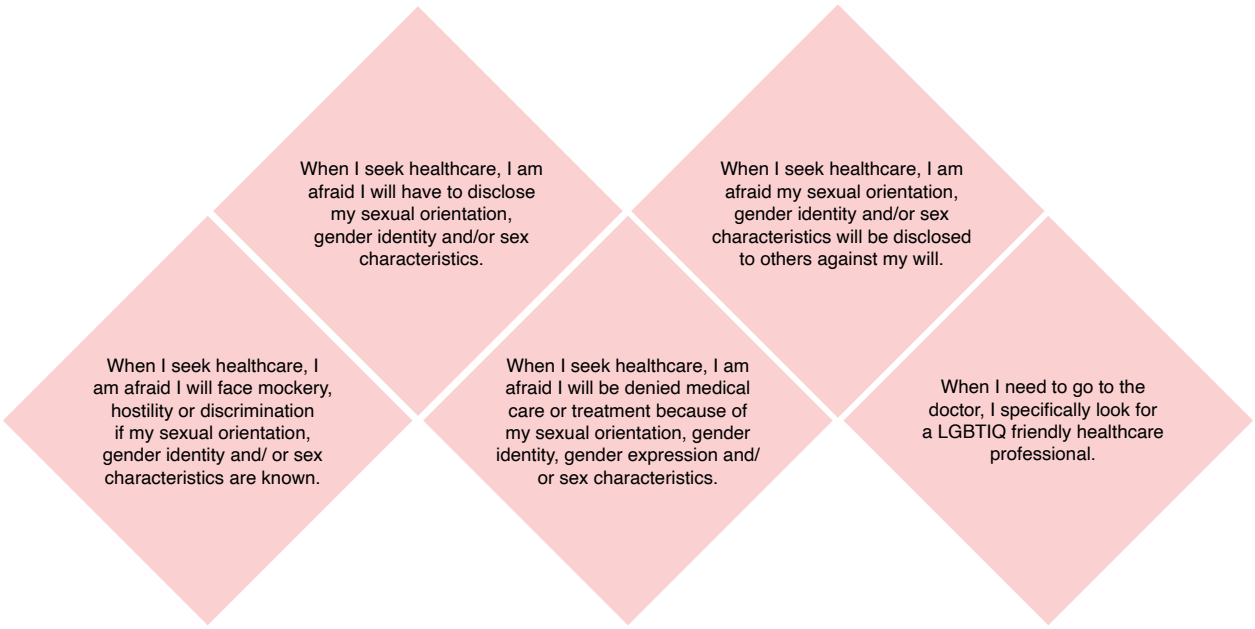
Learning objectives

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

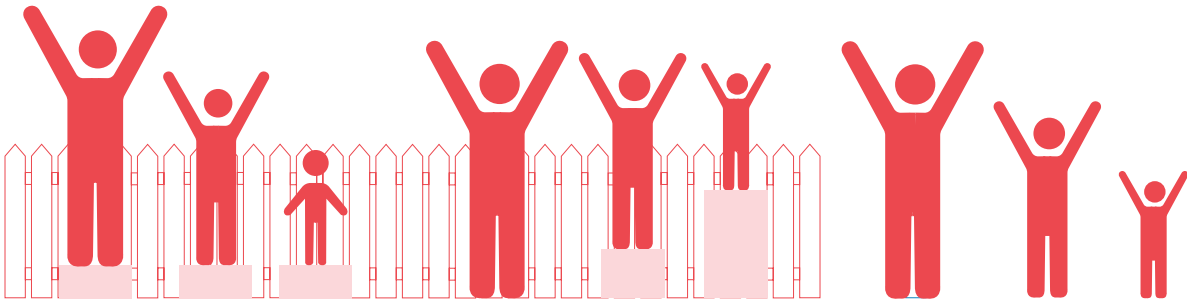
Activity 1: Position & privilege

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]

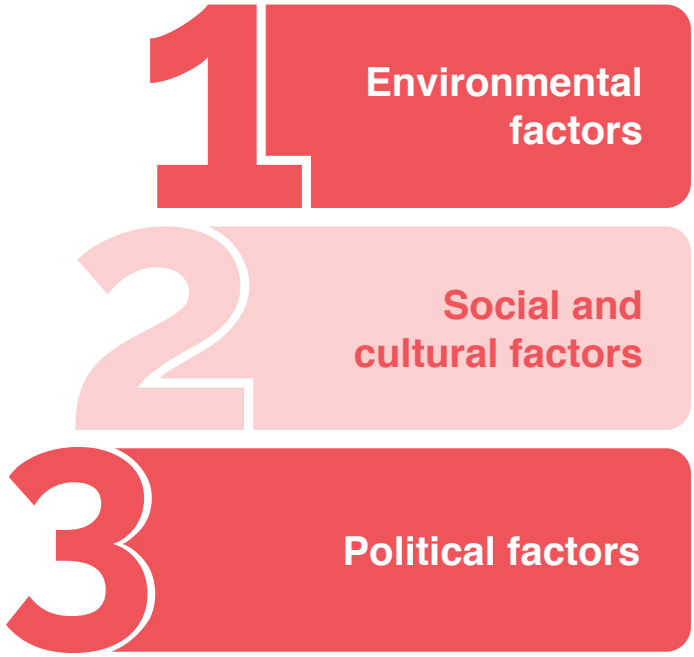


"LGBTIQ people in Europe experience significant health inequalities within heteronormative contexts where heterosexuality based on binary gender is upheld as the social and cultural norm, as well as minority stress associated with sexual orientation, gender identity and sex characteristics, victimisation,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

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

[5] Zeeman 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

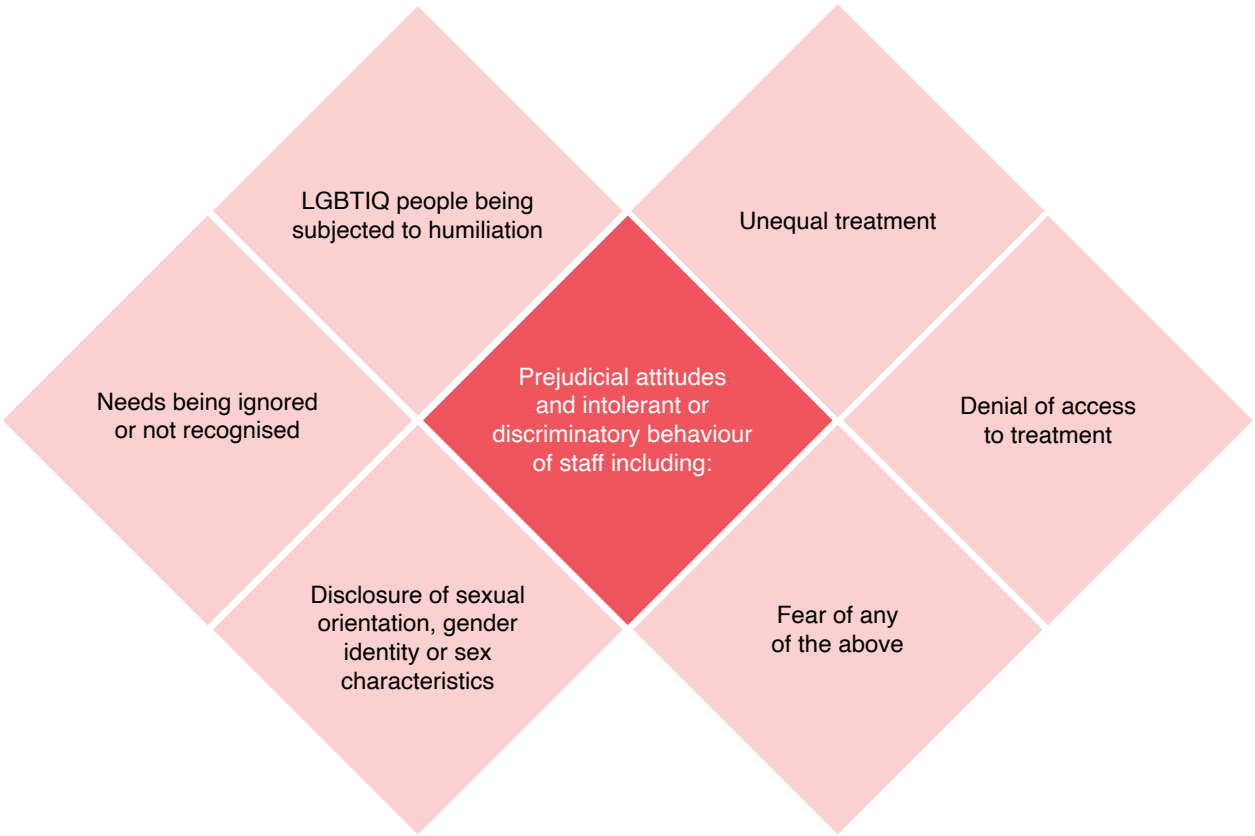
6. ***"A trans woman went to the pharmacy with a valid receipt. The pharmacist did not fill the prescription and said: 'You won't get female hormones; I can see that you are a man'."***

   Trans woman, Austria

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

Potential barriers and challenges faced by health professionals and LGBTIQ people

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.

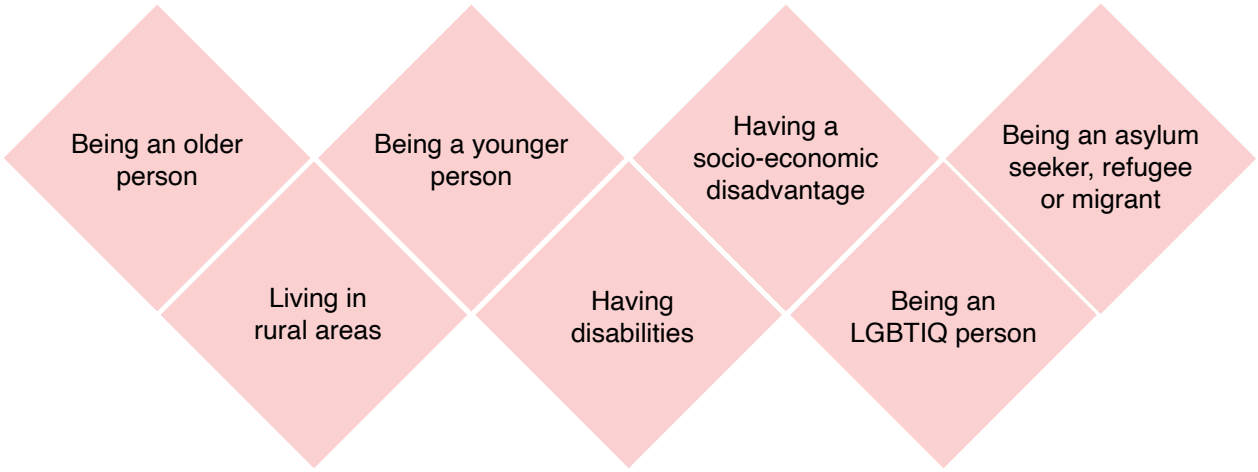
With respect to knowledge and training, the research is overwhelmingly clear; many generic and specialist health professionals lack the appropriate knowledge regarding the lives and related healthcare needs of LGBTIQ people as well as lack the appropriate culturally competent skills necessary to meet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

Guidance Notes

Module 2: Objectives
Slide 30-32

Guidance for trainer

Use these slides to provide overview of learning objectives and content of this module.

Activity 1: Position and Privilege
Slide 33-39

Guidance for trainer

This is a self-reflection exercise. Ask the participants to take off their hat as a healthcare provider and think of themselves as a patient/client. Reflect on the statements in the slides for Activity 1.

Health inequalities – What are they?
Slide 40-43

Guidance for trainer

It is important to explain briefly what health inequalities refer to, by reading the definition in the slide. It is extracted from the Health4LGBTI SSR (pg. 16) where you can find a detailed description of useful contents to be added in the presentation. In slide 42, a picture describes how health inequalities can be addressed by improving the empowerment of patients/clients and/or working directly on causes.

Root causes of Health Inequalities
Slide 44-45

Guidance for trainer

You may explain that in general, research suggests that health inequalities occur due the consequences of a complex interaction of environmental, social, cultural and political factors. For example, in countries where homosexuality and bisexuality are highly stigmatised, the health outcomes of LGB people are significantly impaired compared to countries where there is less stigma and LGB people have equal rights and protection against discrimination. Similar outcomes are observed where identifying with another gender than the one assigned at birth is socially sanctioned, compared to countries where there is greater acceptance of gender plurality.

The causes of health inequalities for LGBTIQ people which have been documented in research reviewed as part of the Scientific Review and grey literature include:

- cultural and social norms that preference and prioritise heterosexuality (heteronormativity) and cisgenderism;
- minority stress associated with sexual orientation, gender identity and sex characteristics;
- victimisation;
- discrimination and stigma.

It is important that you are equipped with knowledge concerning the local/ national social and legal context for LGBTIQ people and use examples to enrich this section. You could for instance include information about the existence of anti-discrimination provisions in healthcare, recognition of same-sex partner as next-of-kin for visitation, access to information and decision-making, legislation on consent and confidentiality, protocols on gender affirmation treatments, laws regulating sex registration on birth certificates for intersex children, etc."

The main root causes of health inequalities are reported in 45. To make these clearer and to create interest, you should use "impact examples" suggested in the Health4LGBTI SSR (p. 20-24) and the following explanation extracted from this document.

To describe stigma, you can explain that "stigma comprises three different but related elements: 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; and enacted stigma where people experience real instances of discrimination. Each strand of stigma may affect health-seeking behaviour in a specific way. For instance, anticipated stigma may create an environment where LGBTIQ people evade or postpone gaining access to treatment and care settings, as they may experience discrimination in these settings."

To describe minority stress you can explain that "Minority stress theory is presently 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".

You can explain that it is clear from the analysis of the primary research literature that LGBTIQ people in Europe experience significant health inequalities and that these ostensibly have their origin (amongst other things) within heteronormative contexts where heterosexuality based on binary genders is upheld as the social and cultural norm, as well as minority stress associated with sexual orientation, gender identity, gender expression and sex characteristics, victimisation, discrimination (individual and institutional) and stigma. Many inequalities stemming from such origins are arguably avoidable and thus maybe preventable. Indeed, it is also clear from the research and the findings of the Scientific review, that such inequalities can potentially be reduced via health services.

Activity 2: Let's talk about LGBTIQ healthcare
Slide 46-47

Guidance for trainer

Read the quotes one by one and discuss the questions. Remind participants that what is discussed shall be kept confidential.

Afterwards, watch the video from 4:30 to 6:28 and discuss the questions once again.

Potential barriers and challenges faced by health professionals and LGBTIQ people
Slide 48-50

Guidance for trainer

Use visual slides 48 and 49 to describe that findings from the research reviewed during the Scientific review of this project show that health professionals face a range of challenges/barriers when providing care for LGBTIQ people in healthcare settings including cultural and social norms, language, the fact of not being aware of the LGBTIQ identity of patients and/or of not knowing how to ask, institutional barriers and lack of knowledge and training.

You can link the discussion back to the root causes of health inequalities (slide 45). To enrich the discussion you could refer also to the results of the Comprehensive Scoping review (see Health4LGBTI SSR) which identified the following barriers: lack of knowledge and cultural competence concerning the lives and healthcare needs of LGBTI people; lack of basic awareness or consideration of the sexual orientation, gender identity and/or sex characteristics of LGBTIQ people who access health services; a lack of specialist mental health services and counselling services for LGBTIQ people; health professionals' own prejudices leading to the unequal treatment of LGBT people with regards healthcare.

Explaining this section, try to refer to the examples reported in the segment before and to the concepts reported in the flipchart. You can also use examples of barriers reported in the tables of Health4LGBTI SSR (pg. 47-51).

Activity 3: Quiz on health inequalities experienced by LGBTIQ people
Slide 51-59

Guidance for trainer

Depending on the time allocated for this activity, the statements may either be discussed as a whole group, or the participants may be divided into smaller groups for discussion.

Health inequalities faced by LGBTIQ people
Slide 60-69

Guidance for trainer

In this section, you will be presenting some statistics and data about certain inequalities and health conditions that have a higher prevalence within the LGBTIQ community than the general population.

Intersectionality
Slide 70-75

Guidance for trainer

In this section, you will present a set of slides outlining the health inequalities experienced by LGBTIQ people who live in rural areas, migrant, refugees and asylum seekers, older people, young people, people with disabilities and those who live in socio-economic poverty, as reported in the Health4LGBTI SSR and FGSR.

Slide 71

Here you should describe the concept of intersectionality and its relevance for healthcare staff using the concepts described in Health4LGBTI SSR report and its complementary documents. You can highlight the fact that within contemporary European health and social care literature, intersectionality can be understood as the intersections between a range of dimensions associated with social and cultural difference that people are subjected to. Markers of difference such as gender, sexual orientation, gender identity, gender expression, sex characteristics, age, ethnicity, race, disability and social class (as well as others) can be used to differentiate and hierarchise people. The response to such markers of difference varies amongst European MS and is influenced by (amongst other things) a range of legal, political and economic factors such as legislation that either prohibits LGBTIQ people from participation in mainstream cultural and social life, or fully includes LGBTIQ people. These markers are interdependent and intersect to create and sustain health inequalities.

Slide 72

Invite the participants to discuss the vulnerable intersections and the range of dimensions associated with social and cultural difference that people experience (for example age, ethnicity, living in rural area) and ask participants if they can see how these intersections can intersect to create and sustain health inequalities. You should allocate 5-10 minutes for this discussion.

Slide 73-74

Here you can show an overview of some of the possible intersections of LGBTIQ identities within specific populations and settings: people in rural or geographically remote areas; older and younger LGBTIQ people; refugee, asylum seekers, and migrant LGBTIQ people; those who live in poverty or are socio- economically disadvantaged and LGBTIQ people with disabilities. In presenting these results you should also underline these two key concepts taken from the Health4LGBTI SSR and FGSR:

- there is a dearth of research that accounts for the health inequalities of intersectional subjectivities;
- further research should be conducted with these LGBTIQ groups to investigate their needs to consider the impact of intersectionality on health outcomes; and
- none of the research in the current primary research literature included a focus on intersex people, therefore highlighting a large gap.

Slide 75

Here you can show a summary of the main results on what is known about the health inequalities of LGBTIQ people focusing on vulnerable intersections. Read the contents in the slides and use the complementary reports to contextualise your presentation and have more information and details.

In this slide read an example of a quote from the Health4LGBTI Comprehensive Scoping Review and then focus on the fact that "Despite assumptions that only younger people are LGBTIQ, older LGBTIQ people obviously do exist and moreover they have endured a historical and social context where their gender and sexual identities were often invisible". At this point, you may wish to show also the ILGA- Europe videos on fighting against exclusion and invisibility faced by older LGBTIQ people (https://www.ilga-europe.org/silverrainbow).

In this slide read an example of a quote from the Health4LGBTI FGSR to focus on the fact that "Private healthcare was frequently identified by LGBTIQ people as preferable and generally more accepting. However, this kind of healthcare was not accessible to all LGBTIQ people."

In this slide you can read an example of a quote connected to living in rural or urban areas from the Health4LGBTI FGSR.

Key findings on intersectionality
Slide 76

Guidance for trainer

Here you can summarise the information from the previous slides. You can add relevant examples or information from the complementary documents according to the interest of your participants. Participants are also encouraged to give feedback and ask questions here.

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

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

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?tients/clients first come into contact with your practice?
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; and
- LGBTIQ people – like any other patients - should be included in decision-making about healthcare

Guidance Notes

Introduction: Language and communication
Slide 77-80

Guidance for trainer

As described in Module 2, language can be a potential barrier faced by health professionals when providing care for LGBTIQ people. Using these slides, you can go back over some main concepts on potential language barriers and describe some key points on how to communicate in an inclusive way.

Activity 1: Cuál es la differencia?
Slide 81

Watch the video and discuss based on the observations identified.

Guidance for trainer

Inclusive Communication
Slide 82-95

Guidance for trainer

Slide 82-84

Remind participants of some concepts that they have already seen during Module 1 on LGBTIQ terms.

You should focus on the main learning points that emerged from the Health4LGBTI SSR:

- "health professionals should show greater cultural awareness and sensitivity towards gender and sexual diversity, and recognise that people might identify as LGBTIQ";
- "where health professionals accept LGBTIQ people unconditionally without making judgements and show respect in their interactions with LGBTIQ people, LGBTIQ people are more likely to open up and in return trust health professionals"; and
- "practitioners should use affirmative language that acknowledge the LGBTIQ status of patients without judgement, for example by using the same terms that the patient uses to describe themselves or by using language appropriate to the gender identity of trans people".

In this way, health professionals can foster better holistic care and greater social inclusion in health settings. You should explain that, at a most basic level, health professionals should avoid making assumptions about gender identity, sexual orientation and sex characteristics (for more detailed suggestions, you can see chapter 15 of the Fenway guide to lesbian, gay, bisexual and transgender health and chapter 6 of Promoting the health of men who have sex with men worldwide: a training curriculum for providers).

Use the question in the slide 83 to generate a brief discussion on assumptions. "There is a woman coming to you and she is married". This woman is not necessarily cisgender, nor heterosexual or intersex.

In slide 84 you can provide participants with examples of good and bad practices when communicating with patients.

Slide 85-91

Please note that in the first example, the trainer should point out that the question "are you married?" is not necessarily an example of bad practice, as in some cases HCP may have to ask about legal civil status (insurance reasons, for example) and therefore the question should be contextualised.

Remind participants that health professionals should use professional and inclusive verbal language, but also should make sure to use comforting body language, gestures, tone of voice, and proximity to create a non-threatening environment to put the patient/client at ease.

Remind participants that if they make a mistake, it is good communication practice to acknowledge the mistake, apologise and asks the patient/client what they should say or do instead.

You can describe some examples of inclusive language in exploring relationship and sexual history by asking open questions (e.g. avoiding assuming the gender of patient's/client's partner). (Some questions in the slide are taken from Makadon et al., 2008; but Health4LGBTI SSR recommends also that practitioners use inclusive language by asking open questions such as "What pronoun do you use?" or "What is your chosen name?"; other examples could be: "What is your chosen or preferred name?", "What gender do you identify with?").

Slide 92-93

An example in slide 92 is "if someone calls himself "gay," do not use the term "homosexual".

Refer to the recommendations on constructive communication reported in the Health4LGBTI Scientific Review for a list of further recommendations/proposals by authors of research included in the review (e.g. "Practitioners should acknowledge the feelings of fear gay and bisexual men may experience prior to screening and treatment for HIV/AIDS and normalise these feelings in order to facilitate greater uptake of services").

You may use slide 93 to sum up the main recommendations related to terminology and language issues when communicating with LGBTIQ patients.

Slide 94

You should focus on the following learning point that emerged from the Health4LGBTI SSR:

"disclosure of sexual orientation can (but not always) bring health benefits and greater levels of satisfaction with care received due to better communication between health professionals and LGB people. Where health professionals hold positive attitudes towards LGBT people, 'coming out' is more likely".

Here you can summarise some results on the disclosure topic as they emerged in the Health4LGBTI Scientific Review and SSR (p.49, 60). Please consider also the note in the document where this concept is explained, stating that being 'out' to one's healthcare provider can be contextual. That is, the need to disclose may depend on the specific nature of the health care required. For example, going to the doctor for an insulin test may not require disclosure of sexual orientation, nor trans or intersex status. Yet a trans or intersex person may nevertheless face a doctor who insists that it is absolutely necessary for them to know, regardless of the desires of the person themselves or the medically based information required (see also the CSR and the report on the focus group study).

Slide 95

Here you can highlight some key messages that emerged in the Health4LGBTI Scientific Review (p.59-60) on what health professionals can do to help LGBTI people come out. You can also mention that "research findings showed that a clear commitment by health professionals to confidentiality made it easier to come 'out', where they were informed of who had access to their information, and were asked to provide consent prior to information being shared with other professionals or related agencies".

Reducing barriers in your practice
Slide 96-104

Guidance for trainer

Slide 96-99

Refer to Activity 2 and ask participants to 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.

Ask them to think what aspects of their practice or the environment that you operate in, they would deem to be inclusive and which not. Use slide 97 to gather the responses from the participants.

The example in slide 98 brings the direct experience of a lesbian woman from the Health4LGBTI Comprehensive Scoping Review. You can explain that in this example “an interview with a lesbian woman drew attention to how the creation of LGBTIQ friendly environments may help reduce fear of accessing health services”.

Slide 100-104

Use slide 100 to ask participants to reflect on how they can make their practice more inclusive. Here you can describe some examples of good practice that emerged from the Comprehensive Scoping Review (pg. 48-49). Read and explain some of these examples of good practice in some of the MS in Europe using also the details in the complementary document.

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 standards 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, 2009; Bockting et al., 2004). 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?

Guidance Notes

Trans Health and Health Inequalities
Slide 105-112

Guidance for trainer

Slide 105-107

This segment is aimed to promote participants' knowledge on the most relevant topics related to trans and intersex health.

This segment is divided in two sections: trans health and intersex health. You should mention in the beginning that you will start with trans health and then move to intersex health.

At any moment, use flipchart to take notes, write keywords, explain a particular concept using figures or diagrams, etc.

Slide 108-112

These slides represent a summary of the main results on what is known about the health inequalities for trans people. As reported in Health4LGBTI SSR, consider that there is very limited large-scale epidemiological data on the burden of disease for trans people. Further research is needed to gain an understanding of the general health profile of trans people.

Below is some information from both the complementary documents (Health4LGBTI SSR and Health4LGBTI FGSR) and further additional international literature that you should know to understand the background of the slides.

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 LGBT 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 three (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).

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).

In slide 111 mention the higher rates of mental distress among trans people, as described in the Health4LGBTI SSR.

As reported in the Health4LGBTI SSR, comprehensive, large-scale research exploring the impact of transitioning for trans people is sparse and more research is required (see additional contents from paragraph 'Impact of transitioning on mental health' in Health4LGBTI SSR, pg.33).

You can also report some specific examples of health inequalities (some examples have been already described in Module 2) reported in the summary table at Health4LGBTI SSR, pg.31).

Gatekeeping and SoCs
Slide 113-118

Guidance for trainer
You may wish to summarise information for participants.

Legal Situation in Europe
N/A

Guidance for trainer

In some 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.

Malta's Legal Framework
Slide 119-121

Guidance for trainer

In slide 119 give a brief overview of the legal context in Malta with the provisions that directly link to trans healthcare.

In slides 120 and 121, you should go into more detail on the services currently being offered by the Gender Wellbeing Clinic and describe the care path.

Intersex Health
Slide 122-128

Guidance for trainer

In slides 122 and 123, there is a brief and useful background from ILGA-Europe & OII Europe (2015) to enrich your explanation.

- Intersex stands for the spectrum of variations of sex characteristics that naturally occur within the human species. It also stands for the acceptance of the physical fact that sex is a spectrum and that people with variations of sex characteristics other than male or female do exist. Historically, the term intersex was used as if it was as a disorder that needed medical intervention to 'fix it'. In the past two decades, the term has been reframed and established by intersex human rights defenders and their organisations as the human rights-based umbrella term.
- Close by saying that "Our sex characteristics are set out from birth, whether we are intersex or not. However, the fact that someone has an intersex body can become apparent at different times in their life: at birth, during childhood, in puberty or even in adulthood. Depending on the specific life circumstances and the degree of taboo in their environment, a person might learn that they have an intersex body at a very early age or later in life. Some intersex people never find out at all."

The lives of intersex people are unnecessarily medicalised as seen in biomedical terms describing intersex variations as "disorders of sex development". Terms such as these pathologise intersex people and their bodies. However, because diagnoses are required to provide access to medical interventions, surgical technologies and hormonal procedures, these can be seen as necessary where some intersex people may want to access medical intervention.

Some participants may be familiar with the term "Disorder of Sex Development" (DSD), and not with the term "intersex". In this regard, it is important to keep in mind the position from OII-Europe & ILGA-Europe (2015)39: "[DSD] is a medical umbrella term, which was introduced in 2006 by a Clinician Consensus Statement. Together with new categories of syndromes, it replaced the older medical terms.

The term refers to intersex sex characteristics as characteristics that are 'deviant' from the norm of male and female bodies and thus need to be 'disambiguated' or 'fixed'. The idea of "disorder of sex development" pathologises intersex people and their bodies. DSD language is used to justify 'normalising' medical treatments to make intersex bodies conform to medical and social norms. In an effort to avoid the pathologising connotations of 'disorder', some clinicians use DSD to stand for "differences of" or "diverse" sex development.

Continue with the slide 124 : "Primary and/or secondary sex characteristics of intersex people may be ambiguous and do not fit clearly defined anatomical male or female features. In a world where the overwhelming majority of people and governments only know and accept two sexes (male and female) the existence of intersex people and their bodies is not recognised. Instead, 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 and sometimes psychological means. Doctors often advise parents to perform surgical and other medical interventions on intersex new-borns and children, to make their body (seemingly) conform to male or female characteristics. In most cases, such interventions are not medically necessary and can have extremely negative consequences on intersex children as they grow older. Currently, in at least 21 Member States, sex 'normalising' surgery is carried out on intersex children (FRA, 2015)."

In slide 125 you can introduce the fact that intersex people face several challenges that relate to non-consensual medical interventions and treatments (FRA, 2015). Read the statement reported in the slide, saying also that it is an interagency statement on eliminating forced, coercive and otherwise involuntary sterilisation, released by various UN bodies in May 2014. These bodies included the World Health Organisation (WHO), the Office of the High Commissioner for Human Rights (OHCHR), UN Women, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the UN Development Programme (UNDP), the UN Population Fund (UNFPA) and the UN's Children's Fund (UNICEF).

In the slide 126 explain how the Council of Europe Issue Paper (2015) "Human rights and intersex people" addresses various deeply problematic issues surrounding the medicalisation of intersex people (to enrich the discussion, see also the table from Health4LGBTI SSR pg.36).

In slide 127 summarise the main barriers faced by intersex persons in accessing general healthcare.

In slide 128 point to national legislation that bans normative medical interventions on intersex children until they reach an age where they are in a position to provide informed consent.

Activity 1: Role Play
Slide 129-130

Guidance for trainer

Divide the participants in small groups. Discuss the situation using questions for guidance. Bring the discussion back to the whole group and ask rapporteurs for a summary of main issues identified.

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