



HEALTH  LGBTI

REDUCING HEALTH INEQUALITIES EXPERIENCED BY LGBTI PEOPLE

# TRAINERS' MANUAL

REDUCING HEALTH INEQUALITIES  
EXPERIENCED BY LGBTI PEOPLE:

**WHAT IS YOUR ROLE AS A HEALTH PROFESSIONAL?**

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**Health4LGBTI website:**

[http://ec.europa.eu/health/social\\_determinants/projects/ep\\_funded\\_projects\\_en.htm#fragment2](http://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en.htm#fragment2)

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# LIST OF ABBREVIATIONS

<b>CoE</b>	Council of Europe
<b>CSR</b>	Comprehensive Scoping Review
<b>DSM-5</b>	Diagnostic and Statistical Manual of Mental Disorders V5
<b>EU</b>	European Union
<b>FGSR</b>	Focus Group Studies Report
<b>FRA</b>	Fundamental Rights Agency
<b>HCP</b>	Healthcare Professional
<b>HIV</b>	Human Immunodeficiency Virus
<b>ICD-11</b>	International Classification of Diseases V11 R
<b>LGBTI</b>	Lesbian, Gay, Bisexual, Trans, and Intersex
<b>MS</b>	Member State
<b>MSM</b>	Men who have Sex with Men
<b>RR</b>	Rapid-Review
<b>STI</b>	Sexually Transmitted Infection
<b>SR</b>	Scientific Review
<b>SSR</b>	State of the Art Synthesis Report
<b>TGEU</b>	Transgender Europe
<b>UN</b>	United Nations
<b>UNDP</b>	United Nations Development Programme
<b>WHO</b>	World Health Organisation
<b>WSW</b>	Women who have Sex with Women

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# INTRODUCTION TO THE DOCUMENT

This manual provides step-by-step guidance to the trainers implementing this training course.

It is divided into two parts.

The first part provides an introduction for the trainer, namely: how and why the training course has been developed; how to prepare for the training; how to implement the training and details on the evaluation.

The second part provides a description of the four training modules and includes: an overview of the module; instructions on how to use the module; aims and learning objectives of the module and suggested preparatory reading.

In addition, for each module, guidance notes have been prepared for the trainers to help them when presenting the slides and facilitating the activities. These can be found in Appendix 1 and 2 of each module respectively. The material required for the activities can be found in Appendix 3 of each module in a print-ready format.

## Note on terminology

In this manual, “trainer” refers to the person who conducts/facilitates the training and their co-trainer whereas “participants” refers to the people who attend the training course. LGBTI people will be referred to as “patients/clients” in order to use a term familiar for all the healthcare professionals and for people working in healthcare environments. The training package uses the pronoun “they” in singular form in order to refer to people in a gender-neutral manner.

# ABOUT THIS TRAINING

## Introduction note

There is substantial evidence demonstrating that lesbian, gay, bisexual, trans and intersex (LGBTI) people experience health inequalities. The social determinants of health, namely the discrimination, social exclusion and stigmatisation faced by LGBTI people are well-recognized root causes of such inequalities.

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

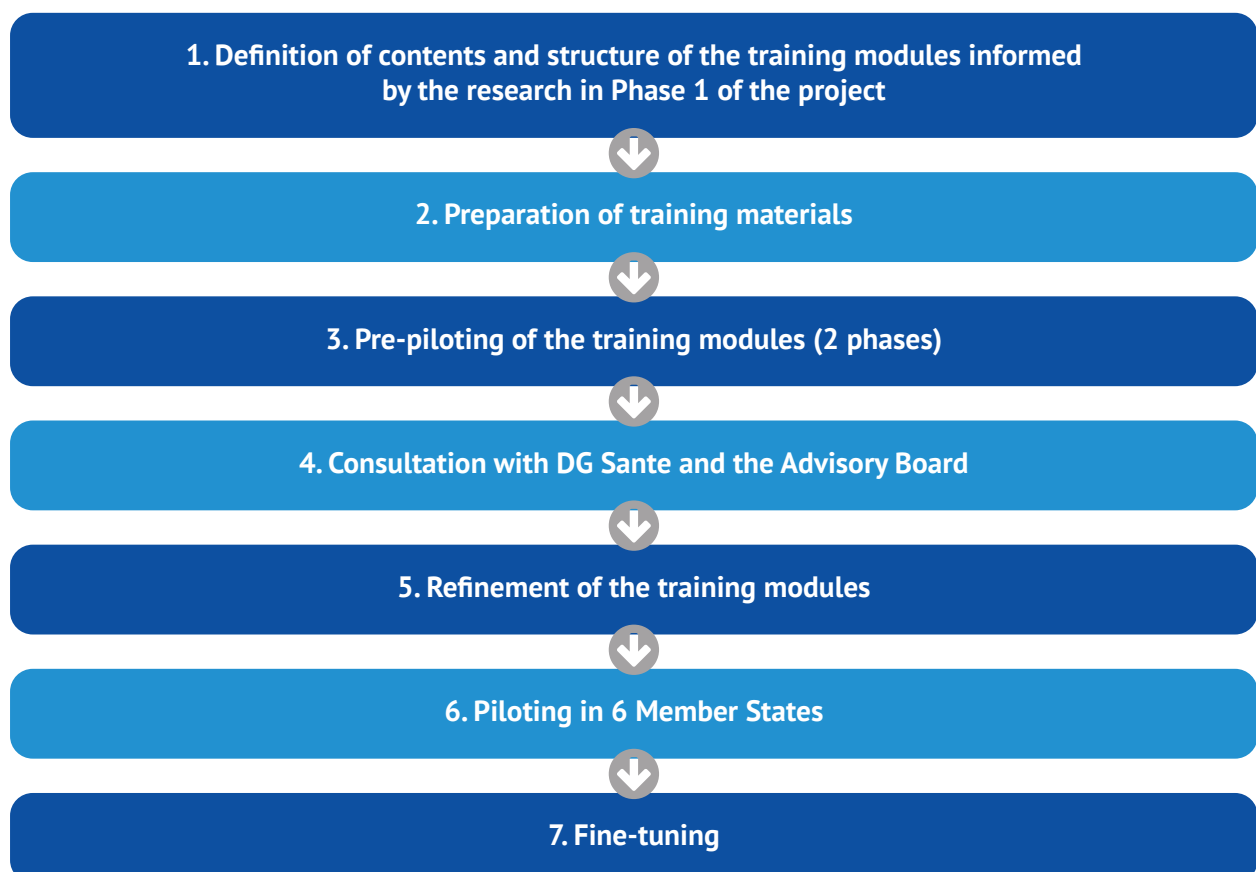


The importance of addressing health inequalities is highlighted within the Europe 2020 strategy as part of achieving the goal of inclusive growth. In this context, the European Commission funded a 2 year pilot project “Health4LGBTI” (i) to further investigate the specific topic of health inequalities suffered by LGBTI people and (ii) to raise awareness and to provide health professionals with specific tools to ensure that they have the right skills and knowledge to contribute to the reduction of health inequalities.

## How was this training course developed?

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).

The structure and content of the course have been elaborated on the basis of the extensive research carried out in the first phase of the Health4LGBTI pilot project<sup>1</sup>, a review of existing training modules and a piloting in the following six EU Member States: Belgium, Bulgaria, Italy, Lithuania, Poland and the UK. (See Figure 1)



**Figure 1. Main Actions to design the training course**

<sup>1</sup> Health4LGBTI State-of-the-art-Synthesis Report (SSR) (Task 1 D1.1 State-of-the-Art-Synthesis Report, including the Health4LGBTI Scientific Review and Comprehensive Scoping Review) and Health4LGBTI Focus Group studies report (FGSR) (Task 2: D2.1 Final overview report on the outcomes of the focus groups)

# STRUCTURE AND CONTENT OF THE TRAINING COURSE

## Course Outline

The training course can be implemented as a complete package or with selected modules only, as suggested in the flow chart below (see Figure 2). For examples of training flowcharts according to different target audiences, please refer to Annex 9.

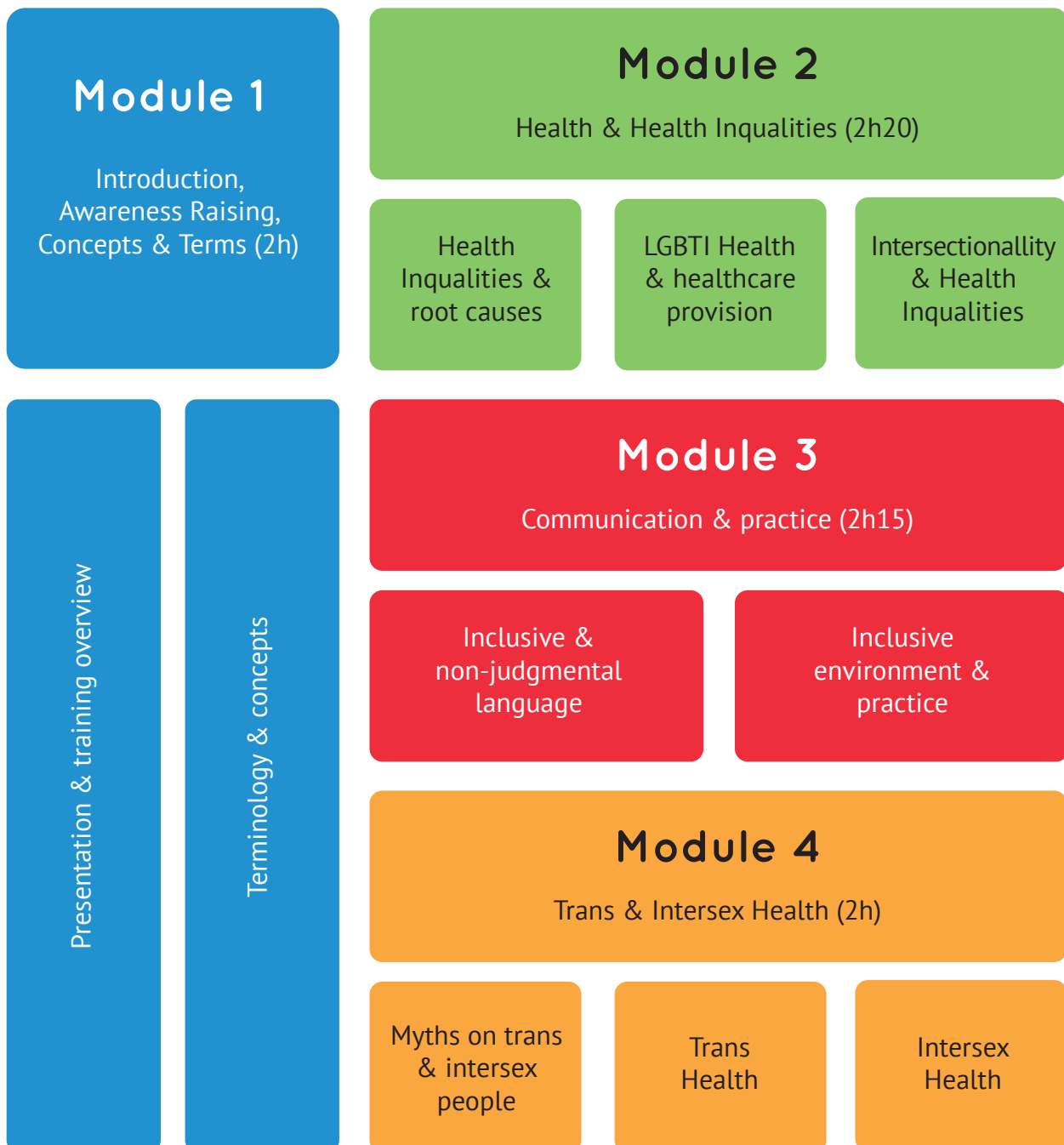


Figure 2. Flowchart of training modules

## 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.

In order to achieve the best possible results, it is recommended that the number of participants be limited to a maximum of fifteen. At present, the training course is designed with a range of professional professionals in mind. If the training course is used for a homogenous group (e.g. all GPs or all psychologists), the content should be tailored to the specific audience.

## 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 LGBTI 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 LGBTI people.

Specifically, the objectives of this training course are:

- to increase knowledge about LGBTI health needs;
- to improve LGBTI-inclusive attitudes;
- to increase LGBTI-inclusive skills in providing healthcare for LGBTI people.

**Knowledge**<sup>2</sup> is about, for example (but not only), understanding the main LGBTI concepts and key terms, of LGBTI intragroup diversity, of LGBTI people's experiences with discrimination, of the barriers faced by LGBTI people and health professionals in the healthcare setting, of the specific health needs of LGBTI people and of health inequalities experienced by LGBTI people.

**Attitudes** are about, for example (but not only), increased awareness of one's own beliefs, biases, assumptions, and feelings of comfort/discomfort towards LGBTI people in the healthcare setting and inclusive attitude.

**Skills** are about, for example (but not only), the use of inclusive language and inclusive practice (e.g. using neutral language, non-judging body language, providing a more inclusive environment).

2 Van Den Bergh and C. Crisp (2004) Defining culturally competent practice with sexual minorities: implications for social work education and practice. *Journal of Social Work Education* 40 (2): 221-238

## Who should the trainers be?

It is recommended that two trainers facilitate this training course in tandem as follows:

1. A **health professional** with a health or mental health educational background (e.g.: medical doctor, psychiatrist, psychologist, etc.). This trainer should be familiar with knowledge and expertise in the area of health inequalities and preferably have experience in training;
2. An **LGBTI NGO/community member**. This trainer should have experience in delivering training.

*<< I find it works well when you have healthcare professionals doing training for other healthcare professionals... You have an implicit understanding of what colleagues are going through and what colleagues have to do. On the other hand, if you get people in who are sort of external to an organisation, people do tend to pay more attention to them. You've got a guest in. It's somebody else who's outside... If you have somebody who's been a patient, somebody from the community who's been in hospital so looking from the patient side perspective on how it felt from that perspective. >>*

*UK LGBTI HCP Interview (Health4LGBTI FGSR pg. 53)*

## How long does this training course last and how should it be implemented?

This is a face-to-face training course. The duration of this training course is between 8-10 hours. It is recommended to implement the training course in two consecutive half day sessions or three or four shorter sessions which can be divided according to the needs of the implementing organisation.

The complete training course consists of four modules to be implemented in the order in which they appear in this manual. The modules can also be taught as standalone modules although it is recommended to complete the core segments of Module 1 before undertaking the other modules.

Trainers can also adapt the training course according to the target audience (e.g. administrative staff, general healthcare professionals, specialist doctors or a mixed audience) and to the training objectives (attitudes, knowledge and skills) by selecting and combining certain segments of the different modules. It is recommended to consider the guidance provided in the charts in the module overview when selecting the appropriate segments.

Module 4 is a dedicated module on trans and intersex health. Topics related to trans and intersex health are included transversally in the other modules. However, research in the first phase of the Health4LGBTI project highlighted the specific need for a more detailed training on this subject, which explains why it is covered in more depth in a separate module.

Depending on how this training course is implemented, the agenda should be adapted and should outline the content of the course, the timing (including the timing allocated for pre and post evaluation as well as for coffee and lunch breaks) and the learning objectives.

The times allotted to each segment are suggested times only with a view to implementing the entire module in approximately 2 to 2.5 hours. The segment lengths can be adjusted according to the amount of time that is considered appropriate for the discussion and elaboration of the slides or for the activity.

See Annex 9 for Sample training flowcharts according to target audience.

## Do I need permission to use this training course?

This training course belongs to the European Commission (© European Union, 2017) and therefore reuse is subject to the Commission’s re-using policy (2011/833/EU)<sup>3</sup>. In short, this means that the training course can be reused provided the source is acknowledged. The relevant copyright notice is already included in the slides and trainers should take care to ensure that this is always included in case of adaptation of the slides.

## Course Materials

The training course is made of the following components:

TRAINERS’ MANUAL	TRAINING MATERIALS	EVALUATION MATERIALS
<ul style="list-style-type: none"> <li>➔ Structure and contents of the training course</li> <li>➔ Detailed description of the content of the training course (slides, training documents, training materials)</li> <li>➔ Recommendations for managing a proper delivery of the training modules</li> </ul>	<ul style="list-style-type: none"> <li>➔ PPT slides</li> <li>➔ Videos</li> <li>➔ A take-home reference manual for participants with additional resources to support the participants after the training</li> </ul>	<ul style="list-style-type: none"> <li>➔ Description of the training evaluation tools, timing and procedures</li> <li>➔ Questionnaires</li> <li>➔ Grids for site-visits</li> <li>➔ SWOT matrix for trainers</li> </ul>

The content of the training modules (including group activities, case studies, and selection of slides) can be adapted in accordance to the local context and specific training needs (see the section on “Training adjustment and update”).

<sup>3</sup> COMMISSION DECISION of 12 December 2011 on the reuse of Commission documents (2011/833/EU), available at: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:330:0039:0042:EN:PDF>

# PREPARING THE TRAINING

## Preparation of trainers

It is of key importance for trainers to prepare themselves to run this training. Regardless of whether the trainers have prior knowledge or experience on health inequalities of LGBTI people, both trainers should take time to study all necessary materials as follows:

- Read and study this training manual;
- Read the information about the Health4LGBTI project at [http://ec.europa.eu/health/social\\_determinants/projects/ep\\_funded\\_projects\\_en.htm#fragment2](http://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en.htm#fragment2);
- Familiarise yourself very well with the whole glossary in [Annex 1](#);
- Study the complementary documents (including the background, the methodological sections and results): Health4LGBTI reports (SSR and FGSR).

In addition, the required reading for each module is specified in the introduction section of the description of the modules.

Trainers should also divide responsibilities among them, both in terms of preparation and management of the training course.

## Preparation of the training materials

The trainers should prepare the following for each participant:

1. Copy of the PPTs (with space on the side for participants to take notes);
2. Material for activities (Appendix 1.3, 2.3, 3.3, 4.3);
3. Wrap up sheet – blank page for participants to note things that they would like to change after the training course;
4. Consent Form (If applicable) (Annex 5);
5. Participant Information Sheet (Annex 6);
6. Individual Confidential Declaration (If applicable) (Annex 7);
7. Pre-training Evaluation questionnaire (Appendix 10.1);
8. Post-training Evaluation questionnaire to be distributed at the end of the training course (Appendix 10.2);
9. Take-home tools for trainees (Annex 8) to be distributed at the end of the training course;
10. Any other documents requested by your Institution (e.g. certificates of attendance).

## Recruitment of participants

Potential recruitment channels may include local professional networks, mailed invitations, medical news bulletins/journals and project websites. See below for a suggested procedure for the recruitment of participants:

- establish a contact with local institutions/trade unions/health care associations and liaise with them in order to identify the best channel of recruitment;
- create a list of potential participants with contact details;
- send the invitation letter/email together with the agenda of the training course to potential participants;
- do a follow up after 15 days (by email/phone);
- create a final list of participants;
- create a list of substitutes;
- send a reminder nearer the date of the training course.

These procedures may vary in accordance with ethical board requirements.

See Annex 4 for the template of the invitation letter.

## Selection of venue

It is recommended that the training course be held in a venue that is appropriate, quiet, comfortable and accessible for participants. This may be a room in the hospital/medical service where the majority of the participants work in order to facilitate their participation. The room should be sufficiently large enough for up to fifteen participants and you should be able to move chairs around in order to facilitate the activities. A slide projector for PowerPoint presentations and a flipchart have to be available.

It is recommended to prepare the room with the seats in a semi-circle. This will encourage both participation and at the same time, ensure the visibility of the slides.

As the trainer, forward preparation is important so that the training course can be conducted in an efficient and timely manner. For this reason, it is important to pay attention to the following aspects:

- ensure that the room temperature is comfortable, the lighting is adequate, and slides readable;
- ensure the room is the appropriate size;
- set up any electronic devices for the training course;
- provide the correct logistical information to participants (e.g. map of the place, location of bathroom, indication on break and lunch, agenda);
- stick to the agenda.

## Training adjustment and update

**Terminology** in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document. For this reason, if these modules are translated into other languages, great care should be taken to ensure that the meanings of terms will be accurately translated. Be aware that some terms may be appropriate in English, but could be considered as derogatory in another language.

The recruitment procedure allows the possibility to adapt and adjust the content of this training course in accordance with the profile of the participants and their expectations.

As reported in different sections of this manual it is possible to use the complementary documents (Health4LGBTI SSR and Health4LGBTI FGSR) to integrate the most relevant information and/or to adapt the contents of the presentation to the local needs (e.g. you can substitute a quote from a country with a contextual framework more similar to your country; you can emphasise a health topic if the participants are mostly from one health field).

In case trainers wish to include slides with updated information on the European/national context, they should contact ILGA-Europe, or consult this page: <https://rainbow-europe.org/>, where they will find updated information on legislation on LGBTI rights for each European country. Trainers might also contact directly Local LGBTI organisations and associations for further information. Please refer to ILGA-Europe's member organisations list: <https://www.ilga-europe.org/who-we-are/members>. In module 1 and 4 slides have been included with the websites from where the updated information can be obtained and the trainer should download the relevant information (e.g. maps, etc.) and include it in the slides.



# IMPLEMENTING THE TRAINING

## General approach

The methodology adopted for the implementation of the training course foresees both theoretical and practical/interactive approaches. Practical/interactive strategies represent the pivotal focus of the training sessions and include PowerPoint slides, small group and large group activities/discussion, media, case studies and role-play. The alternation between the two methods is conducive to an attentive audience.

Throughout the training course, it is recommended to encourage the active participation of participants, including sharing of their personal and professional views, values and beliefs and their contribution to the debate, while facilitating group discussions and ensuring cohesion of participants.

## Managing practical activities

For each activity, it is important that participants are clear about what is expected from them and about how much time they have to complete the activity. The material required for each activity and the instructions for carrying out the activity are described in detail in this manual in the relevant segment together with the assigned time.

In each activity slide you will find a Warning Box to remind participants that this is a confidential space

**Working in small groups:** Encourage participants to work with people with whom they have not worked before (if this does not work, you can also randomly assign participants to the groups). The number of small groups has been suggested in each activity segment; however this will depend on the total number of participants. Having fewer participants in each group will facilitate participation. Move through the different groups to observe the dynamic, help the participants and facilitate the discussion if necessary.

**Working in large group:** Use the flip chart to summarise the main topics that emerge from the discussion. Remind participants that there are no correct answers in order not to inhibit participation. Try to elicit responses from the group, before offering some suggestions. If you do offer suggestions, make sure that the group agrees with your suggestions before you write them up on the flipchart. Alternatively, use post-it notes (e.g. large group activity in Module 1) so that every participant can feel free to express their opinion.

A slide to collect “questions and comments” has been included in different segments of the training course. However, if you feel the need to promote interaction and engage participants in the conversation, consider adding this slide to other segments or ask for “Any questions and comments?” more often.

## Knowing your audience

You should lead the training sessions in a manner that is appropriate for the training participants, namely adult health professionals or professionals working in a healthcare environment.

It is important to have a clear idea of the potential needs and background of the participants. To achieve this goal, it could be useful to consider some factors such as health professional profiles and roles, together with the country local needs<sup>4</sup>.

In addition, it is useful to know what participants expect from the training course (in Module 1 you will explore participants' expectations) so that you can keep in mind and address participants' expectations as far as possible (see the section on "[Training adjustment and update](#)").

## Involving your audience and dealing with difficult conversations

It is your job as a trainer to:

- stimulate discussion;
- provide safe, comfortable, and stimulating training sessions;
- ensure all the participants have the opportunity to express their opinions;
- respect their differing viewpoints and their silence (see "Rules" in Module 1).

In addition, participants may have varying types of reactions to the contents and activities in the training course. While this training aims at equipping health professionals with tools to reduce health inequalities for LGBTI people, participants may not always be friendly towards LGBTI people. Direct attacks against LGBTI people, including to other participants based on their identity or background, included (but not limited to) because of their sex characteristics, gender identity or sexual orientation should not be tolerated. It is your responsibility to address these incidents when they occur and make sure they are not repeated. This should be made clear at the very beginning of the training course, when you establish the rules to be respected throughout the training, including the safe space rule. Trainers should clarify this having in mind that participants need to respect the safe space rule and, at the same time, feel free to express their doubts and misconceptions.

It is more likely that participants will make comments that are not directed at anyone in particular, but are still negative or based on stereotypes and directed to LGBTI people in general. The topic of health inequalities for LGBTI people is likely to be new for many participants who might hold prejudicial, stereotypical or negative views on LGBTI issues. Such views might arise through difficult comments or conversations during the training course. Your responsibility remains to maintain a safe space for all participants during the training course, but also to educate participants through this training.

This section provides you with guidance on dealing with LGBTI-phobic behaviour and difficult conversations during the training course.

Here are some steps to deal with negative comments or conversations:

<sup>4</sup> Please note that during the piloting in the 6 Member States, the sociodemographic information available through the registration procedure was used. For future training you could use the socio-demographic and personal information including age, sexual orientation, sex characteristics, gender identity, previous knowledge of and attitudes toward LGBTI patients/clients, skill level in delivering healthcare to LGBTI patients/clients using a short form of the pre-evaluation questionnaire already during the recruitment phase. This could be useful to understand your audience.

1. **Educate and prepare yourself:** by reading all materials related to this training, making sure you know the proper terminology, and feel comfortable about the topic. Keep in mind that difficult comments can come in many forms and shapes;
2. **Do not directly confront participants on their views,** or tell them they are wrong. Show acceptance and interest in what the participants bring into the training course (e.g. using open questions and paying attention to avoid any judgmental nonverbal behaviour). Make sure to acknowledge what they say: “This is your opinion, however I would like to stress that...” or “I am sure this conversation is important for you; however I would like to stress that...” You may also use help from other participants by saying: “This is your opinion/experience, do other participants have different opinions/experiences?”
3. **Use one of the following approaches to address the problematic comment or conversation:**
  - **Training scope approach:** if it is the case, remind participants that the topic discussed is out of the scope of the training course, and time is too scarce to get into this conversation.
  - **Training goals approach:** remind people of the goal of the training course: increasing awareness among HCPs on health inequalities for LGBTI people & equipping them with tools to counter these inequalities.
  - **Health approach:** everyone should have access to the highest standard of health, regardless of who they are or what rights they are in a given country/setting.
  - **Terminology approach:** bring back participants to LGBTI terminology, and remind them of the importance of using positive, respectful and appropriate terminology when talking about LGBTI issues.
  - **Guidelines approach:** remind participants that, as healthcare professionals, they should follow the national and international guidelines and standards of care, including the ones that are specific to healthcare provision to LGBTI people.
  - **Diversity approach:** in order to avoid negative generalisations, remind participants of the diversity of people within the LGBTI community (participants might know a LGBTI person who behaves in a certain way or says certain things, but that does not mean it is applicable to all people in the LGBTI community).

## Frequent Comments (and how to answer them)

### “People suffer from health inequalities also because of their lifestyles and choices”

The purpose of the Health4LGBTI project is to better understand the specific health inequalities experienced by LGBTI people. By health inequalities, we understand:

“differences in health which arise not from chance or from the decision of the individual but from avoidable differences in social, economic and environmental variables (e.g. living and working conditions, education, occupation, income, access to quality health care, disease prevention and health promotion services) that are largely beyond individual control and can be addressed by public policy.” (Questions and Answers on Solidarity in health: Reducing health inequalities in the EU<sup>5</sup>)

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5 [http://ec.europa.eu/health/archive/ph\\_determinants/socio\\_economics/documents/com2009\\_qa\\_en.pdf](http://ec.europa.eu/health/archive/ph_determinants/socio_economics/documents/com2009_qa_en.pdf)

Therefore, this training course aims at giving tools to health professionals to act, at their level, against health inequalities for LGBTI people.

You could also add (if necessary) that discussing whether sexual orientation, gender identity/ expression or sex characteristics are a choice is not within the scope of the training course.

**“Not all LGBTI people are unhappy («I know an LGBTI person who is very happy»)”**

It is true that LGBTI people are not a monolithic category. This is what is emphasized in module 1 on terminology.

The results of the review of existing research point out that “health inequalities can also be considered in the context of protective factors that facilitate wellbeing rather than focussing only on factors that cause illness. Relatively little research has been done on the factors that protect the majority of gay and bisexual men from suicidal behaviour and how large sections of this population remain resilient in the face of adversity given that they experience minority stress, discrimination and marginalisation.”

It is true that there are a number of protective factors for LGBTI people, such as social support. It is important to stress the need for such support, including as a health professional, in parallel to addressing health inequalities themselves. (Health4LGBTI SRR p.29)

**“Not all LGBTI people are discriminated against or persecuted”**

Research shows that discrimination in health care settings is prevalent and can take many forms. It also emphasises the role of health professionals in countering these inequalities. This training course was developed to give tools to health professionals to address health inequalities suffered by LGBTI people they work with.

**“The situation in the EU is very diverse – how can one training package fit all countries?”**

The training course has been designed in such a way to take into account differences across Member States and suggestions are provided in this manual about where the material can be adapted to the country context. The course was piloted in 6 diverse Member States and it adapted well, notwithstanding the different legal and social contexts. Where the findings from the piloting indicated that some elements of the course did not fit a variety of contexts, changes have been made. Finally, ILGA-Europe, which is an European LGBTI organisation, took part in the elaboration of the training course. This NGO gathers more than 500 LGBTI organisations, from Russia to Portugal. It is therefore used to covering very diverse legal and social backgrounds.

**“LGBTI people are not subject to discrimination in my country. Do we really need training?”**

There is no EU member state, and actually no country in the world, where LGBTI people do not face some form of discrimination. As much as racism or sexism exists everywhere, including in the most progressive societies, rejection and exclusion of people because of their sexual orientation, gender identity or sex characteristics are a reality in all countries of the world. There may be legal protection against discrimination on those grounds in your country, but that does not mean that in practice, LGBTI people are not discriminated, or bullied or stigmatized in different ways. Everyone has a key role to play to challenge stigma and promote diversity. But to be able to make a change, you need first to be equipped with the necessary knowledge and skills.

## Conclusions and Wrap-up

The remaining 5 minutes of each training day are reserved for the wrap-up. Display the wrap-up slide and ask participants to think about:

- something that they have learned;
- something that they would put in place after the training course.

As an example you can ask:

“Now you have 5 minutes to think about something that you have learned during this training session and something that you would put in place once return to your healthcare setting. Feel free to share it with the person next to you and then with the group - it could be inspiring also for other participants.”

A final wrap-up slide is at the end of each module. You will need to move this slide in accordance with how you implement the training (i.e. if you perform more than one module in one day, then you should use this slide only at the end of the day). If the training is implemented over the course of a number of days, a separate wrap-up exercise should be conducted at the end of the entire training course.

## Confidentiality and data protection

Regulation (EC) 45/2001<sup>6</sup> lays down the rules for data protection in the EU Institutions and is distinct from Directive 95/46/EC<sup>7</sup> (soon to be replaced by Regulation (EU) 2016/679<sup>8</sup>) which applies at the level of the individual Member States.

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

In accordance with Regulation (EC) 45/2001, a **Specific Privacy Statement** (see Annex 2 of this General Introduction) was elaborated which described all the possible uses of the data that was collected in the context of the Health4LGBTI project. This statement can be found on the European Commission DG Health and Food Safety website: ([https://ec.europa.eu/health/sites/health/files/social\\_determinants/docs/2017\\_vulnerable\\_sps\\_en.pdf](https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2017_vulnerable_sps_en.pdf)).

A printed copy of this document was distributed to all participants during the pilot training so that they were fully informed about how their data would be treated.

In conjunction with this document, all participants were asked to sign a **Consent Form** (see Annex 2-3 of this General Introduction) whereby the participant consented to the processing (namely the collection, storage and analysis) of their personal data as well as to the dissemination of depersonalised data (identification and contact details were removed) for the purposes of the project.

6 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

7 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

8 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)

In addition, 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 professional experience in the context of a given activity, all participants were asked to sign a **Confidentiality Declaration** (see Annex 7 of this General Introduction) whereby they committed to **not refer to** any personal data of their patients during the training sessions.

It was explained to participants what is intended by personal data and to this end, the trainer explicitly read out the definition of personal data as per article 2(a) of the Regulation (EC) 45/2001, namely <“personal data” shall mean any information relating to an identified or identifiable natural person hereinafter referred to as “data subject”; an identifiable person is one who can be identified, directly or indirectly, in particular by reference to an identification number or to one or more factors specific to his or her physical, physiological, mental, economic, cultural or social identity>.

The trainer also provided an example to ensure that participants had fully understood the information they could and could not share (see box below).

A GP shares their experience of their patient, a trans man who has breast cancer. The GP provides a fictitious name for this patient (John). The GP explains how John had a double mastectomy and how his mental health status improved because he finally achieved what he always wanted but due to his low income could not afford (i.e. access to transition care). Although the GP does not identify the patient by name, they are the only GP in the town of Smallsville with a resident population of 8,000 inhabitants. The GP provided sufficient references to John’s physical, physiological, mental and economic identity for others to be able to indirectly identify John.

The trainer then explained how the same information can be shared by relating it as third-hand information (see box below).

A GP shares a story about a conference on mental health they recently attended. There, a case-study of a trans man with breast cancer was presented. The patient had a double mastectomy and his mental health status improved because he finally achieved what he always wanted but due to his low income, could not afford (i.e. access to transition care). There is no identifying of this person.

Before replicating this training course, the applicable data protection norms should be checked and the appropriate documentation to be signed by participants should be drawn-up.

For more general information on the protection of the security and confidentiality of personal health information, you may also refer to the WHO/UNAIDS guidelines accessible at [http://www.unaids.org/en/resources/presscentre/featurestories/2016/november/20161123\\_confidentiality-security](http://www.unaids.org/en/resources/presscentre/featurestories/2016/november/20161123_confidentiality-security).

# EVALUATION

The training course should be carefully evaluated each time it is implemented to assess if its objectives have been achieved. Specific evaluation tools have been developed to measure:

1. increase in knowledge on the health needs of LGBTI people;
2. variations in LGBTI-inclusive skills;
3. variations in the health professionals' attitudes towards LGBTI people.

See Annex 10.

Additionally, general satisfaction with the training course is assessed.

Where appropriate, the full evaluation package could also include a SWOT (strength, weaknesses, opportunities and threats) analysis performed by the trainers and external observation (site visit)<sup>9</sup>.

## Evaluation of participants' knowledge, skills and attitudes

The knowledge, skills and attitudes evaluation is implemented in the form of pre- and post-training self-administered, anonymous, paper-based questionnaires:

- The pre-test questionnaire contains questions on knowledge, attitudes, behavioural intention and self-perceived skills in addition to contextual information (demographics, role in the health care system);
- The post-training questionnaire also contains a section on satisfaction about the training course and applicability of the particular modules in every day clinical practice.

The questionnaires are included in the Evaluation Tool (Annex 10).

In preparation for the training we recommend that the questionnaires are translated into the language of the country where the training course is being implemented and that a sufficient number of copies of each questionnaire are printed. Translation into the following languages is already available: Italian, Polish, Bulgarian, Lithuanian and Dutch. Please consult the project website for the available translations.

The pre- and post-training questionnaires are individually linked by a unique code for each participant. In order to ensure anonymity you can distribute an individual code to each of the participants before they receive the pre-test questionnaire or ask them to use an easy to remember, but not immediately identifying code. An example of such a code can be 3 initial letters of the older parent's first name and the day and month of their birthday.

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<sup>9</sup> This was done as part of the piloting of the training course carried out in 6 Member States (Belgium, Bulgaria, Italy, Lithuania, Poland and the UK) between October and November 2017.



The questionnaires contain questions which may be sensitive. Therefore attention should be paid to ensure privacy while completing the questionnaires by the participants as well as during collection of completed questionnaires. If possible, the participants should place their questionnaires into individual envelopes before depositing them in a designated box/container.

The learning may be satisfactory, yet the impact of the training course may be limited by structural barriers or social norms at the working place. Whenever possible we recommend to implement a short follow-up questionnaire two months after the training course to assess the real impact on behavioural change and potential difficulties that the participants might face when trying to implement the new skills in practice. This could be in the form of online questionnaire. An example is provided in the Evaluation tool.

## Evaluation of trainers

Whenever the training course is considered for wider use in the country or region or in specific settings (e.g. medical university's curriculum) structured feedback by the trainers may be useful to adapt the training course.

We recommend that the trainers identify:

- the strengths and weaknesses of the training course: characteristics of the training itself and competencies of the available trainers that can positively or negatively influence the effectiveness of training course,
- the opportunities and threats: external factors which can have an impact, e.g. prior knowledge, skills and attitudes of the participants or enabling/hindering factors at their work place or university.

A more detailed guideline for the SWOT analysis is included in the Evaluation tool.

Although the current questions were designed to be based on the experience of having delivered the training course, the SWOT analysis could be also a tool to consider when preparing for the training course. It can help trainers to take into consideration different internal and external factors that maximise the potential of the training's strengths and opportunities, while minimising the impact of its weaknesses and threats.

## Site visit or external observer

Site visits have been designed primarily for the piloting phase during the development of the training course. However, the users of this training course are invited to use a similar methodology to improve their training. The main concept of the site visit is to invite an external observer who could take note of active participation of the participants and the practical experience that they might share during the training course. The observer can also gauge if there are parts of the training course that are well or less well received or easier or more difficult to conduct. The site visit involves direct observation during the training course.

The site visit grid is included in the Evaluation tool.

Should you decide to have an external observer during the training course it is important to clearly communicate this to the participants beforehand so that they can consent to such a procedure.



# RECAP: CHECKLIST FOR TRAINERS

## Before the training

- ✓ **Study** the full training package and other materials (listed in the introduction, and at the beginning of each module);
- ✓ **Divide roles** with the co-trainer;
- ✓ **Recruit participants** and familiarise yourself with the professional profile of the participants;
- ✓ **Select a venue** for the training course;
- ✓ **Adapt the training materials** to the local context and in accordance with the professional profile of the participants (where applicable);
- ✓ **Translate the training materials** (where applicable);
- ✓ **Prepare and print** all the supporting materials that you will need during the training course, including:
  - evaluation questionnaires;
  - agenda (including breaks/lunch);
  - worksheet and materials for the activities;
  - confidentiality form and other ethical forms if required;
  - any other documents requested by your Institution (e.g. certificates of attendance);
  - take-home tool for participants.

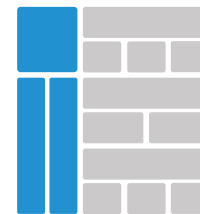
## During the training

- ✓ Before starting the training course, distribute and collect the **pre-training questionnaire**;
- ✓ **Encourage active participation** of participants, their contribution to the discussion and facilitate group discussions, while keeping in mind participants' expectations and profile;
- ✓ **Provide clear instructions** on how to conduct the activities and on the time allocated for each activity;
- ✓ **Keep track of time** and adjust the time according to the amount of time that you feel is appropriate for the discussion and elaboration of the slides or for the activity;
- ✓ **Ensure respect of the ground rules** and refer to the guidelines on dealing with LGBTI-phobic behaviour guidelines if necessary;
- ✓ **Collect and store safely all forms**, including the confidentiality forms, evaluation questionnaires and consent forms (or other forms when due);
- ✓ After the training course, distribute and collect the **post-training questionnaire**.

## After the training

- ✓ **Evaluate the training** with the co-trainer (SWOT analysis, checklist evaluation for trainers);
- ✓ **Debrief** with the co-trainer and the external observer (when applicable);
- ✓ **Distribute & collect the follow-up questionnaire** to participants 2 months after the training course (when applicable).

# MODULE 1: INTRODUCTION, AWARENESS RAISING, CONCEPTS AND TERMS



## 1.1. Module overview

**Duration:** 2 hours

**A** - Attitudes; **K** - Knowledge; **S** - Skills

**Resources:** PowerPoint presentation, laptop, projector, activity sheets, flipchart, a pen, post-its

Content	Aim	Segment	Description	Materials	Duration (mins)	Learning objective*	Guidance notes
		<b>Introduction</b>	Module 1: Main contents learning objectives	Slides 1.1 to 1.4	5		Appendix 1.1
<b>Presentation and training overview</b>	To introduce Trainers and Participants	<b>Discussion</b>	Ground Rules	Slide 1.5	5		Appendix 1.1
		<b>Activity 1</b>	<i>Introduce Yourself</i>	<i>Slide 1.6, Flipchart, Stickers, a Pen</i>	<b>10</b>	A	Appendix 1.2
	To introduce the <b>Health4 LGBTI Project and the training</b> course	<b>Teaching Segment</b>	Project overview: background and main objectives	Slides 1.7 to 1.9	5		Appendix 1.1
		<b>Activity 2</b>	<i>Video: Experience of Healthcare settings: LGBTI people tell their stories</i>	<i>Slide 1.10 to 1.12, Video</i>	<b>10</b>	A, K	Appendix 1.2 Appendix 1.3
		<b>Teaching Segment</b>	Training overview: contents and structure	Slides 1.13 to 1.16	10		Appendix 1.1
To establish <b>group cohesion</b> and a <b>positive learning environment</b>	<b>Activity 3</b>	<i>Values Shuffles</i>	<i>Slides 1.17 to 1.22, a Pen, 4 Cards</i>	<b>25</b>	A	Appendix 1.2	
<b>Terminology and concepts</b>	To raise awareness and improve <b>knowledge on terms and concepts</b> related to LGBTI topics	<b>Activity 4</b>	<i>Correct Use of Terminology</i>	<i>Slide 1.23 to 1.24, Flipchart, Post-its, a Pen</i>	<b>10</b>	K	Appendix 1.2
		<b>Teaching Segment</b>	Terms and concepts	Slides 1.25 to 1.39	20	K	Appendix 1.1
		<b>Activity 5</b>	<i>Let's Practice your Knowledge</i>	<i>Slide 1.40, Flipchart, a Pen</i>	<b>15</b>	S	Appendix 1.2 Appendix 1.3
		<b>Wrap-up</b>	Conclusions	Slide 1.41	5		Appendix 1.1

## 1.2. How to use this module

This module has been designed to provide the foundations for Modules 2, 3 and 4.

To begin with, it includes a number of different activities to introduce participants to one-another, to foster a positive atmosphere within the group and to enter into to the LGBTI subject matter.

Following the opening activities, participants will be provided with an overview of the Health4LGBTI project, so that they can understand how the idea for such a training course came about and how it has been developed. Participants will also be provided with an outline of the overall training course in terms of structure and contents to help them decide about their participation in the subsequent modules.

Finally, it can be expected that participants will have varying levels of knowledge, attitudes, skills and experiences in the field of LGBTI topics/health inequalities. Moreover, even though there may be health professionals who know the concepts, the aim of the module is to ensure that everyone is at the same level of understanding. Therefore, this module will explain the different dimensions and meanings related to sexual orientation, gender identity and sex characteristics. An overview of main terms and concepts in the LGBTI field will also be presented.

## 1.3. Aims

- To introduce trainers and participants;
- To introduce the Health4LGBTI Project and the training course;
- To establish group cohesion and a positive learning environment;
- To raise awareness and improve knowledge on terms and concepts related to LGBTI topics.

## 1.4. Learning objectives

After this module, the participants will:

- Understand the overall aims, background and contents of the project and of the training course;
- Have a greater awareness and knowledge about terms and concepts in the field of gender identity, sexual orientation and sex characteristics;
- Feel more comfortable in discussing LGBTI issues;
- Be able to correctly use the relevant terminology.

## 1.5. How to prepare for this module

- Read the information about the Health4LGBTI project at [http://ec.europa.eu/health/social\\_determinants/projects/ep\\_funded\\_projects\\_en.htm#fragment2](http://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en.htm#fragment2);
- Familiarise yourself very well with the whole glossary, not only the selected terms presented in this module. See Annex 1 - Glossary;
- Study the background and the methodological sections of the complementary documents: Health4LGBTI reports (SSR and FGSR).

## Appendix 1.1 – Guidance notes - slides

Title	Sub-title	Slides	Guidance for trainer
Presentation and training overview	Main contents learning objectives	1.1-1.2	Welcome participants to the training course.
		1.3-1.4	Describe the main aims and contents of Module 1.
	Ground Rules	1.5	<p>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).</p> <p>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.</p> <p>The following are three essential rules:</p> <ul style="list-style-type: none"> <li>➔ <b>Confidentiality/safe space.</b> All participants, the trainers and evaluators have signed a confidentiality form<sup>10</sup> which assures that no personal data of the participants involving in the training course will be reported outside of it. This rule serves the purpose of encouraging the participants to speak freely;</li> <li>➔ <b>Mutual respect of participants'</b> 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 judgemental attitude toward the opinion of participants expressed during the training course;</li> <li>➔ <b>Participation.</b> 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.</li> </ul> <p>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 of all suggested rules before adding them into the list.</p>
	Introduce yourself	1.6	Introduce yourselves and invite all the participants to introduce themselves using the icebreaker activity (Activity 1) (please refer to Appendix 1.2)
	Project overview: background and main objectives	1.7-1.9	<p>Briefly describe here the Health4LGBTI project, its background and objectives following the contents in the slides. You need to underline that this is a training course that has been produced in the context of a European Commission Service contract. This means that the training course belongs to the European Commission and therefore reuse is subject to the Commission's re-use policy (2011/833/EU). In this case, this means that the training can be used provided the source is acknowledged.</p> <p>Briefly describe the Consortium, which is composed of a partnership between EuroHealthNet (a European alliance of not-for-profit public health entities aiming to support European health and equity policies) Verona University Hospital (a University Teaching Hospital in Italy), University of Brighton in the UK, the National Institute of Public Health in Poland (a Public Health body) and The European region of the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA-Europe), the only Europe-wide LGBTI organisation, combining in a unique way the strength in knowledge and know-how of the LGBTI community and health professionals.</p> <p><b>Health4LGBTI project activities include:</b></p> <ul style="list-style-type: none"> <li>➔ A state-of-the-art review of the health inequalities experienced by LGBTI people and the barriers faced by health professionals in providing healthcare for LGBTI people. It consists of: <ul style="list-style-type: none"> <li>- a desk-based scientific review of the International/European research literature published in peer reviewed journals;</li> <li>- a comprehensive scoping review of promising practices which complements the scientific review by focusing on grey literature from all 28 Member States (MS);</li> </ul> </li> </ul>

Title	Sub-title	Slides	Guidance for trainer
			<ul style="list-style-type: none"> <li>➔ Two focus group studies in six EU Member States to map the barriers faced both by LGBTI people and health professionals;</li> <li>➔ Development of training modules aimed at increasing the knowledge, attitudes and skills of healthcare professionals when providing healthcare to LGBTI people. Most importantly, the training modules have been designed so as to be replicable in any of the EU MS taking into account as far as possible, different national and regional health systems.</li> <li>➔ Piloting of the training modules in the same Member States where the focus groups will be conducted, in order to fine-tune and finalise the modules.</li> <li>➔ A final European conference, and wide dissemination and communication targeting civil society organisations representing or working with key population groups, healthcare professionals, European health organisations including the EU as well as national, regional and local policy and decision makers in the area of health.</li> </ul> <p>The focus groups have been performed in six European Member States: Belgium, Bulgaria, Italy, Lithuania, Poland and the UK, representing diverse geographical regions of Europe, and these are the same countries of the piloting phase.</p>
		1.10	Slides for Activity 2 (please refer to Appendix 1.2)
		1.11-1.12	These two slides should be prepared in advance by the trainer by downloading the relevant maps from the website provided.
	<b>Training overview: contents and structure</b>	1.13-1.14	<p>You can explain that the primary objective of the training modules is to improve: knowledge on LGBTI health needs, attitudes and skills when providing healthcare to LGBTI people.</p> <p>The training modules have been informed by both the State-of-the-art synthesis report (Health4LGBTI SSR) (including the Health4LGBTI Scientific Review and Comprehensive Scoping Review) and focus groups with LGBTI people and health professionals, whilst also taking into account existing training modules and other additional sources when relevant.</p> <p>You can specify that the training modules have been co-designed by Verona University Hospital (AOUI-VR) and ILGA-Europe in close collaboration with all the partners of the project.</p> <p>You may take a few moments to explain the process of the focus groups so that the participants can have a better understanding of where quotes come from. You can use the following concepts. Two focus groups with a maximum of ten participants in each group were run in each of the six participating MS. The two groups comprised diverse members of the LGBTI population and diverse health professionals and/or specialists with an interest in the equitable delivery of LGBTI healthcare (e.g. GPs, nurses, mental health workers, midwifery and social care staff). A further six in-depth semi-structured interviews were conducted with health professionals who identified as LGBTI.</p>
		1.15	You may explain that the methodology adopted during the training modules integrates theoretical and practical/interactive approaches. You can say that the training modules are interactive and participants could be asked to share their personal and professional views, values and beliefs. During all training modules, you, as trainer, are invited to actively participate and contribute to the debate. Having said this, there is no obligation to participate and participants should contribute only if they feel comfortable doing so.

Title	Sub-title	Slides	Guidance for trainer
		1.16	<p>You can explain that the training course is made up of four modules.</p> <ul style="list-style-type: none"> <li>➔ Module 1 is an introduction to the others;</li> <li>➔ Module 2 “Health and health inequalities” is a module describing the main findings regarding root causes of health inequalities, barriers faced by LGBTI people and HCPs, health and health inequalities faced by LGBTI people, health inequalities focusing on vulnerable intersections;</li> <li>➔ Module 3 “Communication and practice” is a module describing how to improve communication and practice by making it more inclusive starting from the recommendations made by the Health4LGBTI project;</li> <li>➔ Module 4 “Trans and Intersex health” is a dedicated module to the specific needs of this population. The topics of health of trans and intersex people are already part of the other modules, but here they are analysed more in detail. Indeed, as described in Health4LGBTI SSR and FGSR there is a general lack of research with trans and intersex people to understand their health profile and their experiences and health needs in service provision. In the focus groups, intersex people and their healthcare-related issues were rarely discussed.</li> </ul> <p>During the presentation of this segment, you could also refer to some expectations collected previously during the ice-breaker activity.</p>
	<b>Values shuffle</b>	1.17-1.22	Slides for Activity 3 (please refer to Appendix 1.2)
<b>Terminology and concepts</b>	<b>Correct use of terminology</b>	1.23-1.24	Slides for Activity 4 (please refer to Appendix 1.2)
	<b>Terms and concepts</b>	1.25	<p>You can highlight that this section is aimed at promoting the participants' knowledge on the most relevant terms and concepts related to LGBTI 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.</p> <p>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.</p> <p>Participants might have heard the LGBTI 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.</p> <p>You can explain that LGBTI is an acronym for lesbian, gay, bisexual, trans and intersex people. Most people have heard this acronym and globally understand this meaning, but fewer know the distinction between the groups that each letter designates.</p> <p>The abbreviation “LGBTI” is commonly used within the LGBTI movement itself. Other commonly used acronyms are “LGBTQI”, where Q stands for queer or questioning.</p> <p>In this slide it is important that you provide the following background information to participants:</p> <ul style="list-style-type: none"> <li>➔ The LGBTI acronym refers to different groups of people who have been historically marginalised because they do not fit norms around gender and sexuality;</li> <li>➔ Even though like all acronyms, it both includes and excludes people, it enables to shed light on situations and experiences that are often invisibilised in society, including in healthcare settings;</li> <li>➔ The acronym has changed overtime, and varies across countries, regions and communities. However the LGBTI acronym was chosen for this project because it is widely used by the LGBTI community, and is inclusive of realities that need to be taken into account in healthcare settings;</li> <li>➔ 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.</li> </ul>

Title	Sub-title	Slides	Guidance for trainer
			<p>You should then explain how the LGBTI acronym will be used during the training course:</p> <ul style="list-style-type: none"> <li>➔ The LGBTI 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;</li> <li>➔ Here it is used as pedagogical tool to raise awareness on the experiences of LGBTI 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 LGBTI issues in healthcare settings;</li> <li>➔ The acronym refers to a great variety of people. It is important to recognise the diversity within LGBTI community in order to distinguish the different issues and needs that could be masked when lumping together all the categories;</li> <li>➔ 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.</li> <li>➔ Therefore, varying use of these terms is neither comprehensive nor inviolable but a work in progress.</li> </ul> <p>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”).</p>
		1.26	<p>Here you can remind participants of two important concepts:</p> <ul style="list-style-type: none"> <li>➔ Terms and cultures regarding gender identity, sexual orientation and sex characteristics are constantly evolving and can vary in different countries.</li> <li>➔ The important thing is to listen to people and reflect on the terminology they use to identify themselves.</li> </ul>
		1.27	<p>You can explain that it is important to distinguish between:</p> <ul style="list-style-type: none"> <li>➔ sex characteristics;</li> <li>➔ gender identity;</li> <li>➔ sexual orientation,</li> </ul> <p>as separate concepts. You should remind participants that these concepts concern everyone, and not just LGBTI people.</p> <p>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:</p> <ol style="list-style-type: none"> <li>1. sex characteristics are used to assign your legal sex and gender at birth</li> <li>2. but gender identity and gender expression do not necessarily align with your sex characteristics or your assigned sex</li> <li>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.</li> </ol> <p>You may wish to use the picture “The Genderbread Person v2.0” as support when explaining this slide.</p>
		1.28-1.38	<p>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 LGBTI 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.</p>

Title	Sub-title	Slides	Guidance for trainer
		1.28-1.30	<p>Use these slides to describe and explain what sex characteristics are. To help you, use the following concepts:</p> <ul style="list-style-type: none"> <li>➔ 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</li> <li>➔ 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</li> <li>➔ However, sex characteristics are more complex than genitals only: they include primary and secondary characteristics (see definition on slide 1.35)</li> <li>➔ 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.</li> </ul> <p>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 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.</p>
		1.31-1.34	<p>Use these slides to describe and explain what gender identity is. You can use the following concepts:</p> <ul style="list-style-type: none"> <li>➔ 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.</li> <li>➔ We refer to people who identify with the gender they were assigned at birth as cisgender. The term trans is used to refer to people who identify with another gender.</li> <li>➔ Gender identity is fluid and may change over time.</li> <li>➔ 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).</li> <li>➔ Gender identity differs from gender expression. While 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.</li> <li>➔ 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.</li> </ul>
		1.35-1.37	<p>Use these slides to describe and explain what sexual orientation is. You should focus on the following concepts:</p> <ul style="list-style-type: none"> <li>➔ Some people describe their sexual orientation in diverse ways. For example, some people use terms such as queer, pansexual, same gender loving, or same-sex attracted;</li> <li>➔ 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.</li> </ul>
		1.38	<p>Use these slides to describe and explain what sexual behaviour is. You can use the following concepts:</p> <ul style="list-style-type: none"> <li>➔ Some people are attracted to persons of the same gender, but have not acted on this desire, and may want to discuss their feelings;</li> <li>➔ 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.</li> </ul>



Title	Sub-title	Slides	Guidance for trainer
		1.39	<p>In order to keep the attention on the concepts you should remind participants that all the terms are described in the Take home manual. You can use the Glossary at the end of the Manual if you need the definition of other terms.</p> <p>Promote interaction and engage participants in the conversation and in questions, as well as evaluating the understanding of the terms that have been presented.</p>
	<b>Let's practice your knowledge</b>	1.40	Slides for Activity 5 (please refer to Appendix 1.2)
<b>Wrap-up</b>	<b>Conclusions</b>	1.41	<p>The remaining 5 minutes of each training day are reserved for the wrap-up. If you are at the end of your training day display the Wrap-up slide and ask participants to think about:</p> <ul style="list-style-type: none"> <li>➔ something that they have learned;</li> <li>➔ something that they would put in place after the training course.</li> </ul> <p>Otherwise do not use it and continue with other modules. See Section “Conclusions and Wrap-up” in the general introduction for more details.</p>

10 Please refers here to the Confidentiality form, remind participants of its contents.

## Appendix 1.2 – Guidance notes – activities

### Activity 1: Icebreaker exercise “Introduce yourself”<sup>11</sup>

[Slides: 1.6]

**Duration:** 10 minutes

**Purpose:** An icebreaker exercise is often used at the beginning of a training course to warm up the group, to meet each other, to ease the tension and to encourage interaction among the participants.

Asking people what pronoun they identify with could be an unfamiliar activity for some participants, but it will help raise awareness about the fact that gender identity concerns everyone regardless of which gender they identify with. It can also be a talking point to introduce the contents of Module 1 and/or Module 4.

**Players:** Large group

**Materials:** Cover slide 1.6, a pen, flipchart, stickers

**Process:**

1. Ask the participant to stand or sit in a circle and explain briefly the activity: “I would like now to ask you to introduce yourself by saying: 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. I’m going to start by introducing myself and after that I will hand this pen to another person, who will introduce themselves in the same way”.
2. Start by introducing yourself and hand the pen to the co-trainer (giving also an example of what you expect from this activity).

3. The co-trainer can write down a few main concepts on the flipchart when the participants talk about their expectations. After this activity, when presenting the training objectives you should refer to the expectations reported on the flipchart, in order to clarify what the training course will meet and will not meet.

**Suggestions:**

When you explain your background it is useful to add also information about your experience in conducting training for health professionals, or in the field of health inequalities (included in relation to LGBTI issues).

You might like to ask each participant to write their name (or a nickname) and preferred pronoun on a sticker. This could help the trainers in addressing the participants.

As a trainer, you may have used different icebreaker activities in other contexts. You may decide to use an alternative activity with which you are more familiar and feel more confident or to add another icebreaker exercise in case you think that the group would benefit. However, you should ensure that the activity is appropriate for this training course. You should always make sure that the ice-breaker you chose clearly includes the pronoun used by participants, as this is an important detail when working on gender identity and potentially a new concept for your participants.

<sup>11</sup> The activity is adapted from National LGBT Cancer Network - Best Practices in Creating and Delivering LGBTQ Cultural Competency Trainings for Health and Social Service Agencies [http://cancer-network.org/wp-content/uploads/2017/02/best\\_practices.pdf](http://cancer-network.org/wp-content/uploads/2017/02/best_practices.pdf)

## Activity 2: “Experience of healthcare settings: LGBTI people tell their stories”

[Slides: 1.10-1.12]

In this section, trainers will show a video that was made specifically for the Health4LGBTI project. The video displays gender-neutral paper characters who tell their stories of accessing healthcare. These stories are real stories, which were shared by LGBTI people who participated in focus groups in the context of the Health4LGBTI project.

**Duration:** 10 minutes

**Players:** Large group

**Purpose:** The goal of showing this video is to make the experiences of LGBTI people in accessing healthcare more visible; to present participants with stories that LGBTI experience, but rarely tell their HCP; to use real-life stories to make health inequalities for LGBTI people less theoretical; to create awareness among participants through a personal approach

**Material:** Video, slide 1.11 - 1.12

**Process:**

1. Introduce the video: made for the project, display characters, real sentences expressed during focus groups organised in the context of the project.
2. Show the video to participants.
3. Debrief.

**Debriefing:**

Questions to ask during the debriefing:

- What do you think about this video?
- Have you heard similar stories before?
- Do you think these could be stories of patients/clients coming to your practice?
- Do you think that there are differences regarding treatment of LGBTI people within Europe?
- What about your Country?

In support of the last two questions, show first the ILGA-Europe rainbow map on the legal situation of human rights of LGBTI people in Europe and also the ILGA-Europe country specific information.

Make a link between the video and the module that is about to start. “These are stories that LGBTI people have told us. You may have heard similar stories or not. In the Health4LGBTI project and in this training course, we will look more in depth at the reasons that can explain these experiences”.

## Activity 3: “Values shuffle”

[Slides: 1.17-1.22]

**Duration:** 25 minutes

**Players:** Small group

### Purpose:

This activity reflects how diverse values are and how each person holds certain values based on their heritage, life experiences, cultural norms, traditions and social practices. The activity is designed to create understanding of diversity and to highlight how values that others uphold might differ from our own.

The aim of this activity is to encourage participants to express their individual opinions on topics related to LGBTI people and their lives. You should facilitate the discussion in order to promote self-awareness.

For the purpose of this activity, there are no right or wrong answers. Everyone should approach the task with an appreciation of plurality whilst respecting those who might hold opinions that differ from their own. The sentences discussed by the group are intentionally short and constructed in such a way to allow several interpretations. If participants ask you about the meaning of the sentence, do not express your opinion or personal interpretation – you can just read the sentence again.

This activity is placed in the beginning of the training course because it will allow you to get to know the group, its ideas, opinions and the level of knowledge on LGBTI people and their lives.

**Materials:** Cover slides 1.17-1.18; slides 1.19-1.22 with the statements that have to be used in the activity; 4 paper signs “Strongly Agree, Agree, Disagree, Strongly Disagree”. For this activity, you will need a room where people can move around freely.

### Process:

1. Place the 4 paper signs at 4 distinct points in the room around which the participants can congregate.
2. Display the list of statements on a PowerPoint projector. Your role will be to set the rules, promote and guide the discussion and manage time.
3. Read one statement at a time from the list. Ask participants to position themselves around the paper sign which they feel best represents their position on the statement i.e. agree, strongly agree, disagree or strongly disagree.
4. Once they have gathered around their chosen statement, take time to explore their rationale. Ask volunteers in each corner to explain their reasons for agreeing or strongly agreeing or disagreeing or strongly disagreeing with the statement. Remind participants that the aim is not to defend or convince others of their position.
5. It is possible that someone – during or after the discussion – might change their position within the room as a consequence of changing their opinion, so you should facilitate also moving of the participants depending on their feelings. Repeat this for each statement. You should allocate 5 minutes to each sentence.

Please see below the list of statements that should be used. You may decide to select only some of the sentences considering the level of interaction of the group. Therefore, in case the discussion among the participants appears to be quite difficult (tension/rigidity in the group interactions), you might not use the last sentence in the list and spend, instead, more time working on the group dynamics. Similarly, if you perceive that the group could benefit from a more neutral learning space, you should include the first sentence. Please note that the statements have to be used in this order.

1. *“Speaking more than one language is essential”*
2. *“My personal values affect my professional practice”*
3. *“It is sometimes problematic that new born children have to be registered as boys or girls at birth”*
4. *“Sexual orientation is a personal and intimate dimension of the self, and doesn’t need to be disclosed”*

### **Debriefing:**

After the last sentence you should refer to the fact that the sentences were intentionally constructed in such a way to allow an ambiguous interpretation, in order to promote discussion among the participants, and that during the training course participants will have several opportunities, to update their knowledge and, possibly, to have a better understating on the lives of LGBTI people. At this phase of the training course you should not clarify the “right” or “wrong” side of each statement.

Remind participants that the exercise is not about the content but about the importance of freely expressing ideas.

### **Suggestions:**

If no one in the group has any idea about what one term means (e.g. gender identity), provide them with the definition as it is in the glossary.

On the basis of the discussion and considering also the time, you may stop this activity after 3-4 sentences.

If only one participant moves to a position, we suggest that one trainer move beside them to make them feel more comfortable in expressing their position.

## Activity 4: “Correct use of terminology”

[Slide: 1.24]

**Duration:** 10 minutes

**Players:** Large group

**Purpose:** This activity is intended to raise awareness on the importance of the correct use of terminology.

**Material:** Cover slide 1.24, flipchart, a pen, post-its

**Process:**

1. Read the question “*Why is it important for your everyday clinical activities to understand the correct LGBTI terminology? Please justify your answer.*”
2. Ask participants to write down one or two short answers on some post-its that have been previously distributed. Indicate the time for the activity and tell them that this activity is anonymous.
3. By using post-its, participants are more likely to feel freer to express their opinion.
4. You can stick the collected post-its onto the flipchart and read out each one.

**Debriefing:**

Find some key concepts that summarise all the opinions.

**Suggestions:**

If you think it would be useful, you can also ask participants to place their post-its on the flipchart by themselves. It could provide them more confidentiality and will make it easy to check who already finished the task.

## Activity 5: “Let’s practice your knowledge”

[Slide: 1.40]

**Duration:** 15 minutes (including 10 minutes for large group discussion)

**Players:** Individual

**Purpose:** To assess the degree of understanding and learning of the terms discussed above and to invite participants to start owning the terms related to LGBTI issues.

**Materials:** Flipchart paper with a table reporting four headings (“sexual orientation”, “sex and sex characteristics”, “gender identity”), a pen, a sheet with a list of definitions (without the correspondent term) and a list of terms (Appendix 1.3).

**Process:**

1. Briefly explain the aim and rules of the activity.
2. Each participant is given a sheet that contains some definitions (e.g., “term used to identify a person assigned a male gender at birth and who identifies as a female”) and some terms that are not directly associated.
3. Participants will have to relate the definition provided with the right term (e.g., “trans woman”) and then insert it in the appropriate category (“gender identity”) (5 minutes). Note that in some cases, more than one term and definition will match one category (e.g. there may be two terms and definitions for the category ‘gender identity’) and there may be no term and definition associated to a category (e.g. no term and definition matching ‘sex and sex characteristics’).

4. At the end of the activity the trainer will provide the correct answers and will facilitate the discussion around the exercise itself (e.g.: Was this difficult? Did you get many right answers? Did you get many wrong answers?, etc.); as this might be a tricky exercise, it is important to create an error-friendly atmosphere and therefore participants should not be asked specifically what they responded for a given question.

**Debriefing:**

A debriefing is not necessary but, ask participants if they have questions.

When implementing this activity, keep in mind that the terminology that is presented in this training course and that is deemed ‘correct’ is the terminology currently used by human rights organisations and activists. It may not always match the terminology used by LGBTI persons themselves (depending on the context as well). You can advise healthcare professionals to primarily use this terminology, and if their patients themselves use different words to identify themselves, they can then refer to this alternative terminology. This is also made clear in module 3.

## Appendix 1.3 – Printable materials for activities

### Activity 5: “Let’s practice your knowledge”

#### GROUP 1

SEXUAL ORIENTATION	SEX AND SEX CHARACTERISTICS	GENDER IDENTITY

#### Definitions

- “term used to identify a person assigned a male gender at birth and who identifies as a female”
- “a term that relates to a range of physical traits or variations that lie between stereotypical ideals of male and female”
- “person emotionally and/or sexually attracted to people of the same gender”

#### Terms:

Gay, trans woman, intersex



**GROUP 2**

SEXUAL ORIENTATION	SEX AND SEX CHARACTERISTICS	GENDER IDENTITY

**Definitions**

- “combination of bodily characteristics including chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics”
- “term that refers to people whose gender identity and/or a gender expression differs from the sex they were assigned at birth”
- “person that is emotionally and/or sexually attracted to people of more than one gender”

**Terms:**

Bisexual, sex, trans

**GROUP 3**

SEXUAL ORIENTATION	SEX AND SEX CHARACTERISTICS	GENDER IDENTITY

**Definitions**

- “person at birth whose sex produces spermatozoa and refers to traditionally defined anatomy (e.g., penis, scrotum) and chromosomal makeup (XY)”
- “each person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth”
- “person whose the partner’s gender is the same as the individual’s”

**Terms**

Homosexual, biological male, gender identity

**GROUP 4**

SEXUAL ORIENTATION	SEX AND SEX CHARACTERISTICS	GENDER IDENTITY

**Definitions**

- “person at birth whose sex produces ova and has traditionally defined anatomy (e.g., vagina, uterus) and chromosomal makeup (XX)”
- “a woman who is sexually and/or emotionally attracted to women”
- “an older and medicalised term used to refer to people who identify and live in a different gender”

**Term**

Transsexual, biological female, lesbian woman

**GROUP 5**

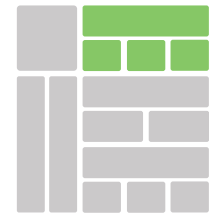
SEXUAL ORIENTATION	SEX AND SEX CHARACTERISTICS	GENDER IDENTITY

**Definitions**

- “term used to identify a person assigned a female gender at birth and who identifies as a male”
- “person whose gender identity and assigned sex at birth correspond and assigned sex at birth correspond”
- “terms that refers to each person’s capacity for profound affection, emotional and sexual attraction to, and intimate and sexual relations with, someone”

**Term**

Sexual orientation, trans man, cisgender



# MODULE 2: HEALTH AND HEALTH INEQUALITIES

## 2.1. Module overview

**⌚ Duration: 2 hours and 20 minutes** \* A - Attitudes; K - Knowledge; S - Skills

**⚙️ Resources:** PowerPoint presentation, laptop, projector, activity sheets

Content	Aim	Segment	Description	Materials	Duration (mins)	Learning objective*	Supporting Documentation
		<b>Introduction</b>	Module 2: Main contents and learning objectives	Slides 2.1 to 2.4	5		Appendix 2.1
<b>Health Inequalities and root causes</b>	To raise awareness and improve knowledge on the <b>root causes of health inequalities</b> experienced by LGBTI people.	<b>Activity 1</b>	<i>Position and Privilege</i>	Slides 2.5 to 2.10	5	A	Appendix 2.2
		<b>Teaching Segment</b>	Health Inequalities – what are they?	Slides 2.11 to 2.14	5	K	Appendix 2.1
		<b>Teaching Segment</b>	Root causes of health Inequalities	Slides 2.15 to 2.16	10	K	Appendix 2.1
<b>LGBTI Health and healthcare provision</b>	To raise awareness and improve knowledge on the <b>health needs of LGBTI people and the health inequalities</b> they experience	<b>Activity 2</b>	<i>Let's talk about LGBTI healthcare</i>	Slides 2.17 to 2.26, video	20	A, K	Appendix 2.2
		<b>Teaching Segment</b>	Potential barriers and challenges faced by health professionals	Slides 2.27 to 2.28	5	K	Appendix 2.1
		<b>Activity 3</b>	<i>Quiz: health Inequalities experienced by LGBTI people</i>	Slides 2.30 to 2.32, 1 page quiz	10	K	Appendix 2.2 Appendix 2.3
		<b>Teaching Segment</b>	Health inequalities faced by LGBTI people	Slides 2.33 to 2.42	10		
		<b>Teaching Segment</b>	HIV and STIs topics	Slides 2.43 to 2.45	5	K	Appendix 2.1 Annex 2
		<b>Activity 4</b>	<i>Case studies</i>	Slides 2.46 to 2.51, a Flip-chart, a Pen	40	K, S	Appendix 2.2 Appendix 2.3
		<b>Teaching Segment</b>	Intersectionality	Slides 2.52 to 2.60	20	K	Appendix 2.1
		<b>Wrap-up</b>	Conclusions	Slide 2.61	5		Appendix 2.1

## 2.2. How to use this module

The contents of this module are based on the findings of state of the art synthesis report (including a scientific review and a comprehensive scoping review) and on the outcomes of focus group studies conducted with LGBTI people and health care professionals in six European Member States (Health4LGBTI SSR and Health4LGBTI FGSR; part of this training package). For this reason, the contents of this module should only be read and contextualized within these reports. You should remind participants about this source material and methodologies at the beginning of the module.

The training slides can be adapted to the situations which the group is likely to encounter and/or to the composition of the group in terms of professional profile of the participants. The proposed set of slides cover all the health topics that emerged from the research and that is documented in the above-mentioned reports. You may add additional information or contents from these reports.

Remind participants that trans and intersex health needs have a dedicated module (Module 4). This said some contents are presented also in this overview of health needs.

## 2.3. Aims

- To raise awareness and improve knowledge on the root causes of health inequalities experienced by LGBTI people;
- To raise awareness and improve knowledge on the health needs of LGBTI people and the health inequalities they experience;
- To improve knowledge on potential barriers and challenges faced by healthcare professionals when providing care for LGBTI people;
- To raise awareness and improve knowledge on the concept of intersectionality and how it relates to health inequalities experienced by LGBTI people.

## 2.4. Learning objectives

After this module, participants will:

- Have a better understanding of factors that affect health outcomes among LGBTI people;
- Be more informed about the specific health needs of LGBTI people;
- Be more informed about access and barriers to proper HIV-STI testing and care;
- Be able to recognise potential barriers and challenges faced by healthcare professionals when providing care for LGBTI people;
- Have a better understanding of the concept of intersectionality and how it can help shed light on how different groups among LGBTI people may have access to healthcare.

## 2.5. How to prepare for this module

- Study the Health4LGBTI State-of-the-art Synthesis Report (SSR)
- Study the Health4LGBTI Focus Group Studies Report (FGSR)

Moreover, a specific summary on HIV and STIs has been prepared (see Annex 2).

## Appendix 2.1 – Guidance notes - slides

Title	Sub-title	Slides	Guidance for trainer
	Main contents and learning objectives	2.1-2.4	Introduce the aims, the contents and the agenda of this module following the slides.
Health inequalities and root causes	Position and privilege	2.5-2.10	Slides for Activity 1 (please refer to Appendix 2.2)
	Health inequalities: what are they?	2.11-2.14	It is important to explain briefly what health inequalities refer to 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 2.13, a picture describes <sup>12</sup> how health inequalities can be addressed by improving the empowerment of patients/clients and/or working directly on causes.
	Root causes of health inequalities	2.15-2.16	<p>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 that the one assigned at birth is socially sanctioned, compared to countries where there is greater acceptance of gender plurality.</p> <p>The causes of health inequalities for LGBTI people which have been documented in research reviewed as part of the Scientific Review and grey literature include:</p> <ul style="list-style-type: none"> <li>➔ cultural and social norms that preference and prioritise heterosexuality (heteronormativity) and cisgenderism;</li> <li>➔ minority stress associated with sexual orientation, gender identity and sex characteristics;</li> <li>➔ victimisation;</li> <li>➔ discrimination and stigma.</li> </ul> <div style="background-color: #e0e0e0; padding: 5px;"> <p>It is important that you are equipped with knowledge concerning the local/national social and legal context for LGBTI 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 reassignment treatments, laws regulating sex registration on birth certificates for intersex children, etc.” See the list of useful resources in the General Introduction to this training course.</p> </div> <p>The main root causes of health inequalities are reported in slide 2.16. To make these clearer and to create interest, you should use “impact examples” suggested in the Health4LGBTI SSR (p. 20-24)<sup>13</sup> and the following explanation extracted from this document.</p> <p>To describe stigma, you can explain that “stigma comprises three different but related elements: anticipated stigma where LGBTI 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 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 LGBTI people evade or postpone gaining access to treatment and care settings, as they may experience discrimination in these settings.”</p> <p>To describe minority stress you can explain that “Minority stress theory is presently the leading narrative that explains the health inequalities of LGBTI people. Stigma, prejudice, and discrimination create a hostile environment where LGBTI people are subject to stressful social exchange that may have adverse implications for health-seeking behaviour and health outcomes later in life”.</p>

Title	Sub-title	Slides	Guidance for trainer
			<p>You can explain that it is clear from the analysis of the primary research literature that LGBTI 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 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.</p>
LGBTI health and health care provision	Let's talk about LGBTI healthcare	2.17-2.26	Slides for Activity 2 (please refer to Appendix 2.2)
	Potential barriers and challenges faced by health professionals and LGBTI people	2.27-2.28	<p>Use visual slide 2.27 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 LGBTI people in healthcare settings including cultural and social norms, language, the fact of not being aware of the LGBTI identity of patients and/or of not knowing how to ask, institutional barriers and lack of knowledge and training.</p> <p>The following contents are taken from the Scientific Review (including in the Health4LGBTI SSR) and should be used to enrich your presentation:</p> <p>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 LGBTI people to heterosexism, homophobia, biphobia, interphobia or transphobia resulting in significant barriers to healthcare.</p> <ul style="list-style-type: none"> <li>➔ 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.</li> <li>➔ Findings from the research revealed that many health practitioners are not always aware of the LGBTI status of their patients/clients nor that their patients/clients could be LGBTI. 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.</li> <li>➔ 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's. 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.</li> <li>➔ 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.</li> <li>➔ For 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 LGBTI 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.</li> </ul> <p>You can link the discussion back to the root causes of health inequalities (slide 2.16) and which are listed again slide 2.27.</p> <p>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 LGBTI people who access health services; a lack of specialist mental health services and counselling services for LGBTI people; health professionals' own prejudices leading to the unequal treatment of LGBT people with regards healthcare.</p>



Title	Sub-title	Slides	Guidance for trainer
			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).
		2.28	Here you can describe some examples of the barriers faced by LGBTI people when accessing healthcare setting, as summarised in Health4LGBTI SSR (see for more details the Comprehensive Scoping Review). These examples include: “prejudicial attitudes and intolerant discriminatory behaviour of staff including inappropriate curiosity; unequal treatment; needs being ignored or not recognised; LGBTI people being subjected to humiliation; denial of access to treatment; disclosure of gender identity, sexual orientation or sex characteristics leading to healthcare avoidance; fear of any of the above. These concerns were more pronounced for trans and intersex people due to their experiences of marginalisation and discrimination whilst accessing care.”
	Quiz on health inequalities	2.30-2.32	Slides for Activity 3 (please refer to Appendix 2.2)
	Health inequalities experienced by LGBTI people	2.33-2.42	As a general consideration, you should explicit that as for trans and intersex people a specific module has been produced, therefore their health issues and needs will be only briefly mentioned in this section. Moreover, there is a need for further dedicated research regarding trans and intersex people to ensure their experiences and health needs are accounted for in service provision. Now we report below a summary of the main concerns related to health inequalities for LGBTI in general.  You might enrich your presentation with suggestions from Health4LGBTI SSR according to the main interest of your participants.
	HIV and STI	2.43-2.45	This slide highlights an example of social stigma effecting individual behavior in the context of HIV-STI testing. For more details and clarification you can refer to the supplementary material in Annex 2.
	Case studies	2.46-2.51	Slides for Activity 4 (please refer to Appendix 2.2)
Intersectionality and health inequalities	Intersectionality	2.52-2.60	In this section, you will present a set of slides outlining the health inequalities experienced by LGBTI 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.
		2.52	Here you should describe the concept of intersectionality concept 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 hierarchize 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 LGBTI people from participation in mainstream cultural and social life, or fully includes LGBTI people. These markers are interdependent and intersect to create and sustain health inequalities.
		2.53	Before presenting the vulnerable intersections and results on health inequalities in the following slides, invite the participants to discuss the vulnerable intersections observed from the case studies presented in the previous Activity “Case Studies”. You can explicitly refer to the range of dimensions associated with social and cultural difference that people experience in the presented case studies (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, or less if the topic has already emerged during the case studies activity.

Title	Sub-title	Slides	Guidance for trainer
		2.54	<p>Here you can show an overview of some of the possible intersections of LGBTI identities within specific populations and settings: people in rural or geographically remote areas; older and younger LGBTI people; refugee, asylum seekers, and migrant LGBTI people; those who live in poverty or are socio-economically disadvantaged and LGBTI people with disabilities. In presenting these results you should also underline these two key concepts taken from the Health4LGBTI SSR and FGSR:</p> <ul style="list-style-type: none"> <li>➔ there is a dearth of research that accounts for the health inequalities of intersectional subjectivities;</li> <li>➔ further research should be conducted with these LGBTI groups to investigate their needs to consider the impact of intersectionality on health outcomes;</li> <li>➔ none of the research in the current primary research literature included a focus on intersex people, therefore highlighting a large gap.</li> </ul>
		2.55-2.58	<p>Here you can show a summary of the main results on what is known about the health inequalities of LGBTI 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.</p> <p>In slide 2.56 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 LGBTI, older LGBTI 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 LGBTI people (<a href="https://www.ilga-europe.org/silverrainbow">https://www.ilga-europe.org/silverrainbow</a>).</p> <p>In slide 2.57 read an example of a quote from the Health4LGBTI FGSR to focus on the fact that “Private healthcare was frequently identified by LGBTI people as preferable as generally more accepting. However, this kind of healthcare was not accessible to all LGBTI people.”</p> <p>In slide 2.58 you can read an example of a quote connected to living in rural or urban areas from the Health4LGBTI FGSR.</p>
		2.59	<p>Here you can summarise the information from the previous slides. You should connect this information with the case studies presented at the beginning. Finally, you can add relevant examples or information from the complementary documents according to the interest of your participants group.</p>
Wrap-up	Conclusions	2.61	<p>The remaining 5 minutes of each training day are reserved for the wrap-up. If you are at the end of your training day display the Wrap-up slide and ask participants to think about:</p> <ol style="list-style-type: none"> <li>1. something that they have learned;</li> <li>2. something that they would put in place after the training.</li> </ol> <p>Otherwise do not use it and continue with other modules. See Section “Conclusions and Wrap-up” in the general introduction for more details.</p>

12 This picture has been created ad hoc for the project

13 Please note that the meaning of victimisation and discrimination are taken from the ones in Health4LGBTI SSR to be consistent with these sources. You can also refer to the definitions in the ILGA-Europe glossary for further information (Annex 1).

## Appendix 2.2 – Guidance notes – activities

### Activity 1: Position & privilege exercise

[Slides: 2.5-2.10]

**Duration:** 5 minutes

**Players:** Large group

**Purpose:** With the previous activity (such as the “Values Shuffle Activity” in Module 1), you should already have an understanding of where participants stand in terms of LGBTI rights.

This exercise is aimed at promoting awareness of the particular challenges and struggles LGBTI people may face within healthcare. You will ask participants to reflect on their own experience within healthcare. You will then ask participants to consider these personal experiences in light of the experiences of LGBTI people.

Furthermore, through this exercise, participants should undergo a process of self-reflection whereby they recognise that because they themselves have never experienced these inequalities – i.e. they are in a position of privilege – they may be oblivious to the particular challenges faced by LGBTI people.

**Material:** Cover slide 2.5 and slides with sentences 2.6-2.10

**Process:**

1. Start by making clear that this is a self-reflective exercise. Ask participants to approach it with an open mind. It is a short exercise, and you will debrief it with participants afterwards.
2. “We will do a short self-reflective exercise. For this, we will ask you to take off your hat as a healthcare provider, and think of yourself as a patient/client. Think about when you seek healthcare for yourself. I will now read some statements. Think in your head: Can you relate to this statement?

Does this statement describe something you experience, or have experienced yourself? Do not answer out loud. The goal of this exercise is for you to think individually, and we will debrief collectively later on”.

Statements that have to be read:

- When I seek healthcare, I am afraid I will have to disclose my sexual orientation, gender identity and/or sex characteristics.
- When I seek healthcare, I am afraid my sexual orientation, gender identity and/or sex characteristics will be disclosed to others against my will
- When I seek healthcare, I am afraid I will face mockery, hostility or discrimination if my sexual orientation, gender identity and/or sex characteristics are known
- When I seek healthcare, I am afraid I will be denied medical care or treatment because of my sexual orientation, gender identity and/or sex characteristics
- When I need to go to the doctor, I specifically look for a LGBTI friendly healthcare professional

**Debriefing:**

During the debriefing, participants should not be asked to share their personal experiences. The goal of the debriefing is for you to introduce the contents of the module.

“You might have answered yes or no to these questions. You may relate to these experiences, have had similar thoughts yourself, or not at all. Whether you have or not, approach this module with an open-mind. Even though you might not be aware of health inequalities for LGBTI people, these are real.

We have developed these sentences on the basis of experiences LGBTI people have shared in the focus groups we conducted for Health4LGBTI pilot project. In this module, we explore barriers to healthcare for LGBTI people, which can explain why such statements emerge, and their root causes“.

## Activity 2: Let's talk about LGBTI healthcare experiences

[Slides: 2.17-2.26]

**Duration:** 20 minutes

**Players:** Large group

**Purpose:** The aim of this activity is to encourage participants to reflect on real life experiences of LGBTI people, by exemplifying the theoretical information with the cases of barriers faced by LGBTI people within healthcare from Rapid-reviews (see Health4LGBTI SSR) and focus groups (see Health4LGBTI FGSR).

**Materials:** Cover slides 2.17-2.18 and final slide 2.26, slides 2.19-2.25 with quotes and the link to the video<sup>14</sup>

### Process:

1. Ask one participant at a time to read each sentence presented. You can explain to participants that all the quotes have been collected either in the context of the focus groups or from the Rapid Reviews that were conducted in the MS. After each quote has been read aloud, ask participants to consider these three questions:
  - Which could be the potential causes of health inequalities in these quotes?
  - Which could be the potential barriers faced by health professionals and LGBTI patients/clients in this healthcare setting?
  - Which potential impact could they have on the healthcare pathways?
2. Facilitate the discussion around the questions making sure that the discussion does not last longer than 20 minutes. Use the flipchart paper to take notes of the most relevant points that emerge from the discussion.

3. After some sentences (the number depends on the time used for the discussion) show the video (slide 2.25), showing a consultation between a medical doctor and a patient and ask participants the same questions above. For this activity, please make sure you only show the part of the video as per indicated times (from min 4:30 to min 6:28). This video will be used again in Module 3 and it is useful also for showing participants how the different modules are interrelated.

### Suggestions:

You should make every effort to elicit responses from the group before offering some suggestions. Make sure not to force the responses and that the group agrees with your suggestions before you write them up.

You should use the slides according to the time available, making sure that the discussion does not last longer than 20 minutes. Six quotes have been provided, but it is recommended that two are sufficient for the purpose of the exercise. You can of course use more quotes, but this would mean that the discussion might last longer than 20 minutes.

When causes, barriers and impacts emerge, try to write the main concepts that appear on the flipchart making a link with the contents you have already described.

Use the results that emerge to introduce the next segment.

<sup>14</sup> Please note the video is available at the following link: <https://www.youtube.com/watch?v=2asPSMg0HDk>.

## Activity 3: “Quiz on health inequalities experienced by LGBTI people”

[Slides: 2.30-2.32]

**Duration:** 10 minutes

**Players:** Individual

**Purpose:**

The aim of this activity is to stimulate participants to reflect on the different health inequalities experienced by LGBTI people.

**Materials:** Slides 2.30-2.32, 1 page quiz (Appendix 2.3)

**Process:**

1. Briefly explain the aim and rules of the activity.
2. Provide each participant with the 1 page quiz and explain that they have 3 minutes to complete the quiz by indicating whether they believe the listed statements to be true or false.
3. After the 3 minutes have passed, ask participants to return to the larger group.
4. Display the questions one by one with the correct answers (note that the right answer is TRUE for all the questions) and ask participants to score their own quiz.
5. Debrief.

**Debriefing:**

The trainer will facilitate the discussion around the exercise itself (e.g.: How did you do in the quiz? Are you surprised by the answers? Which question surprised you most?).

**Suggestions:**

It is important to create an error-friendly atmosphere and therefore participants should not be asked specifically what they responded for a given question.

## Activity 4: “Case studies”

[Slides: 2.46-2.51]

**Note:** On the slides, case-studies are referred to as ‘Situations in clinical practice’. The reason for this is that ‘cases’ can be seen as a pathologising term. Therefore, please use the term ‘situations’ when presenting the case-studies.

**Duration:** 40 minutes (20 minutes for small group discussion and 20 minutes for large group discussion)

**Players:** Small group

**Purpose:** The aim of this activity is to stimulate participants to recognise the main issues discussed during this module through a discussion on real life scenarios of LGBTI people’s challenges in accessing services or being treated in services.

Finally, the activity is a lead in to the following section on intersectionality, as there is a particular focus on the role of other intersections in these case studies.

**Materials:** Cover slide 2.46-2.47, slides 2.48-2.51, sheets with case studies (see Appendix 2.3), flipchart, a pen.

### Process:

1. Ask the participants to form small groups of up to five members each, depending on the size of the group and hand out copies of one case study for each group. Each group will be given a different case study and there should be a maximum of 4 groups.
2. Ask each small group to consider the following questions (projected on a slide). Tell the participants they will have 20 minutes to discuss:
  - What are the specific health issues at stake in this case?
  - Who are the stakeholders and what is their role?
  - What are the factors that lead to this problematic/positive situation?
  - What are the consequences on persons’

health in case of intervention or lack thereof?

- Which preventive measures were / should be taken to address the situation?
3. Ask one participant per group to take notes of the discussion and then report back to the large group.
  4. After the discussion time, invite each group rapporteur to present the results of their discussion. Before each group presentation, project the case study of the corresponding group on a slide and give participants an opportunity to read it. You can ask the group rapporteur to read the case aloud to the group. Write up the main considerations on the flipchart.
  5. Invite participants in the large group to make other considerations about the problematic factors, or to give suggestions about alternative measures to solve the situations.
  6. At the end, summarise the key findings according to the discussion generated.

### Suggestions:

Make sure all participants understand the meaning of the term stakeholder “a person with an interest or concern in something”.

Each small group works on a different case study. This strategy gives the possibility to share different examples of potential real life situations in the large group. If you are not planning to present module 4 to the trainees, please also provide participants with the two additional case-studies on trans and intersex that you will find in the list of case-studies.

## Appendix 2.3 – Printable materials for activities

### ACTIVITY 3 - “Quiz on health inequalities”

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



## ACTIVITY 4 - “Case studies”<sup>15</sup>

### Case 1

Gina is a woman of 78 years old. When she was younger, she struggled to have her family accept her being in a same sex relationship. Unfortunately, this never quite worked out, and until today, Gina has a rather distant relationship with her family. She lived together with her partner for 33 years until her partner died. They never had children. After the death of her partner, Gina lived alone for 3 years. One day, though, she fell from the stairs at home and after a few weeks in the hospital, her family proposed that she move to a senior health care facility. They said she would have appropriate health care and company there so she would not feel lonely. Gina opposed going to the facility as she mistrusts health institutions, painfully recalling how they tried to “cure” her sexual orientation when she was younger. Besides, one of her friends came out in his senior health care facility a couple of years ago and said that he did not feel welcome anymore after his coming out. Therefore, Gina started to feel very anxious, thinking that her health may deteriorate further and force her to move to a senior healthcare facility. She did not go to her general practitioner anymore as she feared he may speak to her family and insist that she could not stay at home any longer.

However, she saw a TV programme about inclusive healthcare facilities for senior people in the US. People seemed very happy there. She had no clue those existed. She took the initiative to look for such facilities in her own city. Although she didn't find one in her small city, she found one in the capital and decided to take an appointment with the Director. She asked very bluntly how it would feel for her to live there as an openly lesbian woman. The Director reassured her that all the staff was trained on diversity issues, that the facility had joined a certification programme and had adopted a code of conduct on respect and inclusion.

### Case 2

Luís is a young gay man aged 17. He never felt comfortable at school as he has a learning disability. Matters got worse when he was outed as gay by a classmate at age 15. The bullying began and even sports class, which Luís used to enjoy so much, became hell as the other boys started telling him he could not share the dressing room with them because he would get aroused. Luís became very dependent. He did not see how he would make it to the end of the school year and even thought about ending his life. He started self-harming and suffered from depression. Luckily, Luís' parents are very supportive. Seeing that he had such a hard time, his father decided to take him to the doctor to look for help. Luís had never felt quite at home at the doctor and at first, he did not want to go. Finally, his father convinced him. At the doctor's they talked about mental health problems due to the school bullying. When the doctor insistently asked for the reason of the school bullying, Luís reluctantly said it was because of his sexual orientation. Upon hearing that, the doctor immediately affirmed he could not provide Luís with any support. He said that in the past, he would have proposed him a conversion therapy, but as “politically correct politicians” had disapproved of those practices, he had really no option for him. The doctor then avoided eye contact and rushed through the rest of the consultation. Luís left the doctor feeling stigmatized and depressed.

<sup>15</sup> Case studies are taken from ILGA Europe

### Case 3

Sarah is a 30 year old woman of African descent. Since puberty, she has been obsessed with her physical appearance. She has suffered from eating disorders since then. When she was in high school, she had a love affair with a girl. She was afraid other students would learn about this relationship and, though she had been a very good pupil in the past, her marks fell drastically. As a result of her under-achievement at school, she was advised not to pursue a university degree but to opt for a vocational education institution where she studied accounting. There, she dated a man for a while but their relationship came to an end. She does not care about the gender of her partner. The only thing she would like is to fall in love with someone. For now, she is dating another student, a woman. Her parents are very disappointed she broke up with her boyfriend and disapprove of this new relationship. Because she was not interested at all in accounting, she put an end to her higher education and is trying to find a job, but so far without success. In the meantime, she still lives at her parents place. She has kept on going out a lot during week-ends and she engages in binge-drinking and even sometimes takes cocaine. She never goes to see her family general practitioner because she does not want her lifestyle to be judged by anyone and because health is not a priority for her right now. In addition, the last time she saw her mother's gynecologist, the doctor refused to prescribe her a contraceptive pill arguing that she did not need any as she was in a relationship with another woman.

Recently, she started to have severe stomach problems and her girl-friend encouraged her to see a doctor. She contacted a local LGBTI organisation and asked for doctors trained in LGBTI issues. Sarah went to see one of those doctors and felt listened to for the first time. She could not stop crying while telling her story. The doctor prescribed her some blood tests, set up a follow-up appointment for the next month and referred her to a colleague who is a psychologist.

### Case 4

Luca is 45. He lives in a small village. He is married to a woman and has three kids but Luca feels attracted mostly to men. He has known this since he was a teenager. He has never felt ready to come out and eventually got married to a friend of his sister. A few times a year, Luca goes out to a gay club in the city. But since he found out about gay dating apps and websites, he has more and more opportunities to meet men, even in other small villages. Whereas in the sex club he was using condoms systematically, he often has unprotected sex with those men he meets online as they always discuss first about their HIV status. Luca sometimes wonders whether he should get tested but does not know where to go to get tested in an anonymous way. His family doctor would never propose him such a test without Luca telling him that he has sex with men, and Luca feels that the doctor could out him to his family. In addition, in case he tests HIV-positive, he could never face it. He would need to tell the truth to his wife, to his family. His colleagues would learn about it. He is sure that he would be fired. He would not be able to pay for the treatment. That would be the end of everything he has built. And anyway, he read that migrants, sex workers and drug users were the ones really at risk of getting HIV infected and he is sure he's never had sex with "one of them".

### Case 5

Frank is 25. He lives in a town in Germany. The sex assigned to him at birth was female but realised by puberty that his gender identity is male and came out to his parents as trans when he was 16. His parents have been supportive of his identity. At the age of 18 he started living simply as a man and, after being unable to identify a trans-friendly doctor willing to prescribe hormones, he started self-injecting testosterone which he bought from a friend with body-building contacts. He has never had any blood tests to check his testosterone levels. He has always wanted a hysterectomy but has been unsure how to get one. Over the last year he has been getting irregular occasional bleeding and cramping pains so he decided to prioritise seeking a hysterectomy. He called a gynaecologist's office, told the receptionist that he was a trans man and asked for an appointment. The phone call was very humiliating, with the receptionist at first misunderstanding his direction of transition and insisting that he would never require gynaecology services. After he reluctantly explained that he was born female and still has a uterus, the receptionist agreed to make him an appointment with the gynaecologist. At the appointment, he told the gynaecologist that he had been living fully as male for seven years and wanted to pay out of pocket for a full hysterectomy. The gynaecologist said that to get a hysterectomy he would need to have a detailed examination, including an internal vaginal ultrasound. During the exam, the Dr told him to "stop being silly" when he said that letting anyone see his genitals was distressing and asked for a smaller speculum to be used. The gynaecologist then said that the examination results showed no need for a hysterectomy and told him to "stop messing around with your hormone levels by abusing testosterone". She continued to say that it would be unethical to operate as "your problem is psychological not physical so you need a psychiatrist not a surgeon". He left the appointment feeling hopeless and like a freak."

### "Case 6

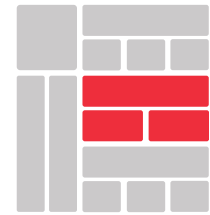
Martina is 50. Martina is intersex. If she was asked about it, she would probably answer she does not fully identify as a woman. But, nor as a male. Then what?

When Martina was born, doctors said it was not clear whether the baby was female or male, but that it could be fixed very easily. The baby had a micro penis and her father said that it would be better if the baby was made a girl, otherwise, all his girlfriends would make fun of him. Doctors promised that after one surgery Martina would be a "real girl" and when she would be a grown-up person, she could get married with a man. But instead of one surgery, Martina had to undergo 15 surgeries. In addition, she suffered of multiple infections and had to skip school regularly to get cured in the hospital.

She did not have a lot of friends at school, and could not speak about her surgeries to anyone. Her first experiences of sexual intercourse with men were extremely painful because of the scars resulting from all the surgeries she had had. She eventually got married to a man who was extremely soft with her during their sexual intercourses. They tried to have a child, but they did not succeed. That's when she started to investigate about the treatments she had undergone as a child and as a teenager. Her parents had told her she suffered of a genital malformation that threatened her life. When she asked the hospital for her medical record, she was told it had been lost when archives had been digitised. She had been taking hormones for more than forty years and wanted to try to live without medication, to see how that would be. Doctors told her she would die if she was not taking her pills. But when she asked what the long-term effects of those medicines were, they were unable to answer her.

And then, she understood she had been a guinea pig for all her life."

# MODULE 3: COMMUNICATION AND PRACTICE



## 3.1. Module overview

**Duration:** 2 hours and 15 minutes

**A** - Attitudes; **K** - Knowledge; **S** - Skills

**Resources:** PowerPoint presentation, laptop, projector, activity sheets, flipcharts, a pen

Content	Aim	Segment	Description	Materials	Duration (minutes)	Learning objectives*	Supporting Documentation
		<b>Introduction</b>	Module 3: Main contents and learning objectives	Slides 3.1 to 3.4	5		Appendix 3.1
<b>Inclusive and non judgmental language</b>	To raise awareness on the <b>importance of inclusive communication</b> with LGBTI patients/clients	<b>Teaching Segment</b>	Language and Communication: Introduction	Slides 3.5 to 3.6	5	A	Appendix 3.1
		<b>Activity 1</b>	<i>"Cuál es la diferencia?"</i>	<i>Slide 3.7, Video</i>	15	A	Appendix 3.2
	To <b>improve communication skills</b> with LGBTI patients/clients	<b>Teaching Segment</b>	Inclusive Communication	Slides 3.8 to 3.14	10	A, K	Appendix 3.1
		<b>Activity 2</b>	<i>Role play – inclusive communication</i>	<i>Slides 3.15 to 3.16, Worksheets</i>	30	A, K, S	Appendix 3.2 Appendix 3.3
<b>Inclusive environment and practice</b>	To improve knowledge on how to <b>better organize and manage healthcare settings</b> with regard to privacy, trust and comfort of LGBTI patients/clients	<b>Activity 3</b>	<i>Creating an inclusive practice</i>	<i>Slide 3.17 to 3.19, Flipchart</i>	20	S	Appendix 3.2 Appendix 3.3
		<b>Teaching Segment</b>	Reducing barriers in your practice	Slide 3.20 to 3.22	5	S	Appendix 3.1
		<b>Activity 4</b>	<i>Promising solutions to make your practice more inclusive</i>	<i>Slide 3.23, Flipchart, a Pen, Worksheets</i>	30	S	Appendix 3.2 Appendix 3.3
		<b>Teaching Segment</b>	Examples of Promising Practice	Slides 3.24 to 3.25	5	K, S	Appendix 3.1
		<b>Discussion</b>	Recommendations	Slides 3.26 to 3.29	5	K, S	Appendix 3.1
		<b>Wrap-up</b>	Conclusions	Slide 3.30	5		Appendix 3.1

## 3.2. How to use this module

The contents of this module are based on the findings of the Health4LGBTI SSR (including the Scientific review and the Comprehensive Scoping Review) and on the outcomes of focus group studies conducted with LGBTI people and health care professionals in six European Member States (Health4LGBTI FGSR). For this reason, the contents of this module should be read and contextualized within these reports. You should remind participants about this source material and methodologies at the beginning of the module.

Recommendations for training in Health4LGBTI SSR and suggestions for constructive communication (Health4LGBTI Scientific Review) have been used to guide the contents of the communication segment, with also additional information taken from existing training material in healthcare settings.

The training slides reported here could be adapted to the situations which the group is likely to encounter and/or to the composition of the group in terms of professional profile of the participants.

## 3.3. Aims

- To raise awareness on the importance of inclusive communication with LGBTI patients/clients;
- To improve communication skills with LGBTI patients/clients;
- To improve knowledge on how to better organise and manage healthcare settings with regard to privacy, trust and comfort of LGBTI patients/clients.

## 3.4. Learning objectives

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

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

## 3.5. How to prepare for this module

- Study the Health4LGBTI State-of-the-art Synthesis Report (SSR)
- Study the Health4LGBTI Focus Group Studies Report (FGSR)
- Read the Fenway guide to lesbian, gay, bisexual and Transgender health<sup>16</sup> (chapter 8 and 15)

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16 H.J. Makadon, K.H. Mayer, J. Potter, H. Goldhammer. Fenway - Guide to Lesbian, gay, bisexual, and transgender health. 2nd edition (2008). American College of Physician (ACP)

## Appendix 3.1 – Guidance notes - slides

Title	Sub-title	Slides	Guidance for trainer
	Main contents and learning objectives	3.1-3.4	Introduce the aim, the contents and the agenda of this module following the slides.
Inclusive and non-judgmental language	Language and communication: introduction	3.5-3.6	As described in Module 2, language can be a potential barrier faced by health professionals when providing care for LGBTI 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.
	Cuál es la diferencia?	3.7	Slides for Activity 1 (please refer to Appendix 3.2)
	Inclusive communication	3.8-3.14	<p>Remind participants of some concepts that they have already seen during Module 1 on LGBTI terms<sup>4</sup>.</p> <p>You should focus on the main learning points that emerged from the Health4LGBTI SSR:</p> <ul style="list-style-type: none"> <li>➔ “health professionals should show greater cultural awareness and sensitivity towards gender and sexual diversity, and recognise that people might identify as LGBTI”;</li> <li>➔ “where health professionals accept LGBTI people unconditionally without making judgements and show respect in their interactions with LGBTI people, LGBTI people are more likely to open up and in return trust health professionals”;</li> <li>➔ “practitioners should use affirmative language that acknowledge the LGBTI 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”.</li> </ul> <p>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 to make assumptions about gender identity, sexual orientation and sex characteristics<sup>5</sup> (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<sup>6</sup>).</p> <p>Use the question in the slide 3.8 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.</p> <p>In slide 3.9 you can provide participants with examples of good and bad practices when communicating with patients.</p> <p>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.</p> <p>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<sup>7</sup>.</p> <p>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.</p>
		3.10	Here 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 <sup>8</sup> ; 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?”).

Title	Sub-title	Slides	Guidance for trainer
		3.11-3.12	<p>An example in slide 3.11 is “if someone calls himself “gay,” do not use the term “homosexual”.”</p> <p>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”).</p> <p>You may use slide 3.12 to sum up the main recommendations related to terminology and language issues when communicating with LGBTI patients.</p>
		3.13	<p>You should focus on the following learning point that emerged from the Health4LGBTI SSR:</p> <p>“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”.</p> <p>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).</p>
		3.14	<p>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 coming 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”.</p>
	Role play: inclusive communication	3.15-3.16	Slides for Activity 2 (please refer to Appendix 3.2)
Inclusive environment and practice	Title slide	3.17	Title slide. You will start the session of this module on the inclusive environment and practice.
	Creating an inclusive practice	3.18-3.19	Slides for Activity 3 (please refer to Appendix 3.2)
	Reducing barriers in your practice	3.20 - 3.22	<p>The example in slide 3.20 brings the direct experience of a lesbian woman and has to be used as an example 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 LGBTI friendly environments may help reduce fear of accessing health services”.</p> <p>Slide 3.21 uses an example from the Health4LGBTI FGSR report pointing out that appropriate signage, such as rainbow flags and LGBTI magazines were not sufficient; more needed to be done to make the services accessible for LGBTI people.</p> <p>You can clarify that the scientific review reported examples of institutional barriers faced by both health professionals when providing care and by LGBTI people when accessing care, especially related to the healthcare environment.</p> <p>When presenting slide 3.22, make sure you highlight that 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 needs to be addressed.</p> <p>You can emphasise this further by adding the following example from the Health4LGBTI Scientific review: “Sex-specific health information such as a man with a cervix or a woman with a prostate for example, will require particular attention and documentation through accurate and appropriate data collection methods. For instance, a trans man who has accessed legal gender recognition (i.e. his legal sex is male) may still have their cervix, ovaries, and uterus, and thus require routine gynaecological screenings”.</p>



Title	Sub-title	Slides	Guidance for trainer
	Promising solutions to make your practice more inclusive	3.23	Slides for Activity 4 (please refer to Appendix 3.2)
	Examples of promising practices	3.24-3.25	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. A visual example of gender-neutral toilet is presented in slide 3.25.
	Recommendations	3.26-3.29	Finally, you can describe some recommendations and proposals suggested by Health4LGBTI SSR and by LGBTI people and Health professionals during the focus groups.
Wrap-up	Conclusions	3.30	<p>The remaining 5 minutes of each training day are reserved for the wrap-up. If you are at the end of your training day display the Wrap-up slide and ask participants to think about:</p> <ul style="list-style-type: none"> <li>➔ something that they have learned;</li> <li>➔ something that they would put in place after the training.</li> </ul> <p>Otherwise do not use it and continue with other modules. See Section “Conclusions and Wrap-up” in the general introduction for more details.</p>

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- 17 An ally's guide on Terminology: Talking about LGBT people & equality (2017). Movement Advancement Project (MAP). 4 pages. From <http://www.lgbt-map.org/effective-messaging/talking-about-lgbt-issues-series>
  - 18 Providing inclusive services and care for LGBT people. A guide for Health Care Staff. National LGBT Health Education Center. A program of the Fenway Institute
  - 19-20 Global Forum on MSM & HIV and the Johns Hopkins Promoting the health of men who have sex with men worldwide: a training curriculum for providers (2014)
  - 21 H. J. Makadon, K.H. Mayer, J. Potter, H. Goldhammer. Fenway - Guide to Lesbian, gay, bisexual, and transgender health. 2nd edition (2008). American College of Physician (ACP)
  - 22 Providing inclusive services and care for LGBT people. A guide for Health Care Staff. National LGBT Health Education Center. A program of the Fenway Institute



## Appendix 3.2 – Guidance notes – activities

### Activity 1: VIDEO “Cuál es la diferencia?” (2nd part)

[Slide: 3.7]

**Duration:** 15 minutes

**Player:** Large group

**Purpose:** In Module 2, you showed the first part of this video where interactions between an LGBTI patient and a health professional was not ideal. You may wish to show the first part of this video again at this point as a recap for participants, especially if you are implementing the modules on different days. By showing the second part of the video and discussing it with participants, this activity gives a clear illustration of how an inclusive language and practice have a better impact on health care pathways for LGBTI people.

**Materials:** Cover slide 3.7, video

**Process:**

Before launching the video, you will ask participants to:

- 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, terms) they notice;

- consider the impact of the two different kinds of communication on the clinician-patient interaction;
- consider the potential impact on the care pathways.

**Suggestions:**

If you consider that participants would benefit from discussing the issues within a small group, you can also organise the activity with smaller groups and then ask one participant per group to report the most relevant considerations to the large group.

## Activity 2: “Role-play: inclusive communication”

[Slide: 3.15–3.16]

**Duration:** 30 minutes (including 10 minutes of final debriefing)

**Players:** Small group

**Purpose:** With this activity, participants will put in practice the communication skills presented in the module. They will have an opportunity to improve their verbal and non-verbal inclusive communication, by putting themselves in LGBTI patients/clients' shoes.

**Materials:** Cover slide 3.15, slide 3.16, work sheets (Appendix 3.3)

**Process:**

1. Introduce the activity explaining the role-play methodology (see suggestions below).
2. Divide the participants into smaller groups (3 or 4 participants each; If possible, divide the groups in such a way that it is composed of different professionals).
3. In each group one participant will play the role of patient/client, one participant will play the role of health professional; the rest of the group will observe. They then rotate their role so that each member plays all roles.
4. Explain the scenario using slide 3.16.
5. Ask the patient/client player from each group to read the scenario.
6. The patient/client player is asked to enter into the role and interpret how they imagine the patient/client would feel and act. The health professional player is asked to adopt the good communication practice learned in the module when interacting with the patient/client.
7. Give indications to all the trainees playing the role of Laura about issues she might have faced or is currently facing, such as:
  - She has been attracted by women for many years and has always been reluctant to see a gynecologist because they would assume she's straight.
  - She has conceived her baby thanks to a friend who gave her some sperm. It was at least the 10th attempt. She never dared to look for a hospital that would help her and her wife to conceive through artificial reproductive treatments.
  - She is in a same-sex relationship, is pregnant and is 42. So, she fears she may be stigmatised or even discriminated, based on her sexual orientation but also on her age.
  - She has actually already been told by a gynaecologist that she was too old to conceive and that her 'lifestyle' did not really allow her to become a mother.
8. At the end of the role-play, the observers give feedback to the health professional player. They can also give suggestions or inputs during the role-play interaction.
9. Ask participants to comment on the role-play exercise, following these few questions:
  - What are your thoughts about the performance of this GP?
  - How do you think Laura felt during this conversation?
  - As a GP, what would you do differently?
  - Which impact do you think this approach by a GP may have on Laura?

**Suggestions:**

Role play has been defined as “one particular type of simulation that focuses attention on the interaction of people with one another. The idea of role-play is that of asking someone to imagine that they are either themselves or another person in a particular situation. They are then asked to behave as they feel that person would.”<sup>17</sup> Introducing role-play can be met with resistance from some participants. For this reason, a small group role-play could be perceived as safer. Remind the participants that the role-play should be taken seriously and encourage them<sup>18</sup>.

Tell participants that each role-play should last not more than 5 minutes (the participants who are observers can monitor the time) and that feedback has to be given in a positive and constructive way.

**Debriefing:**

At this point, participants will probably be able to discuss each case by themselves, with sustained and rich arguments. However, pay attention to each group discussion, and if you feel the discussion should go further you can introduce some triggers based on the following ideas:

As a GP, take the sexual history of Laura in an open, unassuming, and non-judgmental manner<sup>19</sup>;

If needed, explain matters of confidentiality to her: encourage openness by clarifying what is recorded in an individual’s notes and provide information as to whom would have access to sensitive information;

Use professional, comforting body language, tone of voice, and proximity to create a non-threatening environment to put Laura at ease;

Ask Laura to clarify any unclear answer;

Avoid the use of language that assumes Laura is heterosexual;

Use affirmative and not offensive language (for example by using the same terms that Laura uses to describe herself and her partner);

Ensure that history taking and assessments are conducted in such a way as to facilitate disclosure (for example by using open-ended questions);

If you are asking Laura about her partner, use the gender-neutral term “partner” or use the singular “they/them”;

If you make a mistake, apologise and ask Laura what she prefers.

The European review and rapid-reviews (in Health4LGBTI SSR) showed that many LGBTI people across European countries experience ‘fear’ when accessing healthcare settings and disclosing their sexual orientation, gender identity or sex characteristics (e.g. due to concerns of discrimination, lack of privacy and confidentiality and so on). Health professionals could play an important role in accepting LGBTI people without judgement and acknowledge any feelings of fear that may accompany treatment to facilitate greater uptake health services.

17 Van Ments M: The Effective Use of Role Play: A Handbook for Teachers and Trainers. 1989, New York: Nichols Publishing

18 Nestel and Tierney (2007). Role-play for medical students learning about communication: Guidelines for maximising benefits. BMC Medical Education 7: 3

19 Print and distribute these suggestions to all the participants at the end of the activity and discuss them all together.

See below a draft of a possible dialogue for this role play.

**Doctor:** *How are you, Laura? Please, tell me why you are here.*

**Laura:** *Oh, doctor, I'm here because, as you see, I'm 5 months pregnant and I would like to have a suggestion for a gynaecologist. (Non-verbal communication is of embarrassment and closure).*

**Doctor:** *I see. Do you have a trusted gynaecologist?*

**Laura:** *No I don't. I had some problem.*

**Doctor:** *I'm sorry to hear this. Would you tell me something more about these problems?*

**Laura:** *It's difficult for me.*

**Doctor:** *I can understand, but if it's a matter of confidentiality, do not worry: I won't record anything, nor I will share with anyone everything you're willing to tell me. I suppose you are here because you need help.*

**Laura:** *Yes, indeed. I've been looking for several gynaecologists but many of them have refused to follow me because of my relationship.*

**Doctor:** *Oh, I'm really sorry. But I don't understand why your relationship is a problem. In which type of relationship are you?*

**Laura:** *I'm in a same sex relationship and many times I and my partner felt discriminated by the offensive behaviour of some doctors. I even thought I would not be followed by anybody. I don't want to feel so judged anymore. I do not think I'm a bad person and I know I'm not doing something wrong.*

**Doctor:** *Yes, sure. These things should not happen. I know a gynaecologist that could help you and your partner. She has already followed several same-sex couples and she can therefore easily understand your needs. Here's her number. Let me know how it goes with her and when you need a paediatrician for your baby please come back to me! I already have some names.*

**Laura:** *Thank you, doctor.*

**Doctor:** *You're welcome. Good luck.*

## Debriefing:

Even though this exercise comes after a teaching section about good practice in communication, it may still be difficult for participants playing the health professional to ask certain questions. Here are some of the impressions they may share following this exercise, and how you may respond to them:

- I find it difficult to ask direct questions about the sexual history of the patient/client; It is difficult to ask the patient/client about their sexual orientation, or whether they are in a relationship with a man, a woman, other. Refer to what was described in Module 2 (health inequalities), or remind them of the purpose of this module (practising inclusive communication). Finally, keep in mind that if it is difficult for you, it is probably even more difficult for the patient/client to have to silence a key aspect of their life/identity, or to spontaneously disclose it to you. It is likely they have had unpleasant experiences with health professionals before. Asking the question directly removes the taboo and clears the situation.
- I understood from the pronoun she used to refer to her partner ("she") what the issue was, which is enough. I did not need to ask more questions. The patient/client might still be anxious about what you think, or not be sure that you understood properly. Clarifying this is healthier and more productive for your relationship with your patient/client.
- If the patient/client does not feel like disclosing information (about sexual history, sexual orientation...), it is better for me not to ask. As research shows, LGBTI people are often reluctant to share such information (because for example stigma or experiences of discrimination). Remind participants what we saw in Module 2 on health inequalities.

## Activity 3: “Creating an inclusive practice”<sup>20</sup>

[Slide: 3.17–3.19]

**Duration:** 20 minutes

**Players:** Large group

**Purpose:** This activity is aimed to discuss aspects/practice of their services that are very inclusive (green), not very inclusive (yellow), not inclusive (red) and to suggest ways to improve the aspects/practice that are not inclusive.

**Materials:** Cover slide 3.17, slide 3.19, premade flip chart split into three columns marked by three colours (traffic light) with the headings “Inclusive”, “Not Inclusive,” (see Appendix 3.3)

**Process:**

1. Explain that it is important for health professionals to reflect upon the practice/environment that they work in and determine what can be improved to make it more inclusive for LGBTI patients/clients.
2. Invite the participants to reflect upon the practice/environment in which they work and to discuss aspects they identify as inclusive or not and to assign their answers to a specific column.
3. If examples of practice/environment aspects do not emerge you could use the following questions to stimulate discussion:
  - a. *How do patients/clients first come into contact with your practice?*
  - b. *How, through the current documentation or protocol, do you record the legal name or preferred name? Do the intake forms in documentations include binary gender or include also other possibility?*
  - c. *How do the intake forms ask about marital status? Are civil partnerships or same-sex marriages considered?*
  - d. *Are there some areas of documentation and protocols that should be developed to specifically target the health needs of LGBTI people?*
  - e. *And what about physical spaces? Is there anything that suggest to LGBTI people they are in a friendly and open-minded service (flag, poster, pamphlet, LGBTI specific scientific newspaper)?*
  - f. *Is there one universal gender-neutral bathroom at your workplace?*
4. Go through the non-inclusive list and for each example firstly ask if a practice in the inclusive list can be used to improve the environment. If a solution is not there, stimulate to find suggestions for practice improvement: “*How could these not inclusive practice be improved?*”

<sup>20</sup> This activity has been adapted by Jackson et al., 2011 A sexuality & Gender Diversity Training Program. Increasing the Competency of Mental Health Professionals. Jackson, McCloskey, McHaelen. Professional Resource Press Sarasota, Florida

## Activity 4: “Promising solutions to make your practice more inclusive”

[Slide: 3.23]

**Duration:** 20 minutes for small group discussion and 10 minutes large group discussion

**Players:** Small group

**Purpose:** This exercise is aimed to improve awareness of specific health inequalities in health practice and to start thinking about possible solutions in the real context of healthcare services.

Using different problems in each small group and reporting them to the large group will show and discuss a range of different health inequalities and inclusive practice.

**Materials:** Cover slide 3.23, flipchart, sheet with problems to be solved in Appendix 3.2

### Process:

1. Divide participants into smaller groups of 4-5 participants each (if possible it is better to create groups composed of different professionals).
2. Participants from each group read a question including an example of health inequalities to be solved (the examples are taken from Health4LGBTI SSR).
3. Participants from each group discuss and list possible strategies to solve this problem.
4. For each strategy, each group describes a concrete example of a solution.
5. After about 20 minutes, one participant from each group will explain to the large group the problem and the ideas that have emerged from the small group discussion.
6. Facilitate the discussion in the large group asking others their opinions.

### Questions to be used:

You will find a list of questions to choose from at the end of the activity sheet.

Here is a sample of questions you can use:

**Question for group 1 – screening:** Given that MSM are considered at high risk of anal cancer with MSM who are HIV-positive at the highest risk), how might practitioners promote screening programmes to ensure early detection of these forms of cancer?

**Question for group 2 – mental health:** Due to social factors such as minority stress, discrimination and experiences of violence, trans people are significantly more likely to attempt suicide or experience suicidal thoughts. How might practitioners ensure that they provide care in a respectful and inclusive manner?

**Question for group 3 – confidentiality and privacy:** LGBTI people are more likely to come out if they know health professionals who would uphold their confidentiality and privacy. How can practitioners protect the confidentiality and privacy of LGBTI people in healthcare settings?

**Question for group 4 – older LGBTI people:** Older LGBT(I) people in residential care facilities fear “being trapped in a heterosexual world” or “having to return to the closet” (Health4LGBTI SSR). For example, in the Czech Republic review, literature suggests that the managers of health and social care institutions are not always aware that older LGBT(I) people are in their facilities and therefore, their needs are not necessarily considered in the context of care for older

people. Trans people fear they may not be able to be themselves in predominantly cisgender care environments. While there is no specific research on older intersex people, existing research on stigma and discrimination faced by intersex people leads us to believe they would face similar difficulties. How might practitioners in care facilities acknowledge the specific needs of LGBTI elders?

**Suggestions:**

Supervise the work of each small group and help participants if needed.

Depending on the profile of the participants, and the modules you select for the training, you can change some of the questions you will ask. For example:

- If you do not run Module 4 on trans and intersex health, you might want to add questions specific to these groups to make sure each group within the LGBTI acronym is represented;
- If your participant group consists of mental health professionals only, you might want to ask questions related to this topic in particular.

You will find a list of questions to select from at the end of the activity sheet.



## Appendix 3.3 – Printable materials for activities

### ACTIVITY 2 – Role play “Inclusive communication”

Three sheets; one only for Laura, one for the GP and one for the observers

#### Laura

You are Laura. You are 42 and you are looking for advice. You identify as a lesbian woman. You have been together with your partner, Alicia, for 10 years now. After years of trying to get pregnant, you are now 5 months pregnant. Since the beginning of your pregnancy, you have not been able to find a gynaecologist who would follow your pregnancy: the previous gynaecologists you have seen either directly refused because they found out about your sexual orientation, or they made inappropriate comments making you feel very uncomfortable. Now you would like to receive support and advice from your GP. Before you brought your partner with you, but after having faced hostility from previous doctors, this time you have decided to come alone.

Laura: Hi, I'm here because, as you see, I'm 5 months pregnant and I would like to have a suggestion for a gynaecologist... (body language shows embarrassment and closure)

#### GP

Aim as GP: You have seen this patient a few times before, but you do not really know much about her. You should take information from her and understand her problem in order to find the best solution.

- Try to use the communication techniques that you have already learned.
- As a GP, take the sexual history of Laura in an open, unassuming, and non-judgmental manner.
- If needed, explain matters of confidentiality to her: encourage openness by clarifying what is recorded in an individual's notes and who would have access to sensitive information.
- Use professional, comforting body language, tone of voice, and proximity to create a non-threatening environment to put Laura at ease.
- Ask Laura to clarify any unclear answers.
- Avoid the use of language that assumes Laura is heterosexual.
- Use affirmative and not offensive language, for example by using the same terms that Laura use to describe herself and her partner.
- Ensure that history taking and assessments are conducted in a way as to facilitate disclosure, for example by using open-ended questions.
- If you are asking to Laura about her partner, use the neutral term “partner” or refer to “them” (singular form).
- ✓ If you make a mistake, apologise and ask Laura what she prefers.






## Observer

Laura, age 42, has to come to see a GP for help: she would like to receive support and advice. After years of trying she is currently 5 months pregnant but she cannot find a gynaecologist willing to take care of her pregnancy because of her sexual orientation. Because of previous bad experiences with gynaecologists, she has decided to not bring her partner of 10 years, Alicia, to this appointment.

Try to answer to the following questions:

- Which are your thoughts about the performance of this GP?
- How do you think Laura felt during this conversation?
- As a health professional, what would you do differently?
- Which impact do you think this approach by a health professional may have on Laura?

## ACTIVITY 3 – Creating an inclusive practice<sup>21</sup>

		
Inclusive		Non-Inclusive

<sup>21</sup> To be printed for each group.

## ACTIVITY 4 - Promising solutions to make your practice more inclusive

### Question for group 1 - screening

Given that MSM are considered at high risk of anal cancer (with MSM who are HIV-positive at the highest risk), how might practitioners promote screening programmes to ensure early detection of these forms of cancer?

### Question for group 2

Due to social factors such as minority stress, discrimination and experiences of violence, trans people are significantly more likely to attempt suicide or experience suicidal thoughts.

How might practitioners ensure that they provide care in a respectful and inclusive manner?

**Question for group 3**

LGBTI people are more likely to come out if they know health professionals who would uphold their confidentiality and privacy.

How can practitioners protect the confidentiality and privacy of LGBTI people in healthcare settings?

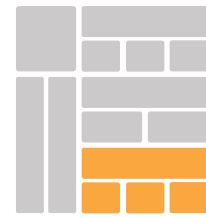
**Question for group 4**

Older LGBT(I) people in residential care facilities fear "being trapped in a heterosexual world" or "having to return to the closet" (Health4LGBTI SRR). For example, in the Czech Republic review, literature suggests that the managers of health and social care institutions are not always aware that older LGBT(I) people are in their facilities and therefore, their needs are not necessarily considered in the context of care for older people. Trans people fear they may not be able to be themselves in predominantly cisgender care environments. Intersex people may often be reluctant to live in a medicalised environment due to the fact that many of them had had traumatic experiences when receiving healthcare throughout their life. How might practitioners in care facilities acknowledge the specific needs of LGBTI elders?

**Other questions to be used according to the health professionals present as participants for this activity.**

- How might LGBTI communities, service providers and health practitioners foster greater social inclusion of bisexual people to promote their health and wellbeing?
- How might practitioners promote screening programs for bisexual women to ensure early detection of cervical cancer?
- Research shows that there are higher rates of depression for ethnic minority gay and bisexual men due to their experience of discrimination and marginalisation. How might practitioners account for this variance in their practice?
- How might mental health services and gender identity clinics become spaces without transphobia, where trans people feel able to discuss gender related health issues, and where they are treated sensitively and with respect?
- Numerous intersex conditions are diagnosed biomedically which unnecessarily medicalise intersex people based on physical difference. These diagnoses can be inconsistent with how intersex people self- identify. How might practitioners ensure intersex people can self-identify instead of imposing limiting biomedical categories or terminology on them?
- Non-consensual medical treatments to masculinise or feminise intersex people's bodies are condemned by human rights organisations and intersex activists. However, many intersex people may still benefit from some interventions. How might practitioners' discuss intervention options with intersex people and their next-of-kin and ensure they have gained full informed consent prior to any intervention?
- How can practitioners ensure that psychological support services and talking therapies are available to intersex people using an inclusive and patient-centred approach.?
- LGBT(I) people over the age of 50 are more likely to be single. Loneliness and isolation of LGBT(I) people as they age can be a significant challenge, specifically for those who lived in geographically isolated areas or for those who have not come out. How might health promotion initiatives target LGBT(I) elders to help prevent social isolation and loneliness?
- Older LGBT(I) people in residential care facilities feared 'being trapped in a heterosexual world' or 'having to return to the closet'. How might practitioners in care facilities acknowledge the specific needs of LGBT(I) elders?
- What kind of documentation and protocols can be developed to specifically target the health needs of lesbian and bisexual women?

# MODULE 4: TRANS AND INTERSEX HEALTH



## 4.1. Module overview

**Duration:** 2 hours

**A** - Attitudes; **K** - Knowledge; **S** - Skills

**Resources:** PowerPoint presentation, laptop, projector, activity sheets, flipchart, a pen

Content	Aim	Segment	Description	Materials	Duration (minutes)	Learning objectives*	Supporting Documentation
		<b>Introduction</b>	Module 4: Main contents and learning objectives	Slides 4.1 to 4.5	5		Appendix 4.1
<b>Myths on trans and intersex people</b>		<i>Activity 1</i>	<i>“To deconstruct myths”</i>	<i>Slides 4.6 to 4.8, Flipchart, a Pen</i>	20	A	Appendix 4.2
<b>Trans Health</b>	To raise awareness and improve knowledge about the <b>specific needs</b> of trans people and the <b>barriers</b> they face in accessing care	<b>Teaching Segment</b>	Trans Health and health inequalities	Slides 4.9 to 4.14, Flipchart, a Pen	10	K	Appendix 4.1
		<b>Teaching Segment</b>	Gatekeeping and SoCs	Slides 4.15 to 4.22	10	K	Appendix 4.1
		<b>Teaching Segment</b>	Legal situation	Slides 4.23 to 4.26, Flipchart, a Pen	5	K	Appendix 4.1
<b>Intersex Health</b>	To raise awareness and improve knowledge about the <b>specific needs</b> of intersex people and the <b>barriers</b> they face in accessing care	<b>Teaching Segment</b>	Intersex Health	Slides 4.27 to 4.31, video	10	K, S	Appendix 4.1
		<b>Teaching Segment</b>	Intersex Health: access to general healthcare	Slides 4.32 to 4.35	5	K, S	Appendix 4.1
		<i>Activity 2</i>	<i>Role-play</i>	<i>Slides 4.36 to 4.39</i>	45	S	Appendix 4.2 Appendix 4.3
		<b>Wrap-up</b>	Conclusions	Slide 4.40,	10		Appendix 4.1

## 4.2. How to use this module

This is a dedicated module aimed to deepen the knowledge, awareness and skills on trans and intersex health. If used as a stand-alone module, you should carry out icebreaker exercises and ensure that participants are knowledgeable of the basic terminology (see Module 1).

The module has therefore integrated the contents with material from other sources (see the list of materials suggested for the trainers).

## 4.3. Aims

- To deconstruct myths, stereotypes and prejudices related to trans and intersex people;
- To provide understanding of barriers faced by trans and intersex people accessing general and specific care;
- To improve awareness about the specific needs of trans and intersex people in healthcare setting.

## 4.4. Learning objectives

After this module, the participants will:

- Have a greater awareness and improved knowledge of concepts in the field of gender identity and sex characteristics;
- Be more familiar with the health needs of trans and intersex people;
- Be aware of the standard of care and human rights of trans and intersex people.

## 4.5. How to prepare for this module

- Study the Health4LGBTI State-of-the-art Synthesis Report (SSR);
- Study the Health4LGBTI Focus Group Studies Report (FGSR).

As the finding in the Health4LGBTI reports on trans and intersex people were limited, you should also refer to these additional materials:

### TRANS HEALTH

- Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People by the World Professional Association for Transgender Health, WPATH, 2011. Available at: <http://bit.ly/2qtf3sc>;
- Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, Center of Excellence for Transgender Health, 2016. Available at: <http://bit.ly/2rdwyLP>;
- Human Rights & Gender Identity: Best Practice Catalogue [particularly chapters 3, 5 and 8], Transgender Europe, 2016. Available at: <http://bit.ly/2rW1zFq>;
- World Medical Association (WMA) Statement on Transgender People, WMA, 2015. Available at: <http://bit.ly/2spSjG9>;
- Position Statement on Discrimination Against Transgender and Gender Variant Individuals, American Psychiatric Association, 2013. Available at: <http://bit.ly/2qCvliF>;
- Guidelines for Psychological Practice with Transgender and Gender Nonconforming People, American Psychological Association, 2015. Available at: <http://bit.ly/26urYWJ>;
- Trans Rights Europe Map & Index 2017, Transgender Europe, 2017. Available at: <http://bit.ly/2rmJxJv>;

### INTERSEX HEALTH

- Human Rights and Intersex people by Council of Europe, Commissioner of Human Rights, 2015. Available at: <http://bit.ly/2rGUXe3>;
- Standing up for the Human Rights of Intersex People, ILGA-Europe & OII Europe, 2015. Available at: <http://bit.ly/1ong0wL>;
- The fundamental rights situation of intersex people, European Union Agency for Fundamental Rights, 2015. Available at: <http://bit.ly/1fDvPdG>.



## Appendix 4.1 – Guidance notes - slides

Title	Sub-title	Slides	Guidance for trainer
	Main contents and learning objectives	4.1-4.5	<p>Introduce the aim, the contents and the agenda of this module following the slides.</p> <p>Slide 4.5 is intended to start raising awareness on the particularities of trans and intersex health among participants. Read the two sentences<sup>28</sup> and ask for a very brief comment. This should take no more than 3 minutes.</p>
Myths on trans and intersex people	To deconstruct myths	4.6-4.8	Slides for Activity 1 (please refer to Appendix 4.2)
Trans health	Trans health and health inequalities	4.9	<p>This segment is aimed to promote participants' knowledge on the most relevant topics related to trans and intersex health.</p> <p>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. You should allocate 25 minutes to the first, and 15 minutes to the second. Yet, you can manage time according to the particular needs of the group. Slides 4.14 and 4.26 may be used as 'checkpoints' in time management.</p> <p>Considering that, as reported in the Health4LGBTI SSR, primary research exploring the health needs, experiences and health profile of trans and intersex people appears to be relatively limited, you will find additional literature references in the text of this module, to help you in better prepare yourself in the specific topics of each slide.</p> <p>At any moment, use flipchart to take notes, write keywords, explain a particular concept using figures or diagrams, etc.</p>
	Trans health and health inequalities	4.10-4.14	<p>Slides 4.10 to 4.13 represent a summary of the main results on what is known about the health inequalities for trans people. Read the contents in the slides and use also complementary training documents (Health4LGBTI SSR and Health4LGBTI FGSR) to have more information and enrich your presentation. 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.</p> <p>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.</p> <p>Trans persons face a range of specific and particularly difficult obstacles when trying to access or accessing health services (TGEU, 2017)<sup>41</sup>. According to the FRA EU LGBT survey, on average one in 10 LGBT respondents (10%) 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 five (19%) say they were discriminated against by healthcare personnel in the year before the survey. Of those trans respondents who were not open vis-à-vis medical staff, 16% reported negative experiences. This rises to 30% when they were open to a few, to most or to all medical staff they encountered (FRA, 2014).</p> <p>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)<sup>29</sup>.</p> <p>In slide 4.13 mention the higher rated of mental distress among trans people, as described in the Health4LGBTI SSR.</p> <p>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).</p> <p>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).</p> <p>If you feel the need to promote interaction and engage participants in the conversation, consider using slide 4.14 now. Although you should adapt the time allocated to each part according to the particular needs of the group, ideally at this point of the teaching segment you should have not spent more than 10min.</p>

Title	Sub-title	Slides	Guidance for trainer
	Gatekeeping <sup>30</sup> and SoCs	4.15- 4.22	<p>Refer to this sentence to describe slide 4.15: “Gatekeeping is the practice of imposing requirements which controls access to resources for trans people. It is often used in regards 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 &amp; Stabb, 2009<sup>31</sup>; Bockting et al., 2004<sup>32</sup>). Gatekeeping may be, in fact, a significant barrier in the access to medical treatments (e.g., Pinto &amp; Moleiro, 2015)<sup>33*</sup>.</p> <p>Here below you can find some information useful for your background. You can summarise it for the participants. See also “Medicalisation and social control” in the Health4LGBTI Comprehensive Scoping Review (p.41-42) to enrich the presentation of this segment.</p> <p>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.</p> <p>Use this suggestion for slide 4.16: “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)<sup>16</sup>, 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 &amp; Pfäfflin, 2010)<sup>17</sup>. 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 &amp; 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 intention of undergo genital surgeries, expected gender expressions, and with heterosexual sexual orientation)”.</p> <p>You can introduce slide 4.18 by saying: “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.”</p> <p>Then you can read the definitions and the statements about gender nonconforming and gender dysphoria, according to the Standards of Care (World Professional Association for Transgender Health, 2011), and the recommendations from The World Medical Association Statement on Transgender People (2015).</p> <p>In order to better describe the slide 4.21, see in the Annex 3 a brief summary of the Standards of Care (2011) from The World Professional Association for Transgender Health (WPATH).</p> <p>You should inform participants about EPATH, which is the European Professional Association for Transgender Health, which aims to promote mental, physical and social health of transgender people in Europe to increase the quality of life among transgender people in Europe and to ensure transgender people’s rights for healthy development and well-being. Its goals are to foster the European knowledge and skills in transgender care, to facilitate and extend the bonds between European countries in transgender care and to spread the results of research and experiences by publishing reports and organising scientific conferences and meetings and to collaborate with international organisations with the same or related aims.</p>
	Legal Situation	4.23-4.26	<p>To be well prepared for this section you can also refer to the Comprehensive Scoping Review p.42-43. 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.</p>

Title	Sub-title	Slides	Guidance for trainer
			<p>In slide 4.23 you should mention that, in 2017, 20 countries in Europe require sterilisation for legal gender recognition<sup>36</sup>. In April 2017, the European Court of Human Rights ruled that requiring sterilisation for legal gender recognition violates human rights. TGEU's Trans Rights Map (2017) highlights States in red where sterilisation is either explicitly or implicitly routinely required in legal gender recognition procedures. "Blue" States have established legal gender recognition procedures and do not require sterilisation, while "brown" States do not offer any reliable procedures. Please make sure that you are using the most updated version of the map.</p> <p>In slide 4.24 you should mention that, in 2017, 36 countries in Europe require 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. Please make sure that you are using the most updated version of this map.</p> <p>In slide 4.25 you should provide information about the local context.</p> <p>If you feel the need to promote interaction and engage participants in the conversation, consider using slide 4.26 now. This is the moment to answers all questions on trans health. Although you should adapt the time allocated to each part to the particular needs of the group, ideally at this point of the teaching segment you should have not spent more than 25min.</p>
Intersex Health	Intersex Health	4.27-4.31	<p>Slide 4.27 - To introduce this segment, you can show the video "#EU4LGBTI stories - Monika &amp; Pot"<sup>37</sup>.</p> <p>Slides from 4.28 to 4.34 represent a summary of the main results on what is known about health inequalities of intersex people. Read the contents in the slides. You can refer to the Health4LGBTI SSR and FGSR to have more information and enrich your discussion.</p> <p>For slide 4.28, here is a brief and useful background from ILGA-Europe &amp; OII Europe (2015)<sup>38</sup> to enrich your explanation.</p> <ul style="list-style-type: none"> <li>➔ 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.</li> <li>➔ 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."</li> </ul> <p>To enrich the explanation of the following slides, see also the Comprehensive Scoping Review pg. 22-23, 28-29, 43-45 and Section 3.3.4 "Intersex people" of the Health4LGBTI SSR. 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.</p> <p>Some participants may be familiar with the term "Disorder of Sex Development" (DSD), and not with the term "intersex". At this regard, it is important to keep in mind the position from OII-Europe &amp; ILGA-Europe (2015)<sup>39</sup>: "[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.</p>

Title	Sub-title	Slides	Guidance for trainer
			<p>Continue with the slide 4.28: "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)."<sup>40</sup></p> <p>In slide 4.30 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).</p> <p>In the slide 4.31 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 (for more details see the Annex 3 and, to enrich the discussion, see also the table from Health4LGBTI SSR pg.36).</p>
	Intersex health: access to general healthcare	4.32-4.35	<p>As reported in the Health4LGBTI SSR, there is a lack of studies about the specific health issues of intersex people and further research is required on the needs of intersex people related to accessing healthcare and greater visibility of intersex people.</p> <p>Start with slide 4.32, reporting some stimulus emerging from Health4LGBTI FGSR. In these studies, intersex people were only discussed specifically 15 times in the entire dataset. The lack of knowledge around intersex issues identified in the other Health4LGBTi document was also raised in this research. The intersex-specific issues raised included the lack of knowledge around intersex lives (particularly as distinct from LGB and T); the difficulty in finding intersex-specific health services; and critiquing widespread assumptions that intersex is an illness which requires 'fixing' – particularly with regard to early childhood. However, there was little in-depth discussion of these important topics. Considering this the following topics could be useful suggestions: "The intersex-specific issues raised included the lack of knowledge around intersex lives, the difficulty in finding intersex-specific health services, and critiquing widespread assumptions that intersex is an illness which requires 'fixing'".</p>
			<p>You can complete the information on slide 4.32 by saying that access to healthcare is particularly difficult for intersex people when it comes to particular services (e.g. availability of preventive check-ups for certain conditions or general health services) that are related to the sex/gender of the individual seeking the service or where the medical history of a person matters (e.g. life insurance, private health insurance, own-occupation disability insurance)".</p> <p>You can also explain that "Contrary to what medical advice often suggests, having sex-altering surgery does not help intersex people to avoid these barriers to health services in later life: incidents have been reported both by intersex individuals who have had surgery and by those who have not".</p> <p>For slide 4.34 you can also give examples of reported physical and psychological abuse such as unconsented examination, rough use of examination tools or blaming intersex people for deliberately not cooperating when their bodies did not allow the traditional examination to take place. You may also highlight that some intersex people may have experienced isolation due to stigma compounded by adversity where many have experienced 'normalising' surgery at a young age (for more details, see the Health4LGBTI SSR).</p> <p>If you feel the need to promote interaction and engage participants in the conversation, consider using slide 4.35 now. This is the end of the teaching segment on Module 4. All questions on intersex health should be answered now.</p>
	Role play	4.36-4.39	Slides for Activity 2 (please refer to Appendix 4.2 and 4.3)

Title	Sub-title	Slides	Guidance for trainer
Wrap-up	Conclusions	4.40	<p>The remaining 5 minutes of each training day are reserved for the wrap-up. If you are at the end of your training day display the Wrap-up slide and ask participants to think about:</p> <ul style="list-style-type: none"> <li>➔ something that they have learned;</li> <li>➔ something that they would put in place after the training.</li> </ul> <p>See Section “Conclusions and Wrap-up” in the general introduction for more details.</p>

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- 28 Human Rights & Gender Identity: Best Practice Catalogue, Transgender Europe, 2016 Human Rights and Intersex people by Council of Europe, Commissioner of Human Rights, 2015
- 29 Lyons, T., Shannon, K., Pierre, L., Small, W., Krüsi, A. & Kerr, T. (2015). A qualitative study of transgender individuals' experiences in residential addiction treatment settings: stigma and inclusivity. *Substance Abuse Treatment, Prevention, and Policy*, 10-17.
- 30 The term gatekeeping does not translate well, and therefore should be kept in English in case of translation.
- 31 Bess, J. and Stabb, S. (2009). The Experiences of Transgendered Persons in Psychotherapy: Voices and Recommendations. *Journal of Mental Health Counseling*, 31(3), pp.264-282.
- 32 Bockting, W., Robinson, B., Benner, A. and Scheltema, K. (2004). Patient Satisfaction with Transgender Health Services. *Journal of Sex & Marital Therapy*, 30(4), pp.277-294.
- 33 Pinto, N. and Moleiro, C. (2015). Gender trajectories: Transsexual people coming to terms with their gender identities. *Professional Psychology: Research and Practice*, 46(1), pp.12-20.
- 34 Drescher, J., Cohen-Kettenis, P. and Winter, S. (2012). Minding the body: Situating gender identity diagnoses in the ICD-11. *International Review of Psychiatry*, 24(6), pp.568-577.
- 35 Cohen-Kettenis, P. and Pfäfflin, F. (2009). The DSM Diagnostic Criteria for Gender Identity Disorder in Adolescents and Adults. *Archives of Sexual Behavior*, 39(2), pp.499-513.
- 36 [http://tgeu.org/echr\\_end-sterilisation/](http://tgeu.org/echr_end-sterilisation/)
- 37 Please note the video is available at the following link: <https://ec.europa.eu/avservices/video/player.cfm?ref=I142954&lg=EN&sublg=none>
- 38-39 Standing up for the Human Rights of Intersex People, ILGA-Europe & OII Europe, 2015. Available at: <http://bit.ly/1ong0wL>
- 40 <http://fra.europa.eu/en/publication/2015/lgbti-comparative-legal-update-2015>
- 41 Transgender Europe (2017). Overdiagnosed but under served. Available at [https://tgeu.org/wp-content/uploads/2017/10/Overdiagnosed\\_Under-served-TransHealthSurvey.pdf](https://tgeu.org/wp-content/uploads/2017/10/Overdiagnosed_Under-served-TransHealthSurvey.pdf)

## Appendix 4.2 – Guidance notes – activities

### Activity 1: “To deconstruct myths related to TI people”

[Slides: 4.6-4.8]

**Duration:** 20 minutes

**Players:** Large group

**Purpose:** This exercise promotes initial awareness among participants on the negative and harmful myths concerning trans and intersex people. It consists in a group discussion around two sentences, one on trans health and another on intersex health.

**Material:** Cover slide 4.6, slides 4.7-4.8 (they contain the sentences that have to be used in the activity), and flipchart

**Process:**

1. For every myth sentence you read, ask for volunteers to start the discussion. If no one volunteers, choose someone to start the discussion. You may want to choose someone who has previously shown strong opinions. Yet, make sure everyone opinions are heard;
2. If most of the opinions are going in the same

direction, or if you feel the discussion is not dynamic enough, you may need to introduce arguments, (some of them are based on factual information, other on myths), playing the role of the ‘devil’s advocate’. The aim is not to reach a final conclusion neither to make everyone agree with the sentence, but to prepare the groundwork for the next segments of the module;

3. Divide the flipchart into two sections: arguments for and against the statement. Take note of the main arguments on both sides. This may help you in guiding and promoting the discussion.
4. Below you will find the two myths with the actual facts. Included are also arguments to guide the discussion if need be. Some are based on facts and others on myths.

#### Myth 1: “All trans people need psychiatric assessment”.

**Fact 1:** There is a growing awareness that trans people should stop being treated as if their identities are pathological (FRA, 2015)<sup>42</sup>. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) released by the American Psychiatric Association replaced the term “gender identity disorder” with “gender dysphoria”. In the DSM-5, gender nonconformity is not in itself considered to be a mental disorder. Instead, the presence of clinically significant distress associated with the condition is the critical element of a gender dysphoria diagnosis (FRA, 2015). Only some gender nonconforming people experience gender dysphoria at some point in their lives. Such a diagnosis is not a license for stigmatisation or for the deprivation of civil and human rights. A disorder is a description of something with which a person might struggle, not a description of the person or the person’s identity. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available.

<sup>42</sup> <http://fra.europa.eu/en/publication/2015/lgbti-comparative-legal-update-2015>



The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments (WPATH, 2011). In the 2017 beta version of the International Classification of Diseases (ICD-11<sup>43</sup>) prepared by the WHO, Section 7 on mental and behavioural disorders does not include the category “gender identity disorders”. Instead, the WHO now proposes a “gender incongruence” category, under the new Section 6 “Conditions related to sexual health” (for more details, see also Health4LGBTI Comprehensive Scoping Review, pg.27). Some community centers and clinics in Europe and in the United States have developed Informed Consent Protocols to provide hormone therapy to trans people (TGEU, 2016). The Informed Consent Protocols revolve around trans people’s right to self-determination and provide hormone treatment in an easy and accessible way. The advantage of these models is that patients are not required to accept a gender dysphoria diagnosis and therefore have no reason to provide a false narrative about their identity. This good practice also results in better alliances between patients and healthcare providers, as it allows for timely treatment of the chief complaint and related symptoms/distress. Whilst the models employed differ slightly, the clinics still rely on the following pillars: (i) an initial medical assessment, (ii) trans counselling and education, (iii) a follow-up medical visit, (iv) ongoing engagement of the patient in primary health care, and (v) other available services as necessary.<sup>44</sup>

#### ARGUMENTS/FACTS 1:

- Gender identity is a profound and personal experience. Every person, trans or cis, knows who they are;
- The role of healthcare practitioners is not to assess or “diagnose” trans people gender identities, including through gender expressions, but only to assess the clinical distress that may be present.

#### ARGUMENTS/MYTHS 1:

- People may be confused or even delusional. Health professionals may have the need to assess if someone is a true trans person;
- It is not possible to assess and diagnose the clinical distress related to gender incongruence, without assessing gender identities and expressions.

#### Myth 2: “Intersex children should undergo cosmetic surgeries to avoid discrimination”.

**Fact 2:** Intersex relates to a range of physical traits or variation that lies between and beyond the binary categories of male and female. Numerous intersex variations are diagnosed medically and intersex bodies are unnecessarily medicalised. These diagnoses can be incongruous with how intersex people self-identify and some terms or definition, such as “Disorders of Sex Development”, pathologise intersex people and their bodies. However, diagnoses are required to provide access to medical interventions, surgical technologies and hormonal procedures that some intersex people may want to access. Alternatives to categorising intersex conditions as “disorders” have been suggested, including “variations of sex development”. The ICD-11 beta draft refers for the first time to “disorders of sex development” therefore reinforcing the pathologisation of intersex people. In the EU intersex issues have gradually been recognised as relevant to fundamental rights protection – even if they are still largely treated as medical issues falling outside the scope of public scrutiny (FRA, 2015). Recently, the Council of Europe (CoE) has been raising attention to the discrimination and Human Rights violations that intersex people face in healthcare. The CoE Commissioner for Human Rights commented (CoE, 2014<sup>45</sup>) that the early “normalising” treatments do not respect intersex people’s rights to self-determination and physical integrity - because intersex babies and younger children are not in a position to give their consent.

43 <http://apps.who.int/classifications/icd11/browse/f/en>

44 Transgender Europe (2016). Human Rights and Gender Identity: Best Practices Catalogue.

45 [https://www.coe.int/en/web/commissioner/-/a-boy-or-a-girl-or-a-person-intersex-people-lack-recognition-in-euro-1?](https://www.coe.int/en/web/commissioner/-/a-boy-or-a-girl-or-a-person-intersex-people-lack-recognition-in-euro-1?__hstc=312123112.1722000000.1522000000.1522000000.1522000000&__hssc=312123112.1.1522000000.1522000000.1522000000&__hsfp=1522000000)

In the Issue Paper (CoE, 2015<sup>46</sup>) “Human rights and intersex people”, the Commissioner for Human Rights makes the following recommendation: National and international medical classifications which pathologise variations in sex characteristics should be reviewed with a view to eliminating obstacles to the effective enjoyment, by intersex people, of human rights, including the right to the highest attainable standard of health. Moreover, the EU Agency for Fundamental Rights acknowledges that “EU Member States should avoid imposing “sex-normalising” medical treatments on intersex people without their free and informed consent. This would help prevent violations of the fundamental rights of intersex people, especially children, by way of practices with irreversible consequences” (FRA, 2015, pg.74)<sup>47</sup> (for more details, see also Comprehensive Scoping Review, pg.22-23, 28).

### ARGUMENTS/FACTS 2:

- The right to body integrity is a basic human right;
- “Corrective” treatments (the ones that are not vital and therefore deferrable) to intersex babies and children are aimed to make sure that they fall in binary categories of men and women. However, it’s not possible to know how people will identify in the future;
- “Corrective” treatments are often not medically necessary, meaning that in most cases we are talking about cosmetic surgeries performed to babies and children.

### ARGUMENTS/MYTHS 2:

- “Disorders of Sex Development” have been studied in medicine for decades, and health professionals know better how to proceed in these situations;
- “Corrective” treatments are necessary to prevent stigmatisation towards intersex babies and children – including in kindergarten and school.

### Debriefing:

You complete with the correct explanation presenting the fact.

### Suggestions:

You should allocate 10 minutes to each sentence.

Both sentences are “myths”, meaning that ideally all participants would disagree with them. However, it is reasonable to expect that some participants will agree. Your role is to promote and encourage the discussion, and allow that different opinions are heard.

Please make sure to create a safe and constructive environment. Remind participants that the exercise is not about the content but about the importance of freely expressing ideas.

<sup>46</sup> <https://www.coe.int/en/web/commissioner/issue-papers>

<sup>47</sup> <http://fra.europa.eu/en/publication/2015/lgbti-comparative-legal-update-2015>



## Activity 2: Role-play

*[Slide: 4.36-4.39]*

**Duration:** 45 minutes (including 5 minutes debrief)

**Players:** Small group

**Purpose:** This activity is aimed to promote skills on competent healthcare provision to trans and intersex people. It consists in a group discussion around examples of encounters with health professionals and in role-play. The purposes are:

- to put in practice the communication skills
- to improve your verbal and nonverbal inclusive communication
- to encourage the participants to put themselves in TI patients/clients' shoes

hard copies of situation A and situation B (Appendix 4.3)

**Process:**

Display slide 4.37 at the beginning of the exercise. Start by dividing the group into two smaller groups – ideally with the same size. Deliver hard copies of situation A to each participant in group 1, and of situation B to each participant in group 2.

**Materials:** Cover slide 4.36, slides 4.37 to 4.39,

The exercise is divided in two parts.

PART 1 should last 20 minutes. Group 1 will discuss situation A and group 2 will discuss situation B. Situation A is an extract of the first appointment Alex, a trans man, had with a clinical psychologist expert on trans health. 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. In the part 2 of the exercise, two volunteers from each group have to carry out a role-play based on situation A and situation B, respectively, for the entire group of participants.

PART 2 should last 25 minutes. The two volunteers from group 1 have to perform a role-play on what they think would be a good practice between Alex (situation 1) and a clinical psychologist. The two volunteers from group 2 have to perform a role-play on what they think would be a good practice between Maria (situation 2) and a doctor. Each role-play cannot last more than 5 minutes, and will be performed in front of the entire group of trainees. Encourage the entire group to discuss each role-play for a maximum of 10 minutes and to give constructive criticism on their colleagues' performance.

Explain the exercise (parts 1 and 2) to the entire group and clarify any doubt. Mention that you just need to know who are the two volunteers from group 1 and group 2 in the end of the first part of the exercise.

**Pointers:**

At this point, participants will probably be able to discuss each situation by themselves, with sustained and rich arguments. However, pay attention to each group discussion, and if you feel the discussion should go further you can introduce some triggers based on the following ideas:

## Situation A

The fact that the psychologist invited another colleague to be present in the clinical appointment without Alex's consent may be felt by Alex as an abuse. Firstly because the psychologist's decision was based on the presumption that Alex was trans and secondly because his colleague is a psychiatrist.

The quote "we can see that" may be upsetting to Alex. As Alex himself explained, the fact that other people perceive him as a girl is hurtful.

Healthcare practitioners may need to have access to trans people legal names for bureaucratic registry. However, the way the psychologist asked about this revealed significant insensitivity, particularly by spelling out load Alex's legal name after he said he does not like to say it or even to remember it.

Although Alex refers to himself as "trans", the psychologist refers to him as "a transsexual". Health professionals have to respect the way trans people self-identify and describe who they are.

While the psychiatrist seems to be more focused on understanding Alex and assessing the distress he feels, the psychologist seems to be more interested in evaluating if Alex is "truly" a trans person, using criteria such as Alex's choices regarding medical treatments, his sexual orientation and gender expressions.

In the end, Alex appears to perceive the healthcare practitioners not as people who can help him, but as gatekeepers.

## Situation B

The approach of the practitioner is deeply problematic, because they encourage Maria to authorise surgeries or hormonal treatments which are not necessary for the health of the baby – just with normalising purposes or, in other words, to make a "perfect girl".

Maria and her parents were probably very scared and the only "solution" mentioned was "treatments"; the doctor did not mention in any moment that intersex bodies are, in most cases, a matter of diversity, not pathology.

Language matters. The expression "normal body" should be avoided. "Diverse body" or "uncommon body" should be used instead.

When the doctor says that "most people are satisfied with treatment and can have an almost regular life", they ignore the fact that a growing number of intersex people understand "normalizing" treatments as a strong violation of their right to body integrity.

Maria mentioned more than one time that she was confused. Most of her questions were not answered in a clear and ethical way.

## Appendix 4.3 – Printable materials for activities

### Activity 2 – Role-play

#### SITUATION A – TRANS MAN

Alex is a trans man. He is 19 years old, and he socially lives 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 boy. Nevertheless, and although his gender expression is noticeably “masculine”, he didn’t undergo any gender confirmation treatment (e.g., hormones, surgeries...). Only now he is 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 know I’m a boy since I was a child. Everyone recognises me as a boy, 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 in 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 feel 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 use 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?

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 to 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 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 to her.

**Doctor:** I know. We also want the best to the baby. There are no reasons for being 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.

What are the problems in both healthcare practitioners performances? Give specific examples.

How do you think Maria and her parents felt during this conversation?

As a health professional, what would you do differently?

Which impact do you think this approach by a health professional may have on the rest of Bianca's life?

## Annex 1. Glossary

Below is a list of terms that are related to LGBTI people. Trainers should make sure they read these definitions to be prepared to answer any doubt or questions of participants.

The definitions are mainly taken from ILGA-Europe's Glossary<sup>48</sup> and Health4LGBTI SSR, other sources are reported in notes.

**Sex** (noun): The term "sex" may refer to biological sex and/or to legal sex. The biological classification of people as male or female at birth is usually based on the appearance of their external anatomy and on a binary vision of sex which often 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 written in the birth certificate and transposed to identification documents.

**Biological male**<sup>49</sup>: 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**<sup>50</sup>: 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.

**Female**: Someone who identifies as a girl/woman, regardless of the sex assigned at birth.

**Male**: Someone who identifies as a boy/man, regardless of the sex assigned at birth.

**Intersex** (adj.): 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).

**Sexual orientation** (noun) refers to each person's capacity for profound affection, emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender. The most visible sexual orientations include, but are not limited to, homosexuality, bisexuality or heterosexuality.

A **lesbian** woman (adj.) is emotionally and/or sexually attracted to other women.

A **gay** man (adj.) is emotionally and/or sexually attracted to people of the same gender. It traditionally 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 lesbian women and bisexual people as well as gay men.

A **bisexual** person (adj.) is emotionally and/or sexually attracted to people of more than one gender.

**Homosexual** (adj.): a term used to describe someone who has an emotional romantic and/or sexual orientation towards someone of the same gender. The term 'gay' is now more generally used.

48 <http://www.ilga-europe.org/resources/glossary>

49 Erickson Cornish J.A., Schreier B.A., Nadkarni L.I., Henderson Mtzger L., Rodolfa E.R., (2010) Handbook of Multicultural Counselling Competencies. Wiley.

50 Ibidem

**MSM**<sup>51</sup> (men-who-have-sex-with-men) (noun): is a term used to refer to men who have sex with other men but do not necessarily identify as gay or bisexual.

**WSW**<sup>52</sup> (women-who-have-sex-with-women) (noun): is a term used to refer to women who have sex with other women but do not necessarily identify as lesbian or bisexual.

**Gender** (noun): Refers to a social construct which places cultural and social expectations on individuals based on their assigned sex.

**Gender identity** (noun): Refers to each person's deeply felt 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 or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms. Some persons' gender identity falls outside the gender binary and related norms.

**Gender expression** (noun): Refers to how a person presents themselves outwardly (e.g. dress, speech and mannerisms). This may not fit their gender identity.

**Trans** (adj.): 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**<sup>53</sup>: 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.

**Trans woman**<sup>54</sup>: 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.

**Transsexual** (adj.): 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 reassignment treatment (which may or may not involve hormone therapy or surgery).

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

**Coming Out** (verb): the process of revealing the identification of a lesbian, gay, bisexual, trans or intersex person.

**Out**: being openly gay, lesbian, bisexual, trans or intersex.

51 Reygan, F., D'Alton, P. (2011). Five things you need to know: a pilot training Programme for Health and Social care Professionals providing Palliative and Oncological care to Lesbian, Gay and Bisexual Patients. From [http://www.ilga-europe.org/sites/default/files/five\\_things\\_you\\_need\\_to\\_know.pdf](http://www.ilga-europe.org/sites/default/files/five_things_you_need_to_know.pdf)

52 Adapted by MSM definition

53 Erickson Cornish J.A., Schreier B.A., Nadkarni L.I., Henderson Metzger L., Rodolfa E.R., (2010) Handbook of Multicultural Counselling Competencies. Wiley. (Adapted from FtM and MtF)

54 Ibidem



**Pride events:** Pride events and marches are annual demonstrations (against homophobia/transphobia and in favour of the rights of LGBTI people) that take place around the world.

**Rainbow flag:** A symbol celebrating the uniqueness and diversity within the LGBTI community. The flag has six stripes, each a different colour, ranging from purple to red.

**Affirmative or Inclusive practice:** requires familiarity with the specific health issues of minority group patients/clients as well as the provision of sensitive, appropriate and accessible health services to these groups.

**Civil union – Civil partnership – Registered partnership:** a legal recognition of relationships; not always with the same rights and/or benefits as marriage.

**Second parent adoption:** where a same-sex partner is allowed to adopt their partner's biological child.

**Successive adoption:** where a same-sex partner is allowed to adopt their partner's adopted child.

## Specific terms on gender identities:

**Cross-Dresser**<sup>55</sup>: 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**<sup>56</sup>: a person who wears the clothing of another gender, often involving the 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 hormone therapy**<sup>57</sup> (noun): the administration of hormone therapy in order to match a person's physical characteristics to their gender identity.

**Gender fluid**<sup>58</sup> (adj.): 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 other days.

**Gender non-conforming**<sup>59</sup> (adj.): describes a gender expression that differs from a given society's norms for males and females.

**Genderqueer**<sup>60</sup> (adj.): 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, etc.

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55 Ibidem

56 Ibidem

57 Providing inclusive practice and Care for LGBT People: A Guide for Health Care Staff. National LGBT Health Education Center - A program of the Fenway Institute. From web <http://www.lgbthealtheducation.org/publication/learning-guide/>

58 Ibidem

59 Ibidem

60 Ibidem



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

**Gender affirmation process (Transition)**<sup>61</sup> (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)<sup>62</sup>: 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)<sup>63</sup>: 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** (adj.): Previously used as a derogatory term to refer to LGBTI 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.

## Terms related to the discrimination area

**Discrimination**: unequal or unfair treatment which can be based on a range of grounds, such as age, ethnic background, disability, sexual orientation or gender identity. Can be divided into four different types of discrimination, which all can lead to victimisation and harassment:

**Direct discrimination**: where a person is treated less favourably than others on grounds of his or her sexual orientation or gender identity.

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61 Ibidem

62 Ibidem

63 Ibidem

**Indirect discrimination:** where an apparently neutral provision or practice would put people of particular sexual orientation or gender identity at a disadvantage compared to others.

**Multiple discrimination:** discrimination based on more than one ground.

**Experienced discrimination:** also called subjective discrimination, is the experience of being discriminated against. Experienced discrimination does not necessarily entail discrimination in the legal sense.

**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:** any act or conduct that is unwelcome to the victim, which could be regarded in relation to the victim's sexual orientation, gender identity/expression and/or as offensive, humiliating or intimidating. It can include spoken words, gestures or the production, display or circulation of written words, pictures or other material.

**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**<sup>64</sup>: 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:** is a set of discriminatory attitudes, bias and behaviour relying on gender as a binary to favour heterosexuality and heterosexual relationships.

**Pathologisation:** The World Professional Association for Transgender Health (WPATH) released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide

(WPATH Board of Directors, 2010<sup>65</sup>). This statement noted that "the expression of gender characteristics, including identities that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative."

64 <http://queerdictionary.blogspot.be/2014/09/definition-of-cisnormativity.html>

65 The World Professional Association for Transgender Health (2011). Standard of Care for the health of Transgender, and Gender Non-conforming People. 7<sup>th</sup> version; from [www.wpath.org](http://www.wpath.org)

## Annex 2. HIV and STIs Topics (Module 2)

### Background

*Data and references included in the present Annex are largely based on the Scientific Review conducted in the framework of the project's Task 1 (Review of health inequalities experienced by LGBTI people and the barriers faced by health professionals in providing healthcare for LGBTI people).*

*Additionally, some relevant recent papers strictly focusing on the role of stigma (including structural stigma) and HIV/STI risk and testing behaviours are mentioned, to further clarify the issue. Results and references of papers based on EU funded projects targeting MSM (namely, EMIS and Sialon II) are also included.*

International literature highlights that LGBTI persons are facing higher health risks and burden of diseases compared to the general population. Considering HIV and STIs, such a burden is particularly high among gay and bisexual man, as well as among transgender people, whilst in case of intersex persons and bisexual women reliable data are not available (Mayer et al., 2008) (Blondeel et al., 2016).

In terms of **HIV infection**, available data show a high level of HIV prevalence among **MSM** compared to the general population (ECDC, 2015). In EU/EEA countries, HIV diagnoses have increased by 33% among MSM since 2004, confirming that this sub-population represents the large majority of the new HIV infected people across Europe (ECDC, 2015). Within the MSM group, self-identified **bisexual males** seem to be less likely to seek for HIV testing compared to the self-identified gay men (Mirandola et al., 2016).

HIV infection in **trans women** seems to be quite high: for this group an almost 50 times higher chance of acquiring HIV is reported, compared to the general population of adults (Baral et al., 2012). In addition, inequity in accessing HIV testing services is also reported for this group (Scheim et al., 2016). Literature support the fact that many MSM and trans people reported being less likely to seek for HIV testing and treatment because of potential discrimination and/or stigmatising attitudes of health professionals (Wao et al., 2016).

Significant data on the spread of HIV, related prevalence/incidence information and behavioural risk patterns are generally lacking for **lesbian and bisexual women**.

With regards to **STIs** other than HIV, **syphilis** infection is reported as among **MSM** (Mirandola et al., 2016) and **trans people** (Giami et al., 2011). According to results of a bio-behavioural survey conducted in four cities through the Sialon II multisite EU-funded survey, prevalence of probable active syphilis among MSM is ranging from 0.1% to 9.7% (Mirandola et al., 2016).

Considering **Hepatitis B and Hepatitis C**, the prevalence of such diseases is representing a critical issue among **MSM** (Mirandola et al., 2016). Even if a limited number of reliable data is available, this subgroup seems to be particularly affected by these infections compared to the general population (Hahné et al., 2013).

It is widely recognised that stigma represents a fundamental cause of health inequalities across several groups and populations (Hatzenbuehler et al., 2013).

Particularly among MSM, a growing body of studies suggests that structural stigma against LGBTI people at the country level is deeply influencing sexual attraction, behaviour, and self-identification (Pachankis et al., 2016). Several publications highlight that, among MSM, stigma influences health seeking behaviour, such as accessing to HIV-STI testing services (Oldenburg et al., 2014; Pachankis

et al, 2015), explaining the lower level of testing within this sub-population. Factors such as self-reported sexual orientation and perceived homonegativity might also greatly impact on the level of testing within the MSM population (Mirandola et al, 2016), representing significant barriers which are considerably shaping the access to testing services.

Considering other studies focusing on LGBTI population, discrimination or stigmatising behaviours faced by MSM and trans people are reported as crucial factors in hindering primary health care in general and HIV-STI testing services in particular (Wao et al, 2016; Whitehead et al, 2016). Other evidence clarifies that bisexual women are more likely to experience social stress due to the so-called double discrimination of homophobia and biphobia; Colledge et al, 2015), potentially reducing the level of health seeking behaviour in this population.

In conclusion, literature seems to confirm the role of both broader (structural stigma) and personal (e.g.: perceived homophobia) factors in substantially shaping the health of LGBTI persons, with particular reference to access to HIV and STI testing services.

A consistent amount of publications support the idea that – among HIV positive people – multiple stigmas might play a role in at least three different components.

Firstly, the disclosure of sexual orientation (and often HIV status) is linked with fear and anxiety when accessing the healthcare system (Wao et al., 2016). This might have an impact in the HIV-positive LGBTI people's experiences in dealing with the healthcare staff for prevention/treatment purposes.

Secondly, Katz and colleagues (Katz et al, 2013) highlight the impact of HIV-related stigma on a proper treatment adherence. Systematic review and meta-synthesis clearly demonstrated that HIV-related stigma affect the capacity of HIV positive persons to follow the antiretroviral treatment. In this case, HIV-related stigma is considered as a multiple factor including different levels (personal, social and structural).

Thirdly, being HIV positive might deeply shape the type of sexual practices adopted, and the type and quality of communication about the serum-status. On one hand, it is widely recognized that the disclosure of HIV status might be mediated by several factors, such as psychological condition, personal communication skills, type of relationships, and so on. On the other, it is undeniable that the fear of being stigmatised by others when disclosing their own HIV positivity plays a significant role. Multiple stigmas related to HIV positivity might therefore heavily impact the serum-status disclosure before sexual encounters. This could lead to wrong assumptions of partners' serum-status and consequently to unprotected sexual behaviours (Chambers et al, 2015; Marcus et al, 2011).

In summary, research confirms that stigma plays a detrimental role on the health of HIV positive people, particularly affecting their access to healthcare services.

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## Annex 3. Additional input for Trans and Intersex Health (Module 4)<sup>66</sup>

### Short summary of Standards of Care (2011) from The World Professional Association for Transgender Health (WPATH)

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 transsexual, 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 Transsexual, 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; thus, adaptations of the SOC to other parts of the world are necessary. 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 transsexual, 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.

### The Council of Europe Issue Paper (2015) “Human rights and intersex people” addresses various deeply problematic issues surrounding the medicalisation of intersex people

First, this report alerts to the still current approaches to reassigning or ‘fixing the sex’ of intersex people: “notwithstanding the significant change in attitudes since the 1950s regarding sexuality and gender diversity, it seems that the medical field often rejects the voices of intersex people harmed by surgery” (p. 20). The psychological distress caused by the negative outcomes of surgery can result in self-harming and suicidal behaviour. To this day, medical and surgical treatment of intersex infants and minors rests on the belief that such treatment is necessary and desirable. Thus, although parents of intersex children 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 fully informed consent.

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<sup>66</sup> Before reading this section, remember that it is mandatory to be aware of the entire documents suggested in the section “How to prepare this module”. Here are reported short views of some of these documents just for the purpose of some slides.

Second, the report clarifies how 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". Thus, "it is worrying that the gap between the expectations of human rights organisations of intersex people and the development of medical classifications has possibly widened over the past decade. This raises serious questions with regards to the medical profession's ability to help intersex people attain "the highest possible level of health" that they have a right to" (p.23).

Additional resources are available on the European Professional Association for Transgender Health (EPATH) website (<https://epath.eu/>).



## Annex 4. Example of invitation letter

(Note: this is just an example of a possible invitation letter; please feel free to edit it in the way that better applies to the regional/cultural/institutional context you are addressing.)

Dear [name/role of recipient (e.g. "Colleague" etc.)],

With this letter, we would like to invite you to take part in a training course on reducing health inequalities for LGBTI people for health care professionals.

This training course has been developed as part of the Health4LGBTI project, a two-year project financed by the European Union.

The overall objective of this training course is to raise awareness about the health inequalities experienced by LGBTI 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 LGBTI people.

The training course, will be hosted on

**[date, time and place]**

The course is open to [ recommended maximum of 15] from [the health care sector (modify as appropriate)].

All participants will receive [a certificate/credits etc., only if applicable].

You will find attached a draft agenda of the training course [+ other attachments, if any].

If you would like to take part in this training course, kindly complete the attached RSVP form with all your details, and return it to us by [date].

We very much appreciate your support of the Health4LGBTI project. Your participation to this training will directly contribute to its success.

For any further questions or need for clarification, we remain at your disposal at [contact] or [e-mail address].

Yours  
[your signature]

faithfully,

*Disclaimer*

## Annex 5. Consent Form<sup>67</sup>

### Consent Form Participant in HEALTH4LGBTI training



**Name of Researcher:** \_\_\_\_\_

The purpose of the “Health4LGBTI” pilot project is to increase the understanding of how best to reduce specific health inequalities experienced by lesbian, gay, bisexual, transgendered and intersex (LGBTI) people. It is jointly organised by the Verona University Hospital - IT, EuroHealthNet - BE, IL-GA-Europe - BE, University of Brighton - UK and the National Institute of Public Health – National Institute of Hygiene – PL (the contractor), on behalf of the European Commission’s Directorate-General Health and Food Safety (the data controller).

This part of the Health4LGBTI pilot project will test the training modules and evaluate their acceptance and effectiveness in potentially diverse European settings and with different health care and social care professionals. The specific purpose of these research, piloting and evaluating training modules is to build the capacity and expertise of health professionals in overcoming barriers to care provision for LGBTI people and, in doing so, to help contribute to reducing health inequalities experienced by lesbian, gay, bisexual, trans and intersex people, as well as the barriers faced by health professionals when providing care to LGBTI people. The training will be piloted in Belgium, Bulgaria, Italy, Lithuania, Poland and the United Kingdom.

In the context of my participation in these modules, I acknowledge/understand that:

1. the researchers involved in these training modules have explained to me the nature and purposes of the project and of the training modules; that I have read the participant information sheet and that I understand the principles, purposes and processes of the project;
2. I will be asked to participate in training modules to reduce health inequalities experienced by LGBTI people together with other healthcare professionals; that, during the training sessions, I will be asked to participate in theoretical sessions, group discussions and practical sessions; that I will be asked to complete questionnaires before and after the training sessions, as indicated to me in the participant information sheet; and that, in addition to the evaluation questionnaires, notes will be taken by the researchers during the training sessions for the purposes of this project;
3. my personal data, namely my name, surname, profession, affiliation, postal and e-mail addresses, phone number/fax number, socio-demographic information and professional characteristics will be processed (collected, stored and analysed). Only depersonalised data (identification and contact details will be removed) will be disseminated to the public at large, for the purposes of this project;

<sup>67</sup> This document has been prepared for the pilot training and is included here for information purposes only.

4. that my participation is voluntary and that I am entitled to withdraw my consent at any point in time, without any repercussions or adverse effects; that I have the right to access data related to me, to be informed about the existence and the extent of data processing, to rectify incorrect personal data as the case may be, to object to the processing of my personal data and request the blocking and erasure of my personal data, in accordance with the legal requirements; that, to exercise these rights, I shall contact the contractor at: [crempe@ospedaleuniverona.it](mailto:crempe@ospedaleuniverona.it) and/or the European Commission at the addresses mentioned in the privacy statement (available at: [https://ec.europa.eu/health/sites/health/files/social\\_determinants/docs/2017\\_vulnerable\\_sps\\_en.pdf](https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2017_vulnerable_sps_en.pdf));
5. that the European Union will have full ownership of all intellectual property rights related to the material developed on the basis of the discussions during the training; that the material will be processed by the European Commission for purposes in line with the objectives of the project in an anonymised form. I recognise that this implies that I will not be acknowledged as the author of my statements;
6. access to all personal data and information collected in the context of these modules will only be granted to Commission officials involved in the project, team researchers and, if necessary, translators, without prejudice to a possible transmission to the bodies in charge of a monitoring or inspection task in accordance with European legislation; that the depersonalised data/quotes (identification and contact details will be removed), collected during this project will be assessed by the Consortium researchers and (where the data is not in English) translators, and that it may be used in reports for the European Commission and academic presentations and scientific publications;
7. my personal data will remain in the European Commission database until the results of the training modules have been completely analysed and made use of; my personal data will be deleted, at the latest, 10 years after the last action based on the contract in the framework of which the project activities were conducted; and that the collected personal data and all information related to the evaluation/project held by the Contractor will be erased, at the latest, six months after the project ends;
8. this consent form will be transferred and stored by the European Commission for the purposes of verifying the provision of consent and ensuring the rights of the data subject for as long as necessary, but no longer than the retention periods foreseen in point 7 above.

In light of the above, I give my consent **to the contractor and to the European Commission** for the processing (namely the collection, storage and analysis) of my personal data and information to the extent necessary for the purposes of this project. I also consent to the dissemination of my depersonalised data (Identification and contact details will be removed) for the purposes of this project.

Name of Participant	Date	Signature

Researcher	Date	Signature

## Annex 6. Participant Information Sheet<sup>68</sup>

### Participant Information Sheet

An EU-funded pilot project related to reducing health inequalities experienced by LGBTI people (Ref: SANTE/2015/C4/035).

#### Who are we?

We are a European partnership (The Contractor) brought together to undertake research on behalf of the European Commission about Lesbian, Gay, Bisexual, Trans and Intersex people's experience of healthcare: EuroHealthNet (European Partnership for Improving Health, Equity and Wellbeing, Europe-Belgium), Verona University Hospital (AUOI-VR) [Italy], National Institute of Public Health – National Institute of Hygiene (NIZP-PZH) [Poland], University of Brighton [UK] and the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA).

The study protocol has been evaluated by the Ethical Committee of the Verona University Hospital (AUOI-VR) [Italy].

#### Why are we doing this research?

The European Commission wants to know more about how to reduce health inequalities for LGBTI people. To perform our contract with the European Commission, we have developed training modules for health care professionals. The training modules will build the capacity and expertise of health professionals in overcoming barriers to care provision for LGBTI people and in doing so, help contribute to reducing health inequalities. This part of the Health4LGBTI pilot project will test the training modules and evaluate their acceptance and effectiveness in potentially diverse European settings and with different health care and social care professionals. The training will be piloted in Belgium, Bulgaria, Italy, Lithuania, Poland and the United Kingdom.

#### Who can take part?

Any health professional (medical doctors, nurses, midwives, social workers, psychologists, etc.) working in health care services can take part in this training. The training will involve up to 20 health professionals in each participating Member State: Italy, Bulgarian, Lithuania, United Kingdom, Belgium and Poland.

Applicants who cannot explicitly provide informed consent, who are not proficient in the training language selected by the country, who cannot participate for the entire duration of the training or who are unable to complete the evaluation questionnaires, may unfortunately not participate.

Identification information cannot be explicitly indicated in the evaluation questionnaire, otherwise the questionnaire will be excluded from the analysis.

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<sup>68</sup> This document has been prepared for the pilot training and is included here for information purposes only.

## **What will be involved?**

You will be asked to take part in training modules. The training will involve up to 20 healthcare professionals, with different experiences and background in healthcare services (such as medical doctors, nurses, midwives, social worker and psychologists, among others). There will be two co-trainers involved in each session, who will lead the training and facilitate the discussion. Both theoretical and practical/interactive methodologies will be adopted during the training sessions. Trainers will encourage the active participation of trainees and their contribution to the discussion and group activities.

We specifically require that you do not refer, in any way, to any personal data of your patients during the training sessions, nor report other participants' experiences disclosed during the training outside of it.

For the purpose of contacting you regarding your participation in the training sessions and evaluation procedures, we will collect the following personal data: name, surname, profession, affiliation, postal and e-mail addresses, phone number/fax number.

You will be asked to complete training evaluation questionnaires, including socio-demographic and professional information at four stages: on recruitment; directly before the training; immediately after the training; and again approximately two months after the training to capture changes in LGBTI-related knowledge and attitudes and self-assessment of skills and satisfaction. Experts from AOUI-VR, ILGA-Europe and NIZP-PZH will attend the training allowing detailed monitoring of the sessions in every participating Member State.

You will be asked to sign a consent form. This consent form will be passed to the European Commission as outlined below.

Your participation will last about 4 months (including pre- and post-evaluation), the training modules will last approximately 8-10 hours in total.

Your participation is completely free of charge.

## **Which benefit and/or risk are connected to the participation?**

There is no risk involved with your participation in the training course. Participating in the training should improve your knowledge, attitudes and skills in dealing with LGBTI clients.

## **What happens to the information?**

The notes taken during the training by the above experts will be kept according to strict code of conduct, personal data protection and confidentiality. They will be used by the contractor's researchers to re-analyse part of the training.

Where the training is in a language other than English, the piloting of the training and all the information collected during the evaluation process could be translated into English by professionals well versed in issues of confidentiality. All translators are requested to sign a confidentiality declaration.

All the collected personal data and information will be stored on a computer of the contractor, who has to guarantee the security and confidentiality of the collected information. Paper versions of the documents containing personal data are stored in secure places, in line with the privacy and confidentiality regulations.

The anonymised findings of the study will be disseminated by the European Commission and used by the contractor in academic articles and presentations. The information will also be used to refine training materials.

All the data and information collected by the contractor in the context of the project will be sent to the European Commission in line with current regulations, following the EC procedures and guaranteeing safety and protection of the data.

These contributions will be stored in a secure and protected database hosted by the Data Centre of the European Commission, the operations of which abide by the Commission's security decisions and provisions established by the Directorate of Security for this kind of servers and services. The database is not accessible from outside the Commission and can only be accessed internally by a restricted group of Commission officials involved in the project, using a UserID/Password.

The contractor will erase all information, including personal data, after the necessary data has been transferred to the European Commission and no further follow-up is required. This should happen at the latest 6 months after the project ends.

Your personal data will remain in the Commission database until the results of the consultation have been completely analysed and made use of. Personal data will be deleted, at the latest, 10 years after the last action based on the contract in the framework of which the project activities were conducted.

### **What if I change my mind? Am I obliged to participate?**

Your participation in the training is entirely on a voluntary basis. If you decide to not participate you don't have to give reasons. You can leave the study at any time. You can withdraw consent for your information to be used at any time, even after the training, up to the point where the report is submitted (please contact the Verona University Hospital researchers - details below). In this case, data already collected will be analysed. No further information will be requested from you.

#### **Contact details:**

If you have any questions or want any clarifications, please contact [insert local contact here] at [crempe@ospedaleuniverona.it](mailto:crempe@ospedaleuniverona.it))

If you want to be informed of the project's findings, feel free to visit its website: [http://ec.europa.eu/health/social\\_determinants/projects/ep\\_funded\\_projects\\_en#fragment2](http://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en#fragment2).

If you have any questions, problems or complaints, please contact Professor Francesco Amadeo or Dr. Massimo Mirandola (Verona University Hospital; [crempe@ospedaleuniverona.it](mailto:crempe@ospedaleuniverona.it), who will be able to assist you or direct you to someone who can.

For any questions regarding the processing of your personal data, please contact the Commission Data Protection Officer at: [Data-Protection-Officer@ec.europa.eu](mailto:Data-Protection-Officer@ec.europa.eu).

### **Recourse**

Complaints, in case of conflict, can be addressed to the European Data Protection Supervisor: [edps@edps.europa.eu](mailto:edps@edps.europa.eu) , [www.secure.edps.europa.eu/EDPSWEB/edps/cache/offonce/EDPS/Contact](http://www.secure.edps.europa.eu/EDPSWEB/edps/cache/offonce/EDPS/Contact) .

## Annex 7. Individual Confidentiality Declaration<sup>69</sup>

### Health4LGBTI – PILOT TRAINING

#### INDIVIDUAL CONFIDENTIALITY DECLARATION<sup>70</sup>

I, the undersigned, \_\_\_\_\_ hereby declare that I will

- a. **NOT** refer, in any way, to any personal data<sup>71</sup> of my patients during the training sessions;
- b. **NOT** refer any personal data<sup>67</sup> related to other participants' experiences disclosed during the training outside of it;
- c. **NOT** attempt to identify any individuals who are discussed in a confidential way during the training;
- d. duly and promptly inform the Project Coordinator (crempe@ospedaleuniverona.it) of any confidentiality breaches whether as a result of my actions or failings or the actions of others, as soon as I become aware of them.

I certify that I have read all of the above clauses, that I understand that I am accountable for correct and responsible use of the information provided during the training session, and that I understand that if I fail to comply with these clauses, I may be liable to sanctions of my professional body (e.g. medical council) or those specified in the applicable civil or penal law.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

<sup>69</sup> This document has been prepared for the pilot training and is included here for information purposes only.

<sup>70</sup> This declaration is to be signed by the Trainers, Trainees, Evaluators and Translators

<sup>71</sup> "personal data" shall mean any information relating to an identified or identifiable natural person hereinafter referred to as "data subject"; an identifiable person is one who can be identified, directly or indirectly, in particular by reference to an identification number or to one or more factors specific to his or her physical, physiological, mental, economic, cultural or social identity (Article 2(a) - Regulation (EC) No 45/2001).

## Annex 8. Take-home tool for trainees

Subject to available resources, it is recommended that trainers print the following material to be given to each participant on conclusion of the training course:

### **Presentation of the Health4LGBTI project;**

Available for download at the following link:

[https://ec.europa.eu/health/social\\_determinants/projects/ep\\_funded\\_projects\\_en#fragment2](https://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en#fragment2)

### **The Glossary (Annex 1);**

### **The online link to Health4LGBTI State-of-the-art Report and Health4LGBTI Focus Group Studies Report;**

Available for download at the following link:

[https://ec.europa.eu/health/social\\_determinants/projects/ep\\_funded\\_projects\\_en#fragment2](https://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en#fragment2)

### **A brief report on HIV and STIs topics and Trans and Intersex topics created ad hoc for the training (Annex 2 and 3)**



## Annex 9. Sample Training flowcharts according to target audience

### Flowchart 1: Complete training

## SAMPLE AGENDA A (FULL TRAINING)

Target: mixed audience of health professionals / Duration: 3 half days (timing to be adapted according to needs)

MODULE 1: Introduction, Awareness Raising, Concepts and Terms		
Contents	Segments	Description
Presentation and training overview	Introduction	Module 1: Main contents and learning objectives
	Discussion	Ground Rules
	Activity 1	Introduce Yourself
	Teaching Segment	Project overview: background and main objectives
	Activity 2	Video: Experience of Healthcare settings: LGBTI people tell their stories
	Teaching Segment	Training overview: contents and structure
Terminology and concepts	Activity 3	Values Shuffles
	Activity 4	Correct Use of Terminology
	Teaching Segment	Terms and concepts
	Activity 5	Let's Practice your Knowledge
	Wrap –up	Conclusions
MODULE 2: Health and health inequalities		
Contents	Segments	Description
Health Inequalities and root causes	Introduction	Module 2: Main contents and learning objectives
	Activity 1	Position and Privilege
	Teaching Segment	Health Inequalities – what are they?
	Teaching Segment	Root causes of health Inequalities
LGBTI Health and healthcare provision	Activity 2	Let's talk about LGBTI healthcare
	Teaching Segment	Potential barriers and challenges faced by health professionals
	Activity 3	Quiz: health Inequalities experienced by LGBTI people
	Teaching segment	Health inequalities faced by LGBTI people
	Teaching Segment	HIV and STIs topics
Intersectionality and health inequalities	Activity 4	Case studies
	Teaching Segment	Intersectionality
	Wrap-up	Conclusions
MODULE 3: Communication and practice		
Contents	Segments	Description
Inclusive and non judgmental language	Introduction	Module 3: Main contents and learning objectives
	Teaching Segment	Language and Communication: Introduction
	Activity 1	“Cuál es la diferencia?”
	Teaching Segment	Inclusive Communication
Inclusive environment and practice	Activity 2	Role play – inclusive communication
	Activity 3	Creating an inclusive practice
	Teaching Segment	Reducing barriers in your practice
	Activity 4	Promising solutions to make your practice more inclusive
	Teaching Segment	Examples of Promising Practice
	Discussion	Recommendations
	Wrap-up	Conclusions
MODULE 4: Trans and Intersex Health		
Contents	Segments	Description
Myths on trans and intersex people	Introduction	Module 4: Main contents and learning objectives
	Activity 1	“To deconstruct myths”
Trans Health	Teaching Segment	Trans Health and health inequalities
	Teaching Segment	Gatekeeping and SoCs
	Teaching Segment	Legal situation
Intersex health	Teaching Segment	Intersex Health
	Teaching Segment	Intersex Health: access to general healthcare
	Activity 2	Role-play
	Wrap-up	Conclusions

## Flowchart 2: Core contents of the training for a group of mixed professionals

### SAMPLE AGENDA B

Target: mixed audience of health professionals / Duration: 2 half days (4 hours + 4 hours)

MODULE 1: Introduction, Awareness Raising, Concepts and Terms		
Contents	Segments	Description
Presentation and training overview	Introduction	Module 1: Main contents and learning objectives
	Discussion	Ground Rules
	Activity 1	Introduce Yourself
	Teaching Segment	Project overview: background and main objectives
	Activity 2	Video: Experience of Healthcare settings: LGBTI people tell their stories
	Teaching Segment	Training overview: contents and structure
Terminology and concepts	Activity 3	Values Shuffles
	Activity 4	Correct Use of Terminology
	Teaching Segment	Terms and concepts
	Activity 5	Let's Practice your Knowledge
	Wrap – up	Conclusions
MODULE 2: Health and health inequalities		
Contents	Segments	Description
Health Inequalities and root causes	Introduction	Module 2: Main contents and learning objectives
	Activity 1	Position and Privilege
	Teaching Segment	Health Inequalities – what are they?
	Teaching Segment	Root causes of health Inequalities
LGBTI Health and healthcare provision	Activity 2	Let's talk about LGBTI healthcare
	Teaching Segment	Potential barriers and challenges faced by health professionals
	Activity 3	Quiz: health Inequalities experienced by LGBTI people
	Teaching segment	Health inequalities faced by LGBTI people
	Teaching Segment	HIV and STIs topics
Intersectionality and health inequalities	Activity 4	Case studies
	Teaching Segment	Intersectionality
	Wrap-up	Conclusions
MODULE 3: Communication and practice		
Contents	Segments	Description
Inclusive and non judgmental language	Introduction	Module 3: Main contents and learning objectives
	Teaching Segment	Language and Communication: Introduction
	Activity 1	"¿Cuál es la diferencia?"
	Teaching Segment	Inclusive Communication
	Activity 2	Role play – inclusive communication
Inclusive environment and practice	Activity 3	Creating an inclusive practice
	Teaching Segment	Reducing barriers in your practice
	Activity 4	Promising solutions to make your practice more inclusive
	Teaching Segment	Examples of Promising Practice
	Discussion	Recommendations
Wrap-up	Conclusions	
MODULE 4: Trans and Intersex Health		
Contents	Segments	Description
Myths on trans and intersex people	Introduction	Module 4: Main contents and learning objectives
	Activity 1	"To deconstruct myths"
Trans Health	Teaching Segment	Trans Health and health inequalities
	Teaching Segment	Gatekeeping and SoCs
	Teaching Segment	Legal situation
Intersex health	Teaching Segment	Intersex Health
	Teaching Segment	Intersex Health: access to general healthcare
	Activity 2	Role-play
	Wrap-up	Conclusions

### Flowchart 3: Core contents of the training for group of participants with administrative roles/front office

## SAMPLE AGENDA C

Target: administrative staff / Duration: half day (4 hours)

MODULE 1: Introduction, Awareness Raising, Concepts and Terms		
Contents	Segments	Description
Presentation and training overview	Introduction	Module 1: Main contents and learning objectives
	Discussion	Ground Rules
	Activity 1	Introduce Yourself
	Teaching Segment	Project overview: background and main objectives
	Activity 2	Video: Experience of Healthcare settings: LGBTI people tell their stories
	Teaching Segment	Training overview: contents and structure
Terminology and concepts	Activity 3	Values Shuffles
	Activity 4	Correct Use of Terminology
	Teaching Segment	Terms and concepts
	Activity 5	Let's Practice your Knowledge
	Wrap –up	Conclusions
MODULE 2: Health and health inequalities		
Contents	Segments	Description
Health Inequalities and root causes	Introduction	Module 2: Main contents and learning objectives
	Activity 1	Position and Privilege
	Teaching Segment	Health Inequalities – what are they?
	Teaching Segment	Root causes of health Inequalities
LGBTI Health and healthcare provision	Activity 2	Let's talk about LGBTI healthcare
	Teaching Segment	Potential barriers and challenges faced by health professionals
	Activity 3	Quiz: health Inequalities experienced by LGBTI people
	Teaching segment	Health inequalities faced by LGBTI people
	Teaching Segment	HIV and STIs topics
Intersectionality and health inequalities	Activity 4	Case studies
	Teaching Segment	Intersectionality
	Wrap-up	Conclusions
MODULE 3: Communication and practice		
Contents	Segments	Description
Inclusive and non judgmental language	Introduction	Module 3: Main contents and learning objectives
	Teaching Segment	Language and Communication: Introduction
	Activity 1	“Cuál es la diferencia?”
	Teaching Segment	Inclusive Communication
Inclusive environment and practice	Activity 2	Role play – inclusive communication
	Activity 3	Creating an inclusive practice
	Teaching Segment	Reducing barriers in your practice
	Activity 4	Promising solutions to make your practice more inclusive
	Teaching Segment	Examples of Promising Practice
	Discussion	Recommendations
	Wrap-up	Conclusions
MODULE 4: Trans and Intersex Health		
Contents	Segments	Description
Myths on trans and intersex people	Introduction	Module 4: Main contents and learning objectives
	Activity 1	“To deconstruct myths”
Trans Health	Teaching Segment	Trans Health and health inequalities
	Teaching Segment	Gatekeeping and SoCs
	Teaching Segment	Legal situation
Intersex health	Teaching Segment	Intersex Health
	Teaching Segment	Intersex Health: access to general healthcare
	Activity 2	Role-play
	Wrap-up	Conclusions

## Annex 10. Evaluation Tool

### 10.1. Introduction to the Evaluation tool

The purpose of this Evaluation tool is to provide a structured framework for the evaluation of the training course “Reducing health inequalities experienced by LGBTI people: what is your role as a health professional?”. Initially, this tool was used to evaluate the training modules during the pilot implementation in 6 countries (Belgium, Bulgaria, Italy, Lithuania, Netherlands, Poland, UK) and served to fine-tune the training modules.

The Evaluation tool consists of four parts:

1. Overview of the training evaluation tools, procedures and timing;
2. Methodology (design and implementation);
3. Ethical, privacy and confidentiality issues;
4. Questionnaires and forms – ready to use tools in English.

The evaluation tools (questionnaires and forms) have been developed in English. Translation in the following languages is already available: Italian, Polish, Bulgarian, Lithuanian and Dutch. Please consult the project website for the available translations. It is recommended to translate the tools into the local language.

**Note:** if you plan to translate evaluation tools, you may consider contacting the local LGBTI community, e.g. ILGA representative in your country, to assist with the translation. It is also recommended to discuss the translated tool with local health care workers for clarity and proper understanding of questions.

## 10.2 Overview of the training evaluation tools, timing and procedures

Both quantitative and qualitative information can be collected through the different tools available in this Evaluation tool. Acceptance and effectiveness of the modules should be assessed identifying the extent of possible differences in reactions to the training course and the need to adapt the modules across potentially diverse European settings and different target groups.

The evaluation consists of five steps: pre- and post-training evaluation completed by the training participants, evaluation by the trainer, site visit and follow-up evaluation. The table below summarises all the proposed steps specifying when they should be performed and who should complete the questionnaire/form and. It should be underlined that while it may be relevant to implement all 5 evaluation steps (as during the piloting of the training course), the basic training evaluation would include just step 1 and 2 (pre- and post-training).

	Evaluation Step	Instrument	Format	Completed by	Timing
1	Pre-training Evaluation	Questionnaire (Appendix 10.1)	Paper only/ electronic database	Participants	Immediately preceding training
2	Post-training Evaluation	Questionnaire (Appendix 10.2)	Paper only/ electronic database	Participants	Immediately after completion of training
3	Evaluation by Trainer	Swot matrix (Appendix 10.5)	Electronic	Trainers	Immediately after completion of training
4	Site visit	Site Visit Form (Appendix 10.4)	Electronic	External Evaluators	After completion of training.
5	Follow-up Evaluation	Questionnaire (Appendix 10.3)	On-line	Participants	2 months after training

*Table A10.1 Summary of the evaluation steps.*

Before and after the training course, all participants should be asked to complete respectively the pre-training and the post-training questionnaire. The post-training questionnaire includes the same set of questions as the pre-test questionnaire to measure the desired change in attitudes, self-efficacy, behavioural intention and knowledge. In addition the post-training questionnaire contains questions measuring the overall satisfaction with the training, also with the training organisation and logistics. We recommend that data are collected as paper-based questionnaires. The pre- and post-training questionnaires from a single person should be linked by a unique code. The choice of code is up to the organisers. It should however guarantee full anonymity of the individuals. In case the follow-up questionnaires is planned it should be also easy to remember for the participant.

The trainers may consider not to repeat questions 1 – 7 in the post training questionnaire if they can assure good linkage between pre- and post- questionnaires via the code or there is not plan to analyse the data by demographic profile of the participants.

**Note:** when organising the training course make sure that you print out a sufficient number of copies of the pre- and post-training questionnaires and allocate enough time for completion of these questionnaires at the beginning and at the end of the training course.

**Note:** An example of an identification code is explained in the questionnaire. It includes the 3 initial letters of the older parent's first name and the day and month of the older parent's birthday.

The follow-up questionnaire, intended to measure the behaviour change, should be linked to the pre- and post-training questionnaires by the same code. We recommend to implement this step through an online questionnaire, which the participants would be able to access using a link distributed 2 months after the training course.

At the end of the training course, if further implementation/roll-out of the training is considered it may be useful to collect feedback from trainers using the Strengths-Weaknesses-Opportunities-Threats (SWOT) approach. The aim of this approach is to collect the reflections of the trainers. The questions included in the SWOT form are simply example topics to consider. Both co-trainers should jointly complete one form per training, having discussed their opinions. We recommend that the trainers perform the SWOT evaluation either immediately after the training course or within a week of the training course.

Finally, the external evaluation (site visits) was included as a step in the training development when piloting the training modules in the 6 pilot countries. However, it may be applicable for some training programs to have an external evaluator present during the training session to provide an independent view on the training implementation. A form to facilitate note-taking during such site visit as well as providing a structured feedback is provided (Site Visit Form).

The quantitative analysis of the responses should compare the pre- and post-results, according to key performance indicators and the different dimensions covered by the questionnaires (anonymously). Analysis stratified by different professional/role groups could be performed given sufficient sample size of the groups. Statistical techniques for repeated measurement could be applied. Note, that with regard to questions regarding sexual orientation, gender identity and sex characteristics participants may be indeed better informed at the end of training. Therefore, in case of discrepancies between the answers in the pre-test and in the post-test, it is recommended to use the post-test answers in the analysis.

The analysis for the pilot countries was processed centrally by Task 4 leaders. An evaluation report is available delineating the statistical methods used and the results of the evaluation analysis along with the recommendations for training improvement gathered from the evaluation of the piloting.

**Note:** the analysis compiled for the purpose of training evaluation during the pilot implementation could be modified and/or extended to elaborate on the specific issues important at the particular site where further implementation is considered.

### 10.3. Tool development methodology

#### 10.3.1 Pre and post training and follow-up evaluation

Four areas of evaluation questions have been defined in line with the purpose of training course: knowledge, attitude, self-efficacy and behavioral intention. It was agreed to use standardised questions in the training evaluation questionnaire for three of the identified areas, namely attitude, self-efficacy and behavioral intention. The medical databases *Pubmed* and *Google Scholar* and *Google* were searched (key words: (evaluation OR training) AND (healthcare OR health) AND (Lesbian OR Gay OR Bisexual OR Trans OR Intersex OR LGBTI OR LGBT OR LGB)) with the aim of finding training evaluation questionnaires concerning the health of LGBTI people or finding tools measuring the defined areas.

Area of Evaluation	Evaluation Instrument	Question Ref. No
Attitude	Pre-training evaluation	11, 12, 13, 15, 16, 17, 18, 20
	Post-training evaluation	11, 12, 13, 15, 16, 17, 18, 20, 30, 31, 32
	Follow-up Evaluation	5
Behavioral Intention	Pre-training evaluation	8, 9, 10
	Post-training evaluation	8, 9, 10
	Follow-up Evaluation	2, 3, 4, 6
Demographics	Pre-training evaluation	1, 2, 3, 4, 5, 6
	Post-training evaluation	1, 2, 3, 4, 5, 6
Evaluation of the training course	Pre-training evaluation	7
	Post-training evaluation	7, 34, 35, 36, 37, 38, 39, 41, 42, 43a-f, 44
	Follow-up Evaluation	7
Knowledge	Pre-training evaluation	21, 22, 23, 24, 25, 26, 27, 28, 29
	Post-training evaluation	21, 22, 23, 24, 25, 26, 27, 28, 29
Self-Efficacy	Pre-training evaluation	14, 19
	Post-training evaluation	14, 19, 33, 40
	Follow-up Evaluation	1, 2a

Table A10.2 Questions in the final tools by intended area of evaluation.

Three validated tools (in English) were selected:

1. LGBTQ cultural competency training<sup>72</sup>
2. Sexual Orientation Counselor Competency Scale (SOCCS) in Mental Health<sup>73</sup>
3. Evaluation of a Pilot Training to Improve Transgender Competency Among Medical Staff in an Urban Clinic; Lelutiu-Weinberger et al. 2016<sup>74</sup>

Each of the tools were profiled to address individual issues (e.g. SOCCS in particular Mental Health; or questions concerning only gay people; or evaluation of a training to improve only competency on transgender issues). Hence, their complete implementation was not possible. Moreover, these tools were long and the questionnaires would have been cumbersome to complete. Therefore, it was necessary to choose only key questions in the areas: attitude, self-efficacy and behavioral intention. It was agreed to use the questions that were the clearest and that measured the most pertinent issues. Language subtlety in subsequent translation into different languages (i.e. the possibility of distorting the meaning if the question through translation) was also considered.

Knowledge questions were designed on the basis of training modules, covering key learning points. Finally, questions regarding overall satisfaction on the training course, training usefulness and organizational aspects were adapted from the tools used locally by the project partners.

72 Liz Margolies, Rej Joo, and Jenna McDavid, 'Best Practices in Creating and Delivering LGBTQ Cultural Competency Trainings for Health and Social Service Agencies National LGBT Cancer Network: Liz Margolies, Rej Joo and Jenna McDavid' <[http://cancer-network.org/wp-content/uploads/2017/02/best\\_practices.pdf](http://cancer-network.org/wp-content/uploads/2017/02/best_practices.pdf)> [accessed 21 March 2017].

73 Markus Bidell, 'Using the Sexual Orientation Counselor Competency Scale (SOCCS) in Mental Health and Healthcare Settings: An Instructor's Guide', *MedEdPORTAL Publications*, 2015 <[http://doi.org/10.15766/mep\\_2374-8265.10040](http://doi.org/10.15766/mep_2374-8265.10040)> [accessed 21 March 2017].

74 Corina Lelutiu-Weinberger and others, 'Implementation and Evaluation of a Pilot Training to Improve Transgender Competency Among Medical Staff in an Urban Clinic', *Transgender Health Volume 1.1*, 2016 <<http://online.liebertpub.com/doi/pdf/10.1089/trgh.2015.0009>> [accessed 21 March 2017].

Pre- and post-training questionnaires (Appendices 10.1-10.2) were tested in a pre-piloting of the training material in one site (Verona) and subsequently modified on the basis of feedback from the participants and following a broad consultation with project partners. The follow-up questionnaire (Appendix 10.3) is based on the questions from the pre- and post-training questionnaires.

### 10.3.2 Site Visits

The Site Visits were initially designed as an external evaluation procedure implemented during the pilot implementation of the training course in 6 countries. Experts from AOUI-VR (Italy), ILGA-Europe or NIPH-NIH (Poland) attended the training courses allowing detailed monitoring of the piloting of the training courses including adherence of the trainers to the training manual, participants' reactions and group dynamics. Specific evaluation grids have been developed (Appendix 10.4) in order to facilitate the monitoring and evaluation process during the site-visits. Site visit grid should be completed by the evaluators present during the training sessions and analysed to find common themes. This tool has three parts. The first part facilitates note-taking during each of the Modules 1-4. It provides guidelines as to what to pay attention to when observing the training session. The second part aims to provide feedback on general organisation of the training session and compliance with the requirements as well as the level of participation and engagement of the trainees. The last part 'Key recommendations' is the space for the evaluators to identify best practice and provide specific suggestions for improving training delivery in the future.

### 10.3.3 Evaluation by trainers

Evaluation by trainers is aimed at providing input for possible further implementation. Having completed a training session, the trainers are in a position to identify strengths, weaknesses, opportunities and threats (SWOT) to a possible wider roll-out of the training course in their local context.

The SWOT analysis is a framework for identifying and analysing the internal and external factors that can have an impact on the future of the project in question. During the piloting phase this analysis was intended to capture factors that could affect possible wider dissemination of the training module in the country, where the pilot was conducted in view of creating an impact on general health care workers' skills and practice. This was to be considered from the perspective of the organisation or a partnership of organisations most likely to take forward such an initiative.

**Note:** If SWOT analysis is considered by, for example, a programme manager wishing to implement the training course within specific settings, the phrasing of the problem to be analysed by the SWOT should be modified according to the considered activities.

The trainers should consider the problem from the internal point of view (i.e. the module itself, the methods of implementation, the organisation capacity) and external point of view (i.e. what factors independent of the organisation would affect the achievement of such a goal). External potentially beneficial factors should be identified as "Opportunities" and internal beneficial factors – as "Strengths". Similarly, external possibly harmful factors should be listed as "Threats" and internal as "Weaknesses".



To assist this analysis a specific SWOT matrix for trainers has been designed (Appendix 10.5) providing sample areas that the trainers might wish to consider when performing the analysis. This form is meant to collect the trainers' critical opinions based on their knowledge of the local context and the experience of the pilot training that they have conducted. The trainers should not rely exclusively on the opinions given by the trainees during the session. Rather they should present their critical judgment taking into consideration the feedback from the trainees.

We recommend that both trainers complete the analysis together, as soon as feasible, preferably immediately after the training course.

#### 10.4. Ethical, privacy and confidentiality issues

During the piloting phase the training evaluation was developed in line with the main ethical principles (Declaration of Helsinki<sup>75</sup> and/or BERA Guidelines<sup>76</sup>) and in line with potential local needs related to cultural/legislation contexts.

The request for approval was submitted to the AOUI-VR Ethical Committee both for the pre-piloting and the piloting of the training course.

When implementing the module rigorous ethical review is not necessary (unless research use of data is envisioned and it is required by local legislation). However, privacy and confidentiality standards should always be in place when collecting possibly sensitive information. We therefore recommend that the questionnaires are collected anonymously and linked only by a code, which should not be linkable personally to individual participants.

Moreover, whenever quotes from the participants are used either in SWOT analysis or Grids for Site Visits the evaluators should make sure that these are provided anonymously and that no information is revealed that would allow to identify the participant.

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75 WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects; <https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/>

76 BERA Ethical Guidelines 2011; <https://www.bera.ac.uk/wp-content/uploads/2014/02/BERA-Ethical-Guidelines-2011.pdf?noredirect=1>



## Appendix 10.1 Pre-training Evaluation questionnaire

### REDUCING HEALTH INEQUALITIES EXPERIENCED BY LGBTI PEOPLE: WHAT IS YOUR ROLE AS A HEALTH PROFESSIONAL?

#### PRE-test

Please put here the 3 initial letters of the oldest parent's/guardian's first name and the day and month of the oldest parent's/guardian's birthday:

□□□-□□□□

Please complete the following questions to reflect your opinions as accurately as possible and answer factual questions to the best of your knowledge. There are no "right" or "wrong" answers. Your responses will be anonymous and will never be linked to you personally. Once you have completed this questionnaire, please put it in the envelope provided and return it to the trainer.

**Instructions:** Please put a 'x' in the box  next to the answer of your choice or write in the space \_\_\_\_\_ provided as the case may be.

The acronym **LGBTI** means **Lesbian, Gay, Bisexual, Trans** and **Intersex**.

#### DEMOGRAPHICS

##### 1. What is your age?

- 18-30                       51-64  
 31-50                       65 and over

##### 2. Which of the following best describes how you think of yourself?

- female                       other  
 male                         I prefer not to say  
 nonbinary

##### 3. Thinking of the answer to the previous question, is this what you were assigned at birth?

- no  
 yes  
 Don't know / Unsure

##### 4. Were you born with a variation of sex characteristics (this is sometimes called intersex)?

- no  
 yes  
 Don't know / Unsure

##### 5. Are you ... ?

- Gay                               Straight / heterosexual  
 Lesbian                         Any other term  
 Bisexual                        I don't usually use a term

##### 6. What is your profession?

- physician                       social worker  
 nurse                            physical therapist  
 midwife                         other, please specify:  
 psychologist                   \_\_\_\_\_

##### 7. What is your specialty in medicine, if any:

##### 8. What were your main reasons for taking part in the training? *You may choose more than one*

- My job or responsibilities have changed.  
 To improve my skills or knowledge.  
 I was asked to take part by my manager.  
 It may be of some use in a future.  
 I was interested in this topic.  
 It was the right thing to do.

Other, please specify:

### ATTITUDE - SKILLS - KNOWLEDGE

**9. How likely are you to intervene if you witness a stigmatizing or discriminatory behavior against an LGBTI person at your work place?**

- very likely
- most likely
- somewhat likely
- not very likely
- I do not know

**10. How likely are you to ask about the sexual orientation, gender identity, and/or sex characteristics of a new patient/client?**

- very likely
- most likely
- somewhat likely
- not very likely
- I do not know

**11. How often do you use a neutral language (e.g.: “partner” instead of “husband/wife”, “parent” instead of “mother/father” etc.) when asking about the family relations?**

- very often
- often
- somewhat often
- not very often
- not often at all

**Do you agree with the statements below (Q12-Q15):**

**12. “I would like all my patients/clients to know that I care about the specific needs of LGBTI patients/clients.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**13. “I do not see how knowing that a person is lesbian, gay, bisexual, trans or intersex might affect my role at work.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**14. “I think it is better if patients/clients keep information on their sexual orientation, gender identity and/or sex characteristics for themselves.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**15. “At this point in my professional development, I feel that I have the competences and skills to provide service to LGBTI patients/clients.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**16. Where do you place yourself in terms of attitude towards the LGBTI people?**

inclusive negative

1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Do you agree with the statements below (Q17-Q19):**

**17. “Generally speaking, in my country LGBTI people have the same access to health care as any other patient/client.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**18. “It’s difficult to talk about sexual orientation, gender identity and/or sex characteristics with my patient/client.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**19. “I think that LGBTI perspective should be an integral part of the medical staff education curriculum.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**20. I know I have had significant professional experience**

With	Yes	No	I do not know
lesbian patients/clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
gay patients/clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bisexual patients/clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
trans patients/clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
intersex patients/clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**21. Do you agree with the statement: “If I could decide myself, I would feel comfortable to change my practice (e.g. the way my office looks like, documentation, communication style) to be more LGBTI friendly.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**22. Using a neutral language (e.g.: “partner” instead of “husband/wife”, “parent” instead of “mother/father” etc.):**

- can be confusing, as it may not be very clear to whom the health professional is referring
- is not necessary for the majority of people, so it is the patient/client that should make things clear when the health professional uses the wrong term or assume a standard situation
- is one of the things that a health professional can do in order to set an inclusive environment

**23. When speaking with patients/clients, health professionals should:**

- refer to them and their situation with the terms that are generally used in the scientific and medical field, as this is what their professional role requires
- be aware both of the medical terms and the terms preferred by the LGBTI community, but they should ask the patients themselves how they want to be addressed
- refer to them with the terms that they know are generally accepted by LGBTI community as soon as it gets clear they belong to this group

**24. The terms “gay” and “MSM (men-who-have-sex-with-men)” are:**

- different, because “MSM” refers to a sexual behavior that does not necessarily imply that the person identifies as gay or bisexual
- synonyms, but “gay” is more well-known also outside the LGBTI community while “MSM” is less known
- synonyms, but the term “gay” can also be used for women, whereas MSM specifically refers to a behavior between men

**25. Check the correct statement:**

- He is homosexual
- He is a gay
- He is a gay man

**26. Intersectionality. When speaking about LGBTI people, this concept highlights social disadvantages and factors other than being LGBTI that people can face:**

- true
- false
- I do not know

**27. The terms “sexual orientation”, “gender identity” and “sex characteristics” are:**

- synonyms, as they all refer to a person’s specific set of characteristics
- different, and they are not necessarily related nor do necessarily affect/imply certain specific development of the other ones
- different, but they are related and each one necessarily implies compliant results in the development of the other ones

**28. Corrective surgeries and other medical, hormonal and psychological treatments for intersex people are:**

- always necessary, as having both male and female sex characteristics leads to medical problems, but they have to be put in place in infancy in order to be followed by a normal life
- always necessary, as having both male and female sex characteristics leads to medical problems, but they should be put in place in adulthood so that patients can choose the sex they feel more comfortable
- not always necessary, as in many cases an intersex body is a perfectly healthy body

**29. The fact that someone has an intersex body:**

- will not certainly become apparent, it is possible that some intersex people never find out at all
- will certainly become apparent at prenatal stage or at birth at last, as soon as it becomes clearly visible to medical staff
- will certainly become apparent, but this could be at different times in life: at birth, during childhood, in puberty or even in adulthood

**30. “Maria is a trans woman”:**

- Maria identifies as a man: her gender identity is female.
- Maria identifies as a woman: her gender identity is female. However, at birth her assigned sex was male
- Maria has both male and female sex characteristics, but she has chosen to identify as a woman

**Thank you very much for completing this questionnaire. Please now put your questionnaire in the envelope and hand it to the trainer**

*Training organised as part of the EU funded pilot project - Health4LGBTI*



## Appendix 10.2 Post-training evaluation questionnaire

### REDUCING HEALTH INEQUALITIES EXPERIENCED BY LGBTI PEOPLE: WHAT IS YOUR ROLE AS A HEALTH PROFESSIONAL?

#### POST-test

Please put here the 3 initial letters of the oldest parent's/guardian's first name and the day and month of the oldest parent's/guardian's birthday:

□□□-□□□□

Please complete the following questions to reflect your opinions as accurately as possible and answer factual questions to the best of your knowledge. There are no "right" or "wrong" answers. Your responses will be anonymous and will never be linked to you personally. Once you have completed this questionnaire, please put it in the envelope provided and return it to the trainer.

**Instructions:** Please put a 'x' in the box  next to the answer of your choice or write in the space \_\_\_\_\_ provided as the case may be.

The acronym **LGBTI** means **Lesbian, Gay, Bisexual, Trans** and **Intersex**.

#### DEMOGRAPHICS

##### 1. What is your age?

- 18-30                       51-64  
 31-50                       65 and over

##### 2. Which of the following best describes how you think of yourself?

- female                       other  
 male                         I prefer not to say  
 nonbinary

##### 3. Thinking of the answer to the previous question, is this what you were assigned at birth?

- no  
 yes  
 Don't know / Unsure

##### 4. Were you born with a variation of sex characteristics (this is sometimes called intersex)?

- no  
 yes  
 Don't know / Unsure

##### 5. Are you ... ?

- Gay                               Straight / heterosexual  
 Lesbian                         Any other term  
 Bisexual                        I don't usually use a term

##### 6. What is your profession?

- physician                       social worker  
 nurse                            physical therapist  
 midwife                         other, please specify:  
 psychologist                   \_\_\_\_\_

##### 7. What is your specialty in medicine, if any:

##### 8. What were your main reasons for taking part in the training? *You may choose more than one*

- My job or responsibilities have changed.  
 To improve my skills or knowledge.  
 I was asked to take part by my manager.  
 It may be of some use in a future.  
 I was interested in this topic.  
 It was the right thing to do.

Other, please specify:

**ATTITUDE - SKILLS - KNOWLEDGE**

**9. How likely are you to intervene if you witness a stigmatizing or discriminatory behavior against an LGBTI person at your work place?**

- very likely
- most likely
- somewhat likely
- not very likely
- I do not know

**10. How likely are you to ask about the sexual orientation, gender identity, and/or sex characteristics of a new patient/client?**

- very likely
- most likely
- somewhat likely
- not very likely
- I do not know

**11. How often do you use a neutral language (e.g.: “partner” instead of “husband/wife”, “parent” instead of “mother/father” etc.) when asking about the family relations?**

- very often
- often
- somewhat often
- not very often
- not often at all

**Do you agree with the statements below (Q12-Q15):**

**12. “I would like all my patients/clients to know that I care about the specific needs of LGBTI patients/clients.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**13. “I do not see how knowing that a person is lesbian, gay, bisexual, trans or intersex might affect my role at work.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**14. “I think it is better if patients/clients keep information on their sexual orientation, gender identity and/or sex characteristics for themselves.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**15. “At this point in my professional development, I feel that I have the competences and skills to provide service to LGBTI patients/clients.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**16. Where do you place yourself in terms of attitude towards the LGBTI people?**

inclusive negative

1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Do you agree with the statements below (Q17-Q19):**

**17. “Generally speaking, in my country LGBTI people have the same access to health care as any other patient/client.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree



**18. “It’s difficult to talk about sexual orientation, gender identity and/or sex characteristics with my patient/client.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**19. “I think that LGBTI perspective should be an integral part of the medical staff education curriculum.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**20. I know I have had significant professional experience**

With	Yes	No	I do not know
lesbian patients/clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
gay patients/clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bisexual patients/clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
trans patients/clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
intersex patients/clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**21. Do you agree with the statement: “If I could decide myself, I would feel comfortable to change my practice (e.g. the way my office looks like, documentation, communication style) to be more LGBTI friendly.”**

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

**22. Using a neutral language (e.g.: “partner” instead of “husband/wife”, “parent” instead of “mother/father” etc.):**

- can be confusing, as it may not be very clear to whom the health professional is referring
- is not necessary for the majority of people, so it is the patient/client that should make things clear when the health professional uses the wrong term or assume a standard situation
- is one of the things that a health professional can do in order to set an inclusive environment

**23. When speaking with patients/clients, health professionals should:**

- refer to them and their situation with the terms that are generally used in the scientific and medical field, as this is what their professional role requires
- be aware both of the medical terms and the terms preferred by the LGBTI community, but they should ask the patients themselves how they want to be addressed
- refer to them with the terms that they know are generally accepted by LGBTI community as soon as it gets clear they belong to this group

**24. The terms “gay” and “MSM (men-who-have-sex-with-men)” are:**

- different, because “MSM” refers to a sexual behavior that does not necessarily imply that the person identifies as gay or bisexual
- synonyms, but “gay” is more well-known also outside the LGBTI community while “MSM” is less known
- synonyms, but the term “gay” can also be used for women, whereas MSM specifically refers to a behavior between men

**25. Check the correct statement:**

- He is homosexual
- He is a gay
- He is a gay man

**26. Intersectionality. When speaking about LGBTI people, this concept highlights social disadvantages and factors other than being LGBTI that people can face:**

- true
- false
- I do not know

**27. The terms “sexual orientation”, “gender identity” and “sex characteristics” are:**

- synonyms, as they all refer to a person’s specific set of characteristics
- different, and they are not necessarily related nor do necessarily affect/imply certain specific development of the other ones
- different, but they are related and each one necessarily implies compliant results in the development of the other ones



**28. Corrective surgeries and other medical, hormonal and psychological treatments for intersex people are:**

- always necessary, as having both male and female sex characteristics leads to medical problems, but they have to be put in place in infancy in order to be followed by a normal life
- always necessary, as having both male and female sex characteristics leads to medical problems, but they should be put in place in adulthood so that patients can choose the sex they feel more comfortable
- not always necessary, as in many cases an intersex body is a perfectly healthy body

**29. The fact that someone has an intersex body:**

- will not certainly become apparent, it is possible that some intersex people never find out at all
- will certainly become apparent at prenatal stage or at birth at last, as soon as it becomes clearly visible to medical staff
- will certainly become apparent, but this could be at different times in life: at birth, during childhood, in puberty or even in adulthood

**30. “Maria is a trans woman”:**

- Maria identifies as a man: her gender identity is female.
- Maria identifies as a woman: her gender identity is female. However, at birth her assigned sex was male
- Maria has both male and female sex characteristics, but she has chosen to identify as a woman

**31. Please, rate your knowledge [to be determined: description of the knowledge – adequate to training content and expected learning results]**

	Before	After	
1.	<input type="checkbox"/>	<input type="checkbox"/>	very good
2.	<input type="checkbox"/>	<input type="checkbox"/>	good
3.	<input type="checkbox"/>	<input type="checkbox"/>	acceptable
4.	<input type="checkbox"/>	<input type="checkbox"/>	poor
5.	<input type="checkbox"/>	<input type="checkbox"/>	very poor
6.	<input type="checkbox"/>	<input type="checkbox"/>	no knowledge

**32. Please, rate your skills [to be determined: description of the skills – adequate to training content and expected learning results]**

	Before	After	
1.	<input type="checkbox"/>	<input type="checkbox"/>	very good
2.	<input type="checkbox"/>	<input type="checkbox"/>	good
3.	<input type="checkbox"/>	<input type="checkbox"/>	acceptable
4.	<input type="checkbox"/>	<input type="checkbox"/>	poor
5.	<input type="checkbox"/>	<input type="checkbox"/>	very poor
6.	<input type="checkbox"/>	<input type="checkbox"/>	no skills

**33. How confident do you feel about applying your learning in your job role?**

- very confident
- confident
- somewhat confident
- not very confident
- not confident at all

**34. How often do you expect to be able to apply your learning in your job role?**

- very often
- often
- somewhat often
- not very often
- not often at all

**35. How relevant were the following training parts/units, in terms of future utility in your professional practice? (from 1 = completely not relevant to 5 = very relevant)**

	1	2	3	4	5
<b>Module 1.</b> Introduction, Awareness Raising, Concepts and Terms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Module 2.</b> Health and Health Inequalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Module 3.</b> Communication and practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Module 4.</b> Trans and Intersex Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**EVALUATION THE TRAINING**

**36. How did you find the length of the training?**

- very good
- good
- acceptable
- poor
- very poor

**37. How did you find the structure of the training?**

- very good
- good
- acceptable
- poor
- very poor

**38. How useful did you find the following methods in helping you to learn? (from 1 = not useful to 5 = very useful)**

	1	2	3	4	5
Group Discussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain storming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Role playing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lecture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Videos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**39. Please rate your trainers in the following areas (from 1 = very poor to 5 = very good)**

	1	2	3	4	5
knowledge in the subject/activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
creating interest in the subject/activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
relating the training to your job role	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
understanding your needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
responding to questions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**40. Please rate the following aspects of the training facilities and its administration (from 1 = very poor to 5 = very good)**

	1	2	3	4	5
administration and recruitment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
room/venue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
convenience of location	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
technical support during training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
catering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

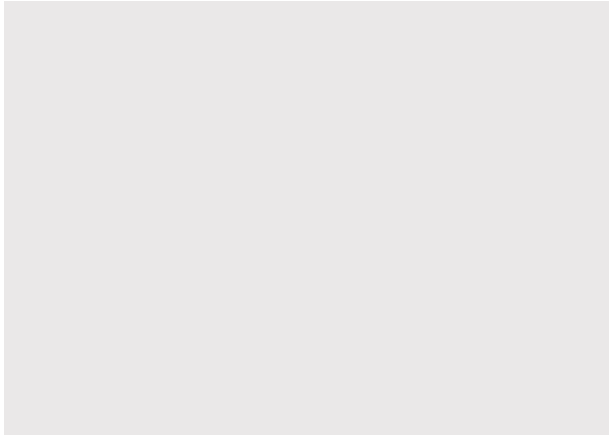
**41. Would you recommend this training to your work colleagues?**

- 1. Yes
- 2. No
- 3. Not sure

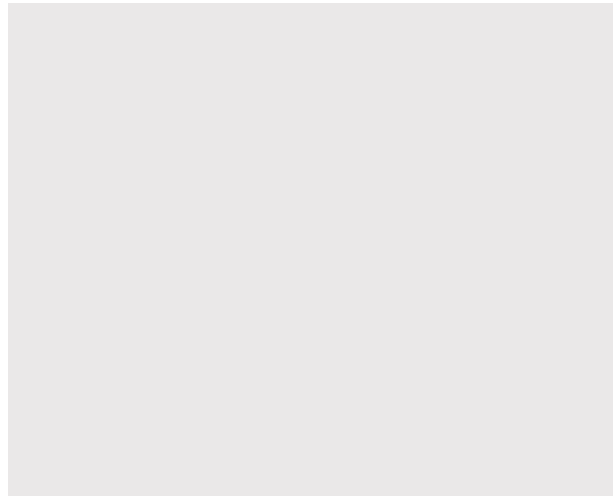
**41a. Please, explain briefly why:**

**42. What did you like most and the least about this training?**

**43. How do you hope to change your practice as a result of this training?**

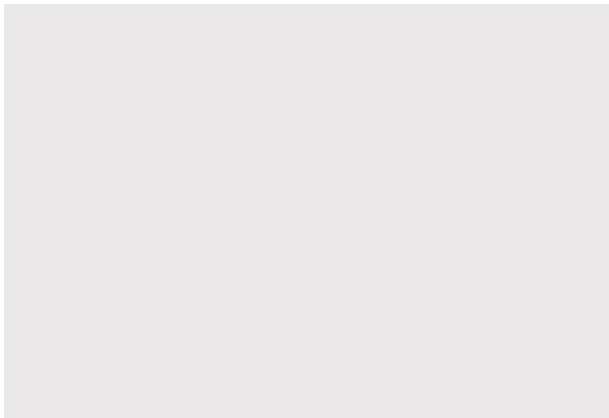


c) comments on the content of the training:

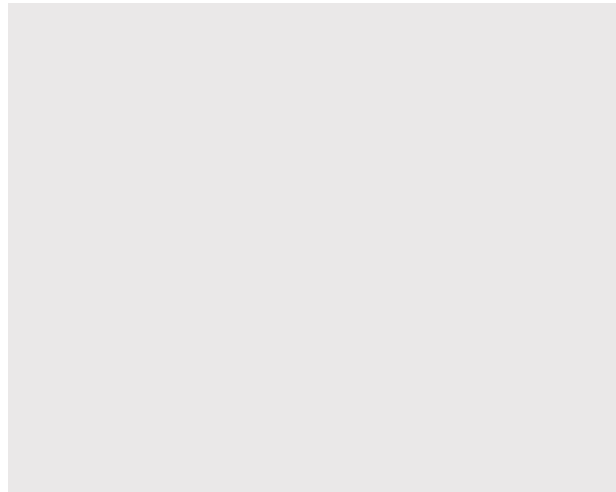


**44. If you have any comments please add them here:**

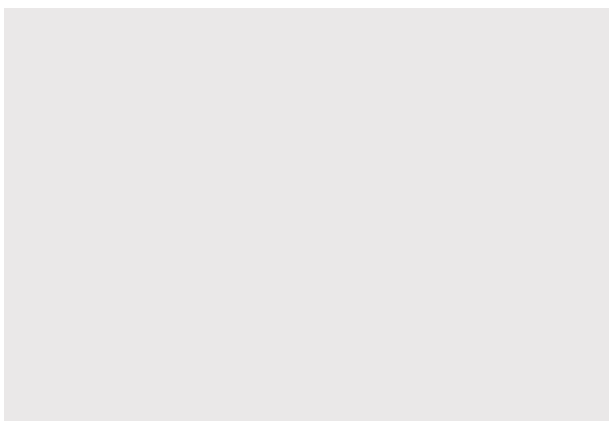
a) how far the training helped you developing how far the training helped you developing self-awareness on the discrimination and stigmatization affecting LGBTI people:



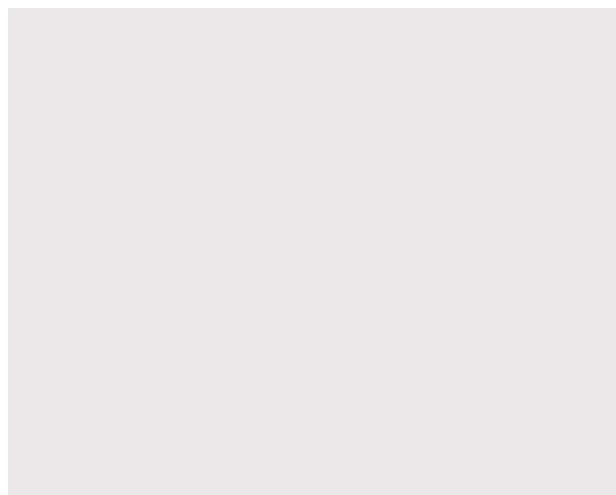
d) comments about training methods:



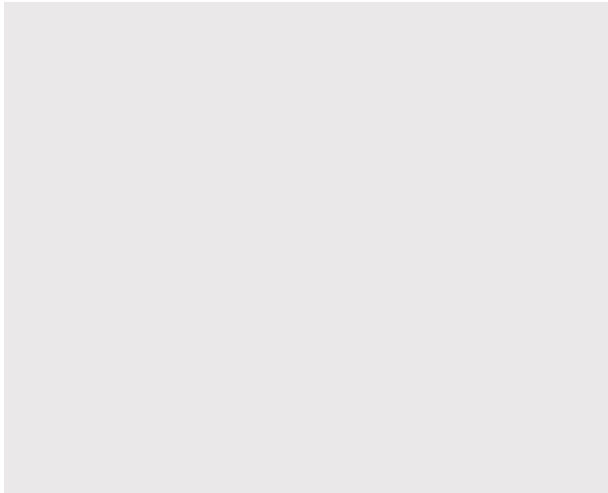
b) comments about the relevance of the training:



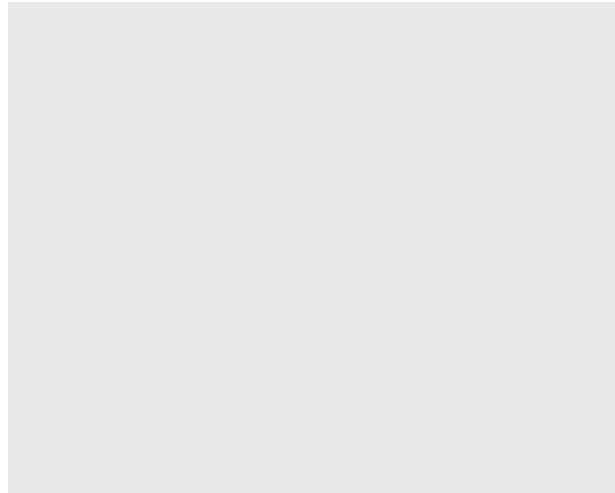
e) comments about the trainers:



f) comments about the event facilities or administration:



**45. Please share other comments or expand on previous responses here:**



**Thank you very much for completing this questionnaire. Please now put your questionnaire in the envelope and hand it to the trainer**

*Training organised as part of the EU funded pilot project - Health4LGBTI*



## Appendix 10.3 Follow-up questionnaire

### REDUCING HEALTH INEQUALITIES EXPERIENCED BY LGBTI PEOPLE: WHAT IS YOUR ROLE AS A HEALTH PROFESSIONAL?

#### FOLLOW-UP

Please put here the 3 initial letters of the oldest parent's/guardian's first name and the day and month of the oldest parent's/guardian's birthday:

\_|\_|\_|-|\_|\_|\_|\_|

We would like to take this moment and thank you once again for attending **training within Health-4LGBTI project**. It has been **two months since** we had a chance to foster our skills of working with LGBTI patients and clients.

Now we would like to ask you to fill in short survey, which will enable us to assess effectiveness of the training and benefits for participants. This information will be used to evaluate and improve future content.

All records are kept anonymously and will not be in any way associated with your identity.

Thank you!

**1. Since completing the training, how often have you been able to apply what you learnt in your job?**

- very frequently
- frequently
- occasionally
- rarely
- very rarely
- never

**2. Since completing the training, have you witnessed any stigmatizing or discriminatory behaviour against an LGBTI person at your work place?**

- Yes / go to filter questions 2a /
- No
- Not sure

*/ filter questions /* **2a. While witnessing a stigmatizing or discriminatory behaviour against an LGBTI person at your work place were you able to intervene?**

- always
- more often than not
- on half of such occasions
- less often than not
- never

**3. Since completing the training, how often have you used a neutral language (e.g.: "partner" instead of "husband/wife", "parent" instead of "mother/father" etc.) when asking about the family relations ?**

- very often
- often
- somewhat often
- not very often
- not often at all

**4. Since completing the training, how often have you asked about the sexual orientation / gender identity / sex characteristics of your new patients?**

- very frequently
- frequently
- occasionally
- rarely
- very rarely
- never

**5. Do you agree with the following statement: “It’s difficult to talk to talk about sexual orientation / gender identity with my patient/client.”**

- strongly disagree
- disagree
- neither agree nor disagree
- agree
- strongly agree

**6. Since completing the training, how often have you discussed the content of the training with your colleagues at work?**

- very frequently
- frequently
- occasionally
- rarely
- very rarely
- never

**7. If you would like to share a particular relevant experience or a comment related to the training please use dedicated space here:**

*Training organised as part of the EU funded pilot project - Health4LGBTI*



## Appendix 10.4 Grid for the site visit

### SITE VISIT FORM

This tool has three parts. The first part facilitates note-taking during each of the Modules 1-4. It provides guidelines as to what to pay attention to when observing the training session. The second part aims to provide feedback on general organisation of the training session and compliance with the requirements as well as the level of participation and engagement of the trainees. The last part 'Key recommendations' is the space for the evaluators to identify best practice and provide specific suggestions for improved training delivery in the future.

Date \_\_\_\_\_ City \_\_\_\_\_

The name of Inspector \_\_\_\_\_

### Part I. Note-taking during piloting

#### A. GUIDELINES FOR NOTE-TAKING

##### General

- Notes should quote what participants are saying as much as possible, but always in an anonymous way (no names or genders). e.g. "one participant said:..."
- Team dynamics (dominant participants/quiet participants, what are people feeling comfortable to say vs. what they are not comfortable to say)
- Time management (within specific exercises, and in general): write down how much time was used for each section, and each exercise (to compare with allocated time in the training manual)

##### Participants specific

- LGBTI-phobic behaviors / friendly behaviors
- Incomprehension & misunderstandings
- about vocabulary
- about exercises (instructions, purpose)
- misunderstandings between participants
- Participants' use of LGBTI terminology (do they use the terminology discussed, or use other terminology? For instance, if they use the term "homosexual" in English, even though it is made clear in Module 1 that it is often a pejorative term and should be avoided)
- Responses to each activity (feedback on the spot)
- Responses to the value shuffle activity (e.g. level of participation, assessing the group dynamics – anonymously)
- Suggestions made by participants during the training

## Trainers

- Trainers' use of key terminology
- What terms are used?
- Are trans & intersex mainstreamed in the presentations?
- How trainers address the use of different/pejorative terminology
- How trainers handle misunderstandings or difficult discussions



## B. EVALUATION OF MODULES

Topic	MODULE 1: Introduction, Awareness Raising, Concepts and Terms
Aims	<ul style="list-style-type: none"> <li>• To introduce Trainers and Participants;</li> <li>• To introduce the Health4 LGBTI Project and the Training course;</li> <li>• To establish group cohesion and a positive learning environment;</li> <li>• To raise awareness and improve knowledge on terms and concepts related to LGBTI topics.</li> </ul>
After this module, the participants will:	<ul style="list-style-type: none"> <li>• Be able to understand the overall aims, background and contents of the project and of the training;</li> <li>• Have a greater awareness and knowledge about terms and concepts in the field of gender identity, sexual orientation and sex characteristics;</li> <li>• Feel more comfortable in discussing LGBTI issues and be able to correctly use the relevant terminology.</li> </ul>
Planned duration: 2 hours	
Start time: <input type="text"/>	
End time: <input type="text"/>	
Main issues presented	<p>Presentation of the Health4LGBTI project <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Presentation of the work carried out to date and how it forms the basis of the training <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Presentation of the objectives of the training <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Presentation of ground rules – explanation of privacy statement etc., respect, participation (participants were asked if they wanted to add any ground rules) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Terminology (sexual orientation, sexual characteristics, gender identity) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Activity:	
Introduce Yourself	Comments:
Start time: <input type="text"/>	
End time: <input type="text"/>	
Video: Experience of Healthcare settings: LGBTI people tell their stories	Comments:
Start time: <input type="text"/>	
End time: <input type="text"/>	
Ground rules – large group discussion	Comments:
Start time: <input type="text"/>	
End time: <input type="text"/>	

<p><b>Values Shuffles</b></p> <p>Start time: <input type="text"/></p> <p>End time: <input type="text"/></p>	<p>Comments:</p>
<p><b>Correct Use of Terminology</b></p> <p>Start time: <input type="text"/></p> <p>End time: <input type="text"/></p>	<p>Comments:</p>
<p><b>Lecture - Terms and concepts</b></p> <p>Start time: <input type="text"/></p> <p>End time: <input type="text"/></p>	<p>Comments:</p>
<p><b>Let's Practice your Knowledge</b></p> <p>Start time: <input type="text"/></p> <p>End time: <input type="text"/></p>	<p>Comments:</p>
<p><b>Feedback from participants AND/OR notes from an Observer</b></p>	<p>Comments:</p>

Topic		MODULE 2: Health and Health Inequalities
<b>Aims</b>		<ul style="list-style-type: none"> <li>• To raise awareness and improve knowledge on the root causes of health inequalities experienced by LGBTI people;</li> <li>• To raise awareness and improve knowledge on the health needs of LGBTI people and the health inequalities they experience;</li> <li>• To improve knowledge on potential barriers and challenges faced by healthcare professionals when providing care for LGBTI people</li> <li>• To raise awareness and improve knowledge on the concept of intersectionality and how it relates to health inequalities experienced by LGBTI people</li> </ul>
<b>After this module, the participants will:</b>		<ul style="list-style-type: none"> <li>• Have a better understanding of factors that affect health outcomes among LGBTI people;</li> <li>• Be more informed about the specific health needs of LGBTI people;</li> <li>• Be more informed about access and barriers to proper HIV-STI testing and care;</li> <li>• Be able to recognise potential barriers and challenges faced by healthcare professionals when providing care for LGBTI people;</li> <li>• Have a better understanding of the concept of intersectionality and how it can help shed light on how different groups among LGBTI people may have access to healthcare.</li> </ul>
<b>Planned duration: 2 hours and 20 min</b>		
Start time: <input type="text"/>		
End time: <input type="text"/>		
<b>Main issues presented</b>		Health Inequalities and root causes (heteronormativity, heterosexism, discrimination, stigma, minority stress) <input type="checkbox"/> Yes <input type="checkbox"/> No  Health Inequalities – what are they? <input type="checkbox"/> Yes <input type="checkbox"/> No  HIV <input type="checkbox"/> Yes <input type="checkbox"/> No  STI <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Activity:</b>		
<b>Position and Privilege</b>		Comments:
Start time: <input type="text"/>		
End time: <input type="text"/>		
<b>Lecture – Health inequalities</b>		Comments:
Start time: <input type="text"/>		
End time: <input type="text"/>		
<b>Let's talk about LGBTI healthcare</b>		Comments:
Start time: <input type="text"/>		
End time: <input type="text"/>		

<b>Quiz</b> Start time: <input type="text"/> End time: <input type="text"/>	Comments:
<b>Case studies</b> Start time: <input type="text"/> End time: <input type="text"/>	Comments:
<b>Lecture – Intersectionality</b> Start time: <input type="text"/> End time: <input type="text"/>	Comments:
<b>Feedback from participants AND/OR notes from an Observer</b>	Comments:

Topic		MODULE 3: Communication and Practice
<b>Aims</b>	<ul style="list-style-type: none"> <li>• To raise awareness on the importance of inclusive communication with LGBTI patients/clients;</li> <li>• To improve communication skills with LGBTI patients/clients;</li> <li>• To improve knowledge on how to better organise and manage healthcare settings with regard to privacy, trust and comfort of LGBTI patients/clients.</li> </ul>	
<b>After this module, the participants will:</b>	<ul style="list-style-type: none"> <li>• Have a better understanding of the relevance of using inclusive language taking account the spectrum of sexual orientation, gender identities and sex characteristics.</li> <li>• Be able to take case histories of LGBTI patients/clients with an attitude of inclusivity and without judgment;</li> <li>• Be better informed on how to make their practice/healthcare setting more welcoming for LGBTI patients/clients, respecting privacy and ensuring trust and comfort.</li> </ul>	
<b>Planned duration: 2 hours and 15 min</b>		
Start time: <input type="text"/>		
End time: <input type="text"/>		
<b>Main issues presented</b>	<p>Language as a potential barrier <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Video as example of inclusive language and related discussion <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Assumptions during the interview (and tips for asking properly) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Role playing in a general practitioner setting <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<b>Activity:</b>		
<b>Lecture - Language and Communication: Introduction</b>	Comments:	
Start time: <input type="text"/>		
End time: <input type="text"/>		
<b>Video “Cuál es la diferencia?”</b>	Comments:	
Start time: <input type="text"/>		
End time: <input type="text"/>		
<b>Lecture – Inclusive Communication</b>	Comments:	
Start time: <input type="text"/>		
End time: <input type="text"/>		
<b>Role play – inclusive communication</b>	Comments:	
Start time: <input type="text"/>		
End time: <input type="text"/>		

<p><b>Creating an inclusive practice</b></p> <p>Start time: <input type="text"/></p> <p>End time: <input type="text"/></p>	<p>Comments:</p>
<p><b>Lecture – Reducing barriers in your practice</b></p> <p>Start time: <input type="text"/></p> <p>End time: <input type="text"/></p>	<p>Comments:</p>
<p><b>Promising solutions to make your practice more inclusive</b></p> <p>Start time: <input type="text"/></p> <p>End time: <input type="text"/></p>	<p>Comments:</p>
<p><b>Discussion – Recommendations</b></p> <p>Start time: <input type="text"/></p> <p>End time: <input type="text"/></p>	<p>Comments:</p>
<p><b>Feedback from participants AND/OR notes from an Observer</b></p>	<p>Comments:</p>

Topic		MODULE 4: Trans and Intersex Health
<b>Aims</b>		<ul style="list-style-type: none"> <li>• To deconstruct myths, stereotypes and prejudices related to trans and intersex people;</li> <li>• To provide a better understanding of barriers faced by trans and intersex people accessing general and specific care;</li> <li>• To improve awareness about the specific needs of trans and intersex people in healthcare setting.</li> </ul>
<b>After this module, the participants will:</b>		<ul style="list-style-type: none"> <li>• Have a greater awareness and improved knowledge of concepts in the field of gender identity and sex characteristics;</li> <li>• Be more familiar with the health needs of trans and intersex people;</li> <li>• Be aware of the standard of care and human rights of trans and intersex people.</li> </ul>
<b>Planned duration: 2 hours</b>		
Start time: <input type="text"/>		
End time: <input type="text"/>		
<b>Main issues presented</b>		To deconstruct myths related to TI people <input type="checkbox"/> Yes <input type="checkbox"/> No  Topics related to trans health <input type="checkbox"/> Yes <input type="checkbox"/> No  Topics related to intersex health <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Activity:</b>		
<b>To deconstruct myths</b>		Comments:
Start time: <input type="text"/>		
End time: <input type="text"/>		
<b>Lecture – Trans Health and health inequalities</b>		Comments:
Start time: <input type="text"/>		
End time: <input type="text"/>		
<b>Lecture – Gatekeeping and SoCs</b>		Comments:
Start time: <input type="text"/>		
End time: <input type="text"/>		
<b>Lecture – Legal situation</b>		Comments:
Start time: <input type="text"/>		
End time: <input type="text"/>		

<p><b>Lecture – Intersex Health</b></p> <p>Start time: <input type="text"/></p> <p>End time: <input type="text"/></p>	<p>Comments:</p>
<p><b>Lecture – Intersex Health: access to general healthcare</b></p> <p>Start time: <input type="text"/></p> <p>End time: <input type="text"/></p>	<p>Comments:</p>
<p><b>Role-play</b></p> <p>Start time: <input type="text"/></p> <p>End time: <input type="text"/></p>	<p>Comments:</p>
<p><b>Feedback from participants AND/OR notes from an Observer</b></p>	<p>Comments:</p>



## Part II. Overall Evaluation

### 1. Organization and logistics

Please rate the following (from 1 – *poor* to 5 – *very good*)

	1	2	3	4	5
Adequacy of the premises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Punctuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Logistics information provided to participants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Technical support during training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Comments:*

### 2. Implementation of the activities

Please rate the participation of trainees in the modules (from 1 – *not active at all* to 5 – *very active*)

	1	2	3	4	5
<b>Module 1.</b> Introduction, Awareness Raising, Concepts and Terms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Module 2.</b> Health and Health Inequalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Module 3.</b> Communication and practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Module 4.</b> Trans and Intersex Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Comments:*

Please rate the efforts of the trainer to involve all the participants (from 1 – *no efforts made* to 5 – *all participant actively involved*). If no problem with participation was encountered, please mark N/A

	1	2	3	4	5	N/A
<b>Module 1.</b> Introduction, Awareness Raising, Concepts and Terms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Module 2.</b> Health and Health Inequalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Module 3.</b> Communication and practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Module 4.</b> Trans and Intersex Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Comments:*

Please rate the efforts made to manage problematic group interactions, including intimidating or aggressive behaviours (1- no efforts made to 5 – all problems efficiently resolved). If no problem with participation was encountered please mark N/A

	1	2	3	4	5	N/A
<b>Module 1.</b> Introduction, Awareness Raising, Concepts and Terms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Module 2.</b> Health and Health Inequalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Module 3.</b> Communication and practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Module 4.</b> Trans and Intersex Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Comments:*

### 3. Adherence to requirements

Please rate the following (from 1 – *poor* to 5 – *full adherence*)

	1	2	3	4	5
Requirements for promotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trainers' competencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diversity of participants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Comments:*

## Part III. Key recommendations

### A. Organisational aspects

*Comments:*

### B. Group dynamics

*Comments:*

### C. Implementation of modules

*Comments:*



## Appendix 10.5. SWOT matrix for the Trainers

### REDUCING HEALTH INEQUALITIES EXPERIENCED BY LGBTI PEOPLE: WHAT IS YOUR ROLE AS A HEALTH PROFESSIONAL?

#### Trainer's feedback form (SWOT matrix)

This form is meant to collect the trainers' critical opinions based on the knowledge of the local context and the experience of the conducted pilot training on the following issue:

*<<In your country, if an organization, which is independent but willing to collaborate with relevant stakeholders, would plan for wider dissemination of this Training course, what would be the factors which could have an impact on such initiative>>*

The SWOT matrix is a tool for identifying and understanding the internal and controllable (strengths and weaknesses) and uncontrollable external forces (opportunities and threats) affecting possible future training courses.

<p><b>STRENGTHS</b> <b>the areas, in which the training course is doing well</b></p> <ul style="list-style-type: none"> <li>• Which aspects of the training content and implementation method were effective?</li> <li>• Which aspects of the training manual and recruitment strategy are useful?</li> <li>• What are the benefits of the training for the participants?</li> <li>• What competencies of the trainer help?</li> <li>• What capacities of the organisation would be useful for wider implementation?</li> </ul>	<p><b>WEAKNESSES</b> <b>specific areas we need to improve</b></p> <ul style="list-style-type: none"> <li>• Which methods, implementation strategies did not work?</li> <li>• Which content turned out to be the least useful and what was lacking?</li> <li>• What should be added to the training manual?</li> <li>• Which were the draw-backs of the recruitment strategy?</li> <li>• What could the trainees improve?</li> <li>• What trainers' capacities may be lacking in the organisation?</li> </ul>	<p>INTERNAL ANALYSIS</p>
<p><b>OPPORTUNITIES</b> <b>outside factors or situations that exist or may occur and that may contribute to the training success</b></p> <ul style="list-style-type: none"> <li>• What benefits could the trainees gain by completing the training?</li> <li>• What trends can support applying the lessons learnt in medical practice?</li> <li>• What structures are available where such training could be implemented?</li> <li>• Who (institutions, opinion leaders) could support future training implementation?</li> </ul>	<p><b>THREATS</b> <b>outside factors or situations that exist or may occur and that may affect the training in a negative way</b></p> <ul style="list-style-type: none"> <li>• What characteristics of participants may hinder successful training?</li> <li>• What are the institutional barriers to applying the skills acquired during training at work?</li> <li>• What are the barriers to future use of training (e.g. in the formal education system)?</li> <li>• Are there other competing needs that would prevent training and/or application of the lessons learnt?</li> </ul>	

POSITIVE FACTORS

NEGATIVE FACTORS

Please enter text here:

**STRENGTHS:**

**WEAKNESSES:**

**OPPORTUNITIES:**

**THREATS:**

