



HEALTH  **LGBTI**

REDUCING HEALTH INEQUALITIES EXPERIENCED BY LGBTI PEOPLE

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TASK 2: Qualitative research - Focus groups studies with LGBTI people and health professionals

D2.1 Final overview report on the outcomes of the focus groups

June, 2017

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Health4LGBTI website: http://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en.htm#fragment2

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Executive summary

Aims

This document reports on Task 2 of the project *Health4LGBTI: Reducing health inequalities experienced by LGBTI people* (SANTE/2015/C4/035). This is a pilot project by the European Commission to increase understanding of how best to reduce specific health inequalities experienced by lesbian, gay, bisexual, trans and intersex (LGBTI) people. Task 2 sought to map the barriers faced both by LGBTI people and healthcare professionals (HCPs) in six European Member States (MS), and support the development of training for healthcare professionals (HCPs).

Methods

Two focus group studies were conducted in each of the six participating European MS (Belgium, Bulgaria, Italy, Lithuania, Poland and the UK). The first study involved six focus groups with LGBTI people (n=52), and the second study involved six focus groups with health professionals and/or specialists (n=51). A further six in-depth semi-structured interviews (n=6) were conducted with LGBTI health professionals.

Results

What are the healthcare inequalities facing LGBTI people?

The findings showed that there are key health inequalities experienced by LGBTI people across the six European Member States. These included: a lack of knowledge on the part of HCPs around LGBTI-specific health issues; healthcare systems that are ill-equipped to deal with the complexities of gender identity; laws and policies restricting access to healthcare and preventing trans people in particular from accessing appropriate medical services. LGBTI people experience discrimination when using healthcare, however, the experiences and needs of intersex people were rarely noted. Experiences which may be seen as minor or insignificant by non-LGBTI people can have a serious impact on LGBTI people.

What are the barriers in accessing healthcare services for LGBTI people?

LGBTI people said that there were barriers facing them when they tried to access healthcare. LGBTI people are still being refused healthcare services. Because LGBTI people experience discrimination, this acts as a barrier to accessing health services. Patients' ability to be open with their HCPs, which is connected to experiencing good healthcare, is limited by assumptions that all patients are heterosexual, cisgender and/or non-intersex and repeated experiences can result in LGBTI patients avoiding healthcare services altogether. Societal stigmas, 'shame' and national politics can be barriers to accessing healthcare by LGBTI people. There are specific barriers encountered by groupings within 'LGBTI', particularly bisexual, trans and intersex people and intersections with class, race/ethnicity and age are not well recognised by HCPs. LGBTI people in rural areas are believed to be particularly affected by anti-LGBTI attitudes.

What are the barriers for HCPs in providing care for LGBTI people?

The barriers faced by HCPs in trying to provide healthcare for LGBTI people echoed some of those experienced by LGBTI people themselves. One of the key barriers identified by this research was that HCPs assumed that LGBTI people did not face discrimination in accessing healthcare services. Some HCPs believed LGBTI people were contributing to their own marginalisation. Many HCPs were not aware that assumptions that patients are heterosexual/cisgender/non-intersex are barriers to

LGBTI people, and that this assumption itself was a key barrier for HCPs to providing appropriate healthcare services for LGBTI people. The idea that LGBTI issues are too niche to study can result in ill-equipped HCPs and negative experiences for LGBTI people and HCPs can find it difficult to challenge anti-LGBTI attitudes from both patients and colleagues. Institutional policy and care pathways can lead to some LGBTI people being rendered non-existent or incomprehensible at an administrative level, challenging HCP's attempts to provide healthcare services for them. Both policy-led and culture-shifting approaches were recommended by LGBTI people and HCPs to tackle existing barriers.

What kind of training do LGBTI people think HCPs need?

LGBTI people had specific and detailed ideas about the training needed by HCPs. The research found that training for HCPs should raise the importance of being visible and identifiable as LGBTI-friendly for LGBTI patients. This includes aligning training and LGBTI-friendly HCPs with LGBTI-inclusive signage. Some LGBTI people actively seek out LGBTI-friendly HCPs and LGBT identified HCPs, who may be seen as more accepting and approachable, as well as knowledgeable around 'in-group' issues. Current HCPs need to be updated on the most recent literature on LGBTI issues, particularly regarding trans and intersex people. HCPs' training was connected to making wider societal changes in the acceptance of LGBTI people and LGBTI people believed that HCPs' training could contribute to this, as well as enhancing experiences of healthcare. LGBTI people wanted supportive HCPs to use their connections and influence to promote positive attitudes towards LGBTI people, or at least erase open discrimination as a form of informal 'training'.

What kind of training do HCPs think HCPs need?

HCPs highlighted the absence, or outdated nature of, LGBTI specific training in medical training, which needed to be addressed. Changes to student training it was argued, need to be complimented with training for those already in HCP positions. Although many respondents suggested that HCPs would only listen to other HCPs, they also believed that LGBTI people could and should be involved in delivering training. A focus on the diversity of LGBTI lives was needed as training focused around presenting 'normal' LGBTI lives would exclude some LGBTI people. HCP respondents argued that training on LGBTI issues needs to be mandatory for all staff on a healthcare site, not just medical professionals. Senior staff were seen to have an important role in leading by example and small numbers of staff with additional formal training in LGBTI issues could support their under-equipped colleagues.

Conclusions

There are ongoing inequalities and barriers in LGBTI healthcare in the EU. Specific groupings within 'LGBTI' – particularly bisexual, trans and intersex people – encountered their own specific barriers relating to their sexual orientation, gender identity and/or sex characteristics. Bisexuals and intersex people were only rarely mentioned in the data. Training needs to be universal and mandatory, covering a range of experiences. This could have broader societal implications for the inclusion of LGBTI people.

Recommendations cover frequency and organisation of training, content of training, changing institutional cultures, and future research directions.

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List of abbreviations

AIDS	Acquired immune deficiency syndrome
CAIS	Complete Androgen Insensitivity Syndrome
CoE	Council of Europe
CSR	Comprehensive Scoping Review
DSD	Disorders of Sex Development
DSM-5	Diagnostic and Statistical Manual of Mental Disorders V5
EC	European Commission
EP	European Parliament
EU	European Union
FGR	Focus Group Report (this report)
FRA	Fundamental Rights Agency
HCP	Healthcare Professional
HIV	Human Immunodeficiency Virus
ICD-11	International Classification of Diseases V11 R
LGBTI	Lesbian, Gay, Bisexual, Trans, and Intersex
MS	Member State
MSM	Men who have Sex with Men
RR	Rapid-Review
SOGI	Sexual Orientation and Gender Identity
STI	Sexually Transmitted Infection
SR	Scientific Review
SSR	State of the Art Synthesis Report
TGEU	Transgender Europe
UN	United Nations
UNDP	United Nations Development Programme
UNPFA	United Nations Populations Fund
WHO	World Health Organisation
WSW	Women who have Sex with Women
PACE	Parliamentary Assembly Council of Europe

Glossary of key terms

Here we provide some of the most commonly terms used throughout this report. They are taken directly from ILGA-Europe’s most commonly used phrases and acronyms which can be found here: www.ilga-europe.org/resources/glossary.

Cisgender	A term referring to those people whose gender identity and gender expression match the sex they were assigned at birth.
Gay	Refers to a person who is sexually and/or emotionally 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.
Gender	Refers to a social construct which places cultural and social expectations on individuals based on their assigned sex.
Gender expression	Refers to people's manifestation of their gender identity to others, by for instance, dress, speech and mannerisms. People's gender expression may or may not match their gender identity/identities, or the gender they were assigned at birth.
Gender identity	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 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.
Homosexual	People are classified as homosexual on the basis of their gender and the gender of their sexual partner(s). When the partner's gender is the same as the individual's, then the person is categorised as homosexual. The term focuses on sexuality rather than on identity and may, in some contexts, have a negative and pathologising connotation.
Intersex	Relates to a range of physical traits or variation that lie between binary ideals of male and female. Intersex people are born with physical, hormonal or genetic features that are neither wholly female nor wholly male; or a combination of female and male; or neither female nor male. Many forms of intersex exist; it is a spectrum or umbrella term, rather than a single category.
Heteronormativity	Refers to the set of beliefs and practices that gender is an absolute and unquestionable binary, therefore describing and reinforcing 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'.
Heterosexism	Heterosexism is a set of discriminatory attitudes, bias and behaviours relying on gender as a binary to favour heterosexuality and heterosexual relationships.
Queer	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
Sex	The classification of a person as male or female. Sex is assigned at birth and written on a birth certificate, usually based on the appearance of their external anatomy and on a binary vision of sex which excludes intersex people. A person's sex however, is actually a combination of bodily characteristics including: chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics.

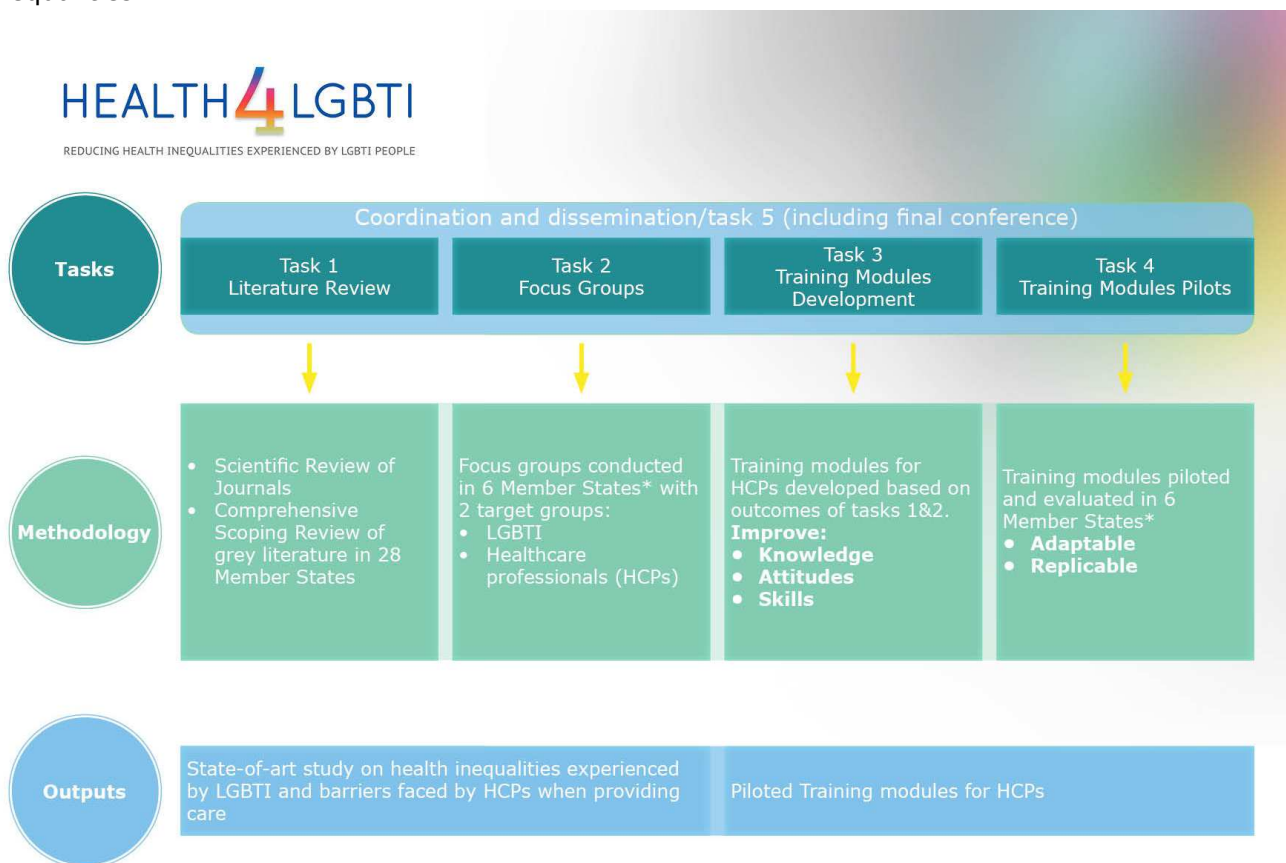
<p>Sex characteristics</p>	<p>A term that refers to a person's chromosomes, anatomy, hormonal structure and reproductive organs. OII Europe and its member organisations recommend protecting intersex individuals by including sex characteristics as a protected ground in anti-discrimination legislation. This is because many of the issues that intersex people face are not covered by existing laws that only refer to sexual orientation and gender identity. This is seen as being a more inclusive term than 'intersex status' by many intersex activists, as it refers to a spectrum of possible characteristics instead of a single homogenous status or experience of being intersex.</p>
<p>Sexual orientation</p>	<p>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.</p>
<p>Trans</p>	<p>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.</p>
<p>Transsexual</p>	<p>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).</p>
<p>Transition</p>	<p>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.</p>

SECTION ONE: Background

1.1 The Health4LGBTI Project

Health4LGBTI: Reducing health inequalities experienced by LGBTI people (SANTE/2015/C4/035) is a pilot project of the European Commission to increase understanding of how best to reduce specific health inequalities experienced by lesbian, gay, bisexual, trans and intersex (LGBTI) people, focusing in particular on overlapping inequalities stemming from discrimination and unfair treatment on other grounds (e.g. age, ethnicity, disability).

Through action on five key Tasks (Figure 1 below) over two years (2016-2018), the project will explore the particular health needs and challenges faced by LGBTI people, and analyse the key barriers faced by health professionals when providing care. The aim is to raise awareness of the challenges and provide European health professionals with the tools by giving them the right skills and knowledge to overcome these barriers, and thereby contribute to the reduction in health inequalities.



(*) The 6 Member States are: Belgium, Bulgaria, Italy, Lithuania, Poland, UK

Figure 1: The Health4LGBTI Project.

1.2 The Health4LGBTI Consortium

The Health4LGBTI project is led by Verona University Hospital in Italy (Figure 2 below). The wider consortium represents a partnership between EuroHealthNet (a health inequalities network based in Belgium), Verona University Hospital (a University Teaching Hospital in Italy), University of Brighton (Centre for Health Research, School of Health Sciences, in the UK), the National Institute for Public Health-National Institute of Hygiene (a Public Health body in Poland) and ILGA-Europe (the European region of the International Lesbian, Gay, Bisexual, Trans and Intersex Association).

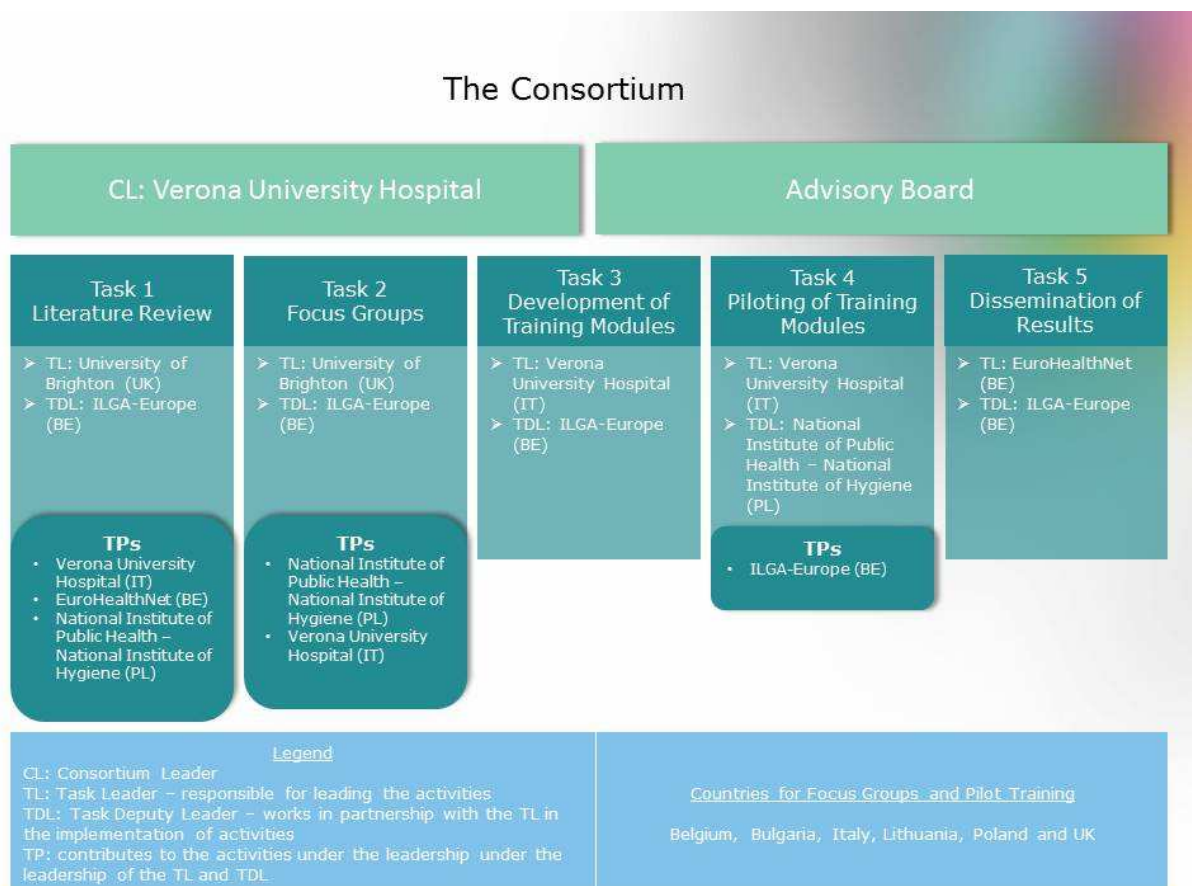


Figure 2: The Health4LGBTI project consortium

1.3 About Task 2

This report represents the findings from the two qualitative research studies as set out in Task 2 of the LGBTI project. The overall aim of Task 2 was to conduct two focus group studies to map the barriers faced both by LGBTI people and health professionals in six European Member States (Belgium, Bulgaria, Italy, Lithuania, Poland and the UK) representing diverse geographical regions of Europe (North West Europe, Central Europe, Southern Europe, and Eastern Europe). These focus groups were supplemented with individual interviews with LGBTI individuals, including LGBTI-identified HCPs (see Section 2 for details). Building also on the outcomes of Task 1 (D1.1; see Zeeman *et al.*, 2017a), the findings from these focus groups are intended to inform the development

of the training modules for Task 3 and Task 4 of the project (see Figure 2) as well as identify key areas for further research beyond this European pilot study.

Co-led by the University of Brighton with ILGA-Europe in collaboration with all Consortium partners, specific objectives of Task 2 were to:

- To gain a better understanding of the specific **health inequalities experienced by LGBTI people**, focusing in particular on overlapping inequalities stemming from discrimination (also unintentional) and unfair treatment on other grounds (e.g. age, disability, socioeconomic status, race and ethnicity).
- To gain a better understanding of the **barriers faced by health professionals** when providing care to these groups (including health promotion and mental health services).

1.4 About this report

This final overview report on the outcomes of the focus groups (and additional individual interviews) is divided into **four key Sections** as follows:

Following this first **introductory Section** which sets the context for the qualitative research studies, **Section Two** outlines the protocol and methods used. **Section Three**, presents the findings from the two qualitative studies and the main conclusions. Finally, **Section Four** presents the conclusions of the report and a series of recommendations and insights for future research based on the findings.

An **Appendix** includes further selected key quotes and stories, for use in developing training packages.

SECTION TWO: Protocol and Methods

2.1 Methods

2.1.1 Design

The design of this study was a cross-sectional qualitative study comprising focus groups and in-depth semi-structured interviews. Focus groups formed the main bulk of the data collection, with interviews supporting the method where the participant either did not want to take part in focus groups, or where specific individuals were targeted.

All participants across the six countries were informed fully about the focus groups and interviews they were asked to participate in. This was achieved through attention to excellence and established best practice in research and ethical procedures with vulnerable populations. Ethical approval was received on 12th April 2016 from the University of Brighton's College of Life, Health and Physical Sciences Research Ethics Committee. Where required, additional ethical approvals were also obtained for Italy and Poland.

2.1.2 Procedure

Focus Groups

Two focus groups with a maximum of ten (10) participants in each group, were run in each of the six participating MS: Belgium, Bulgaria, Italy, Lithuania, Poland and the UK.

The two groups comprised:

- 1) Diverse **members of the LGBTI population** (with a specific focus on the inclusion of intersectionalities of marginalisation, e.g. young/older LGBTI people, women, trans and intersex, lower socio-economic groups, rural communities)
- 2) Diverse **health professionals and/or specialists** with an interest in the equitable delivery of LGBTI healthcare (e.g. GPs, nurses, mental health workers, midwifery, social care staff).

The following **indicative areas** were explored: experiences of health and social inequalities; examples of good practices (e.g. efforts made on visibility of LGBTI people, existing training initiatives of health professionals, code of mutual respect, etc.); risks and resilience for LGBTI people; barriers for health/social professionals; issues relating to communication and confidentiality.

The LGBTI focus groups were facilitated by individuals with expertise in LGBTI and/or health issues and experience of facilitation, represented by Consortium partners for Italy, the UK, and Poland. In Belgium, Bulgaria and Lithuania, ILGA-Europe assisted in identifying appropriate experts to facilitate the focus groups in those countries. In line with the focus group study protocol (available on request), 're-fresher' training in organising, recruiting, running, and reporting on focus groups was provided

by the University of Brighton where specifically requested¹. The health professionals' focus groups were facilitated by a health expert with experience of facilitation, to provide a 'safe/neutral space' for the discussions.

Focus groups were conducted in venues assessed by local partners to be discreet, accessible and safe for participants, as well as appropriate for focus groups.

Individual Interviews

For added value and to create additional depth and nuance to the data generated from the LGBTI and health professionals' focus groups, further efforts were made to identify and engage, through qualitative interviews with selected health professionals who also identified as LGBTI. As anticipated, a total of six individual interviews were conducted with health professionals who identified as LGBTI (one per country). These interviews used the topic guide for health professionals². Demographic data for these participants is not available.

2.2 Participants and recruitment

2.2.1 LGBTI Participants

Participants were recruited through purposeful and snowball sampling techniques with the aim of recruiting samples related to the local context and including diverse representation of groups that typically experience additional marginalisation (e.g. older/younger people, migrants, disability, socio economic disadvantage, minority ethnic/religious background, intersex, trans, bisexual, female, Roma, rural isolation, etc.). See Table 1 for demographic details of LGBTI people. Whilst members of each of these additionally marginalised groups were represented in the research there were difficulties recruiting larger numbers. For example, only 3 intersex and 2 regionally isolated LGBTI people were recruited. See the findings in Section 3.3.4 around diversity within the LGBTI grouping.

In the three partner countries (Italy, Poland, and the UK) recruitment was led by the respective project partners. For Belgium, Lithuania and Bulgaria, the consortium partner ILGA-Europe identified appropriate experts to facilitate the focus groups in those countries and, in doing so, also oversaw the recruitment. In order to be eligible to participate in the study participants had to: be a self-identified LGBTI individual, be aged 18 or over, explicitly provide informed consent, and be articulate in an official language of the host country. They were not able to take part if they could not understand sufficient language to participate in a discussion about healthcare services and unable to provide informed consent.

1 Poland (training provided in July 2016), Bulgaria and Lithuania (training provided in August 2016).

2 Available on request.

		BELGIUM (N=7)	BULGARIA (N=13)	ITALY* (N=5)	LITHUANIA (N=9)	POLAND (N=8)	UK (N=10)
SEX	Male	2	6	1	7	4	5
	Female	3	6	4	2	4	2
	Other	2	1	0	0	0	1
	Missing	0	0	0	0	0	2
GENDER	Male	2	7	3	4	4	5
	Female	2	6	2	4	3	2
	Other	3	0	0	1	1	2
	Missing	0	0	0	0	0	0
SEXUAL ORIENTATION	Gay	2	3	1	2	4	5
	Lesbian	1	4	2	1	4	2
	Bisexual	1	1	0	3	0	1
	Heterosexual	0	3	1	1	0	2
	Other	3	2	1	2	0	0
	Missing	0	0	0	0	0	0
GENDER IDENTITY	Trans / questioned gender identity	3	5	2	3	1	3
SEX CHARACTERISTICS	Intersex	1	1	1	0	1	0
ADDITIONAL MARGINALISED GROUPS	Disabled	0	0	0	1	1	5
	Economically disadvantaged	2	0	0	3	1	2
	Regionally / geographically isolated	1	0	0	1	0	-
AGE RANGE	(AVERAGE)	26-45 (33.1)	20-49 (34.5)	30-63 (43.0)	20-53 (29.1)	25-40 (32.8)	31-62 (45.8)

Table 1: Demographics of LGBTI People (n=52)

2.2.2 Healthcare Professionals (HCPs)

HCP participants were recruited by local study teams (and by ILGA-Europe members in Belgium, Bulgaria, and Lithuania) based on professional and community contacts, providing diverse sampling related to the local health service context³. In order to be eligible to participate in the study participants had to hold an identified professional role in health services, be aged 18 or over, be articulate in an official language of the host country, and explicitly provide informed consent. Some HCPs identified themselves as LGBTI. See Table 2 (next page) for demographic details of healthcare professionals.

³ In the UK all of the healthcare professionals were recruited through known networks and LGBTI groups. They were not recruited through the National Health Service (NHS).

		BELGIUM (N=6)	BULGARIA (N=8)	ITALY* (N=10)	LITHUANIA (N=11)	POLAND (N=9)	UK (N=7)
SEX	Male	2	3	2	5	6	3
	Female	4	5	6	6	3	4
	Other	0	0	0	0	0	0
	Missing	0	0	0	0	0	0
GENDER	Male	1	3	6	5	6	3
	Female	2	5	2	5	3	3
	Other	0	0	0	1	0	1
	Missing	2	0	0	0	0	0
SEXUAL ORIENTATION	Gay	2	0	0	2	0	1
	Lesbian	1	0	0	0	0	1
	Bisexual	0	0	2	1	1	1
	Heterosexual	3	5	6	7	7	3
	Other	0	1	0	1	1	1
	Missing	0	2	0	0	0	0
GENDER IDENTITY	Trans / questioned gender identity	0	1	0	0	0	2
SEX CHARACTERISTICS	Intersex	0	0	0	0	0	0
ADDITIONAL MARGINALISED GROUPS	Disabled	0	1	0	0	0	1
	Economically disadvantaged	0	0	0	1	0	0
	Regionally / geographically isolated	0	0	0	0	0	0
AGE RANGE	(AVERAGE)	26-68 (39.6)	31-56 (43.5)	31-67 (48.5)	25-58 (33.8)	26-70 (43.4)	30-60 (46.6)

* Demographic data missing for n=2

Table 2: Demographics of Healthcare Professionals (n=51)

2.3 Data analysis

Focus group and interview data were explored separately. An initial analysis matrix was produced which included a series of key thematic codes based on the project's objectives and the SR (Zeeman *et al.*, 2017b) and CSR (Zeeman *et al.*, 2017c). Qualitative thematic analysis was used to inductively (from the data) and deductively (based on the project's objectives and indicators) analyse the interviews, with new emerging thematic codes logged and added to the analysis matrix. The full analysis was carried out using NVivo qualitative data analysis software. A final overview report was sent to consortium partners for further discussion and input. For this report, direct quotes are coded using an abbreviated location, a participant number, and marker (LGBTI or HCP) to ensure anonymity.

SECTION THREE: Findings

3.1 Introduction to findings

In Section Three, we report on findings from the qualitative data generated via the focus groups and individual interviews around five key questions:

- 1) What are the healthcare inequalities facing LGBTI people?
- 2) What are the barriers in accessing healthcare services for LGBTI people?
- 3) What are the barriers for HCPs in providing care for LGBTI people?
- 4) What kind of training do LGBTI people think HCPs need?
- 5) What kind of training do HCPs think HCPs need?

Direct quotations are used to evidence and emphasise particular findings. In some places, extended discussions are presented in boxes as 'case studies'. These case studies offer an in-depth and nuanced exploration of some of the issues involved in providing appropriate, inclusive healthcare for LGBTI patients. It is hoped that these quotations and case studies will be useful in developing training packages for HCPs.

3.2 What are the healthcare inequalities facing LGBTI people?

3.2.1 Introduction

A wealth of empirical research and related grey literature already exists which identifies and analyses the variety of healthcare inequalities facing LGBTI people (see Zeeman *et al.*, 2017a, 2017b, 2017c). Based on data gathered through the focus groups and interviews with LGBTI people (including some LGBTI-identified HCPs), here we outline three key areas of healthcare inequality that extend the literature reviewed:

- Lack of specialist healthcare and knowledge around LGBTI-specific health issues;
- Legal, administrative and bureaucratic inequalities;
- Poor treatment and active discrimination from staff in healthcare facilities.

3.2.2 Lack of specialist healthcare and knowledge around LGBTI-specific health issues

The data indicates that LGBTI people do not expect healthcare providers to be knowledgeable about their healthcare. LGBTI people are an extremely diverse group, and there are health issues which were seen by participants in the focus groups to be of greater significance to them than to non-LGBTI people. One particular concern expressed in the data pertains to sexual health and sexually-transmitted infections (STIs). Whilst LGBTI people are seen as a key risk population for STIs (Zeeman *et al.*, 2017a: 33), HCP's specialist knowledge in these areas was seen to be desirable:

BG LGBTI [4]: We're much more likely to suffer from Hepatitis, venereal disease, AIDS etc... When our GP or any medical specialist is aware of that part of our lives, it is much more likely

⁴ Speakers were not distinguished in Bulgarian transcripts.

that if they are well-educated and good at their jobs they will diagnose some of our health problems earlier and faster than if we are hiding our sexual orientation. This applies to every aspect of life. The fact that it's not acceptable in Bulgaria to share our sexual orientation impacts on the health services and any other services negatively.

Bulgaria LGBTI Focus Group

This Bulgarian respondent highlights the importance of knowledge around sexual health issues and STIs for many people in the LGBTI grouping. Crucially, they add that being 'out' to HCPs about their sexual orientation is a factor in receiving good care around sexual health.

Although sexual health issues and STIs are commonly associated with LGBTI communities by both LGBTI and non-LGBTI people, a much wider variety of health issues need to be considered when developing engagements with LGBTI health. For example, this respondent highlights a connection between particular forms of cancer and gay men's sexuality:

PL LGBTI HCP 1: I remember one problem for an elderly gay who had prostate cancer. He was looking for a urologist and sexologist to find out about sexuality after this procedure. Unfortunately for him he was unable to find a specialist in [country] who would know or be interested in this subject especially in homosexual men... Everyone says they do not know and they don't even know where to refer those patients.

Poland LGBTI HCP Interview

Sex and sexuality are not only a matter of STIs but also of wider significance to many health issues such as living a full life after prostate cancer. In this instance, not only were healthcare specialists unable to give this elderly gay man information about sex following his cancer treatment, but they were also unable to even refer him to anyone with that information. The lack of key information about LGBTI-specific impacts of health problems which appear, at first glance, not to be related to LGBTI identities, is a healthcare inequality.

Whilst much ostensibly 'LGBT' or 'LGBTI' research tends to be dominated by the 'LGB' (and more usually Lesbian and Gay) sexual orientation component, in this research trans lives emerged as a regular topic and many discussions in each country concentrated on trans-specific issues and experiences (intersex lives, however, remained marginal - see Section 3.3.4). Throughout the focus groups and interviews, healthcare professionals and LGBTI individuals expressed concerns around the general lack of knowledge – both medical and cultural – amongst healthcare providers with regard to issues of sexual orientation and especially gender identity. This lack of knowledge was also identified as a key theme in the report by Zeeman *et al.*, (2017b; especially pages 43-44). Discussing trans people in the UK, this respondent related their experience as a trans person with local HCPs:

UK LGBTI 7: She referred me to my local mental health trust over in [area]. And they took me on. The first [healthcare provider] talked with me and said, 'well, I know nothing about gender identity, I don't know how to help you. Who can help you?' I said, [name of health centre specialising in trans people]? "Oh, would they...?" I explained about the [health centre]. "Oh, didn't know that existed". He referred me, so that was a long... It was malice to start with, then incompetence on the next.

UK LGBTI Focus Group

Here we see that the trans person in question had greater knowledge of trans healthcare pathways than did their HCP. This lack of knowledge emerged as a particular concern for trans people, who were worried about being physically harmed during medical components of transition:

BG LGBTI: We need special attitudes and well-educated doctors to benefit from. Otherwise, they can damage us because they don't know us and the processes that we're going through. I also don't know exactly how my body is changing. I know why it is changing but I don't know whether I do things that damage it; whether my transition is damaging it in any way; I haven't got the slightest idea. Because there isn't a doctor to say to me that everything is fine or not fine.

BG Facilitator: So, doctors know this very poorly.

BG LGBTI: Yes, doctors don't know the specifics of a transition very well. I don't know if they even study this at the university at all.

Bulgaria LGBTI Focus Group

The lack of knowledge around LGBTI healthcare issues can be a dangerous inequality to face, because a lack of knowledge can lead to physical (as well as psychological and social) harm. Furthermore, whilst trans lives are becoming more widely known across the EU (Zeeman *at al.*, 2017b: 19-20), existing medical models may be unable to deal with the lived complexities of gender identities. This may have a knock-on impact on what kinds of treatment people can get, particularly if they do not identify within a gender binary:

UK LGBTI HCP 1: In order to call yourself trans, and even trans people say this, you need to have a "diagnosis", using inverted commas... But what [trans advocacy] has done is to really sort of broaden out the range of gender expression and gender identities and people now don't talk about binary genders. They talk about gender transition, going from one gender to another and there's much more fluidity in people's gender expression and in gender identity. We talk about having non-binary identity. And these don't fit naturally or easily into the pathological model... If there isn't a pathology that you're trying to fix, that really flies against the healthcare model that we are brought up with.

UK LGBTI HCP Interview

To conform to healthcare models, trans people recognise that they are required not only to fit binary genders but also to fit particular established medical 'pathologies'.

3.2.3 Legal, administrative and bureaucratic inequalities

There are particular legal, bureaucratic, and administrative policies and processes which were seen as leading to an unequal healthcare situation for LGBTI people. This was raised particularly regarding LGBTI people's partners and families:

PL Facilitator: What about this situation: two women bring up a child. If there is an accident and the child is with the second, not birth mother. They go to A&E [Accident & Emergency]. That mother in the eyes of law has not got parental responsibility; she does not have a right to...?

PL LGBTI 1: She has not got a right to agree to non-life-threatening surgeries. She would have to get the agreement from the parent with parental responsibility... This is the case of

the lack of formal recognition of same sex partnerships creating serious disadvantages for these children.

Poland LGBTI HCP Interview

In this case, Polish law restricts the same-sex parent's right to make important medical decisions for her child. However, as this respondent points out, it is not only that the same-sex parent is treated unequally, but also that there is a risk to the child who is left without a parent's ability to intervene in their healthcare. These legal inequalities extend beyond LGB people themselves and impact on the health of their families (Zeeman *et al.*, 2017b:19).

On the other hand, the rights of parents to make decisions for their children was also highlighted as potentially negative for LGBTI children themselves. In this situation, the parents use their authority to shut down discussion of a young trans person's 'underlying internal core self-issues', which this HCP identified as central to the child's distress:

UK HCP 6: It gets really tricky with parents going, "No, I'm not having this. Nothing to do about gender." And then the young person, one-to-one is saying, "I don't want to grow into a woman, it's really torturing me." The parents are not on board and the unit get split... Gender does get pushed away a lot... If they're not addressing the underlying internal core self-issues, that's where I get really frustrated.

UK HCP Focus Group

A young LGBTI person's inability to influence their own healthcare with regard to their LGBTI status can be immensely difficult to deal with, to the point where it feels like 'torture'. In both this case and the previous one, LGBTI people and their families can experience unequal treatment in healthcare in part due to existing legal and administrative policies, processes and guidelines, specifically regarding being LGBTI in familial relationships. These kinds of legal inequalities for LGBTI people, then, can impact on more than just LGBTI people themselves but also people connected with them.

In addition to partners and families, these kinds of bureaucratic features were also seen as resulting in inequalities in access to medical treatments and procedures. National laws were a key factor in LGBTI people's discussions around their experiences of unequal access to healthcare:

LT Facilitator: Can LGBTI people access all necessary health services across Lithuania in the same way to other people?

LT LGBTI 1: No

LT Facilitator: I mean not LGBTI people. If no, then why?

LT LGBTI 1: Well, some services are illegal according to Lithuanian law.

LT Facilitator: Mhm, those specifically related to trans people's needs. I understand.

Lithuania LGBTI Focus Group

In this instance, seemingly LGBTI people cannot access healthcare in the same way that other people can. This is then specifically related to trans people who it is inferred cannot get access to particular healthcare relating to gender reassignment (medication and/or surgeries). Respondents in other countries raised exactly the same issue for trans people, suggesting once more that trans people encounter some of the strongest inequalities in their healthcare (though by no means only trans

people – see Box 2). Whilst some intersex people may seek medical intervention, this did not appear in these discussions. This may indicate a lack of awareness of the specific needs and experiences of intersex people (see also Zeeman *et al.*, 2017a, 2017b, 2017c).

Box 2: 'Why don't you just wear condoms?'

UK LGBT 3 shared his story of getting a particular form of medication; Pre-Exposure Prophylaxis (PrEP). This medication greatly reduces the risk of contracting HIV, but in the UK it is not available on the NHS and must be prescribed privately. UK LGBTI 3 wanted to take PrEP to protect himself from HIV whilst having unprotected sex with other men. He explained that he *'didn't want to have the doctor look down at me and say "Why don't you just wear condoms?"'*. Instead, he lied to his doctor and pretended that he had an HIV+ boyfriend. The doctor prescribed PrEP for him, and he has since encouraged friends in the same situation to use the same story.

UK LGBTI 3 says that it is the difficulty of having discussions around unprotected sex with HCPs which lead to him lying: *'It's a bit sad that we can't actually have a conversation with our GP where there aren't all the kind of prejudices that come out of the woodwork. If you were a straight woman, for instance, and you go to your GP and say, "Can I go on the pill, please?", he doesn't turn around and say "Why don't you just wear a condom?"'*

UK LGBTI 3 sees a real inequality for gay and bisexual men in getting access to PrEP, which he considers to be important medical care. Whilst women's access to contraception may not be as easy and stigma-free as UK LGBTI 3 suggests, his testimony shows that gay/bisexual men's unprotected sex is still highly stigmatised even within LGBTI communities, and that health inequalities and the fear of encountering stigma from HCPs contributes to these tense relationships with HCPs.

UK LGBTI Focus Group

3.2.4 Poor treatment and active discrimination from staff in healthcare facilities

Although attitudes towards LGBTI people throughout Europe are often said to have greatly improved in recent decades (Kuyper *et al.* 2013), LGBTI people still experience negative attitudes and outright discrimination including from HCPs (Zeeman *et al.*, 2017b; Zeeman *et al.*, 2017c). This extends to healthcare, and the experiences relate to both intervention from professionals and from non-clinical staff. LGBTI respondents in the focus groups and interviews shared numerous examples of this. For instance, this trans respondent from Lithuania disclosed a story of transphobia:

LT LGBTI 2: I feel horrible when they refer to me as 'she' only because it is in my documents... There was a situation. I went to see an eye doctor, and they referred to me as 'she', 'she', 'she', 'she'. I felt horrible, I hate to hear this. Hence, I try not to go there.

LT LGBTI 9: Did you ask them to refer to you as "he"?

LT LGBTI 2: I did. Funnily, when I came they were saying 'he', 'he', then they read 'she' in my documents and that was it. I was referred to as 'she' for the rest of my visit.

Lithuania LGBTI Focus Group

Despite initially presenting himself as 'he' and expressly asking the healthcare staff to use the male pronoun, this respondent nevertheless was repeatedly and insistently misgendered. Misgendering is one of the most common forms of transphobia and is experienced by virtually all trans people, and it can have extremely serious impacts (see Zeeman *et al.*, 2017b:20). As this respondent notes, he *'tr[ies] not to go there'* and later explained that he now only visited private healthcare clinics which accepted his gender identity.

Throughout the focus groups and interviews LGBTI people identified and discussed numerous examples of healthcare inequalities resulting from discriminatory and stigmatising treatment by healthcare staff. Whilst to non-LGBTI people some of these examples may seem to be minor or even insignificant, the data shows that such experiences can have serious impacts.

IT LGBTI 3: There was a particular [HCP] that was right on the mouth of all gays as the one not to go to, because he was really not able to manage LGBTI people. He was judgmental, made jokes or anyway hints, to make you understand that he thought bad of gay sex... These [people] were vulnerable in their HIV status. It was so trivial asking to change doctor, yet they suffered. And only thanks to the internal work of the [HIV support group] where some of us said 'Excuse me, but why? Change! Why should you suffer?' Also because the result was that they put off as much as possible the time to go for the analysis, or even just called for the results because they did not actually go to the visits. Or just said nothing. They lie. Omit.

Italy LGBTI Focus Group

In this case 'jokes' or even just 'hints' means that LGBTI people avoided seeing a HCP, avoided receiving healthcare, and lied or omitted information when dealing with their HIV infection. These respondents' experiences and avoidant practices have also been identified in the wider literature (Zeeman *et al.*, 2017c:23). Perhaps as a result of negative experiences, positive interactions between LGBTI patients and healthcare professionals which may also be seen as minor or insignificant could be experienced as profoundly important and moving. One UK respondent explained that they believe that trans people have become so used to poor healthcare experiences that they have internalised simply not being actively discriminated against as a 'super-excellent experience' – even when they experience poor healthcare outcomes:

UK LGBTI 6: [Cisgender people] are like, oh gosh, that all sounds so terrible [but] to me it just sounds completely normal. That's every trans person I know's experience... Often we think of not being treated badly as super-excellent experiences... There was a point where I went, oh yes, actually I suppose sometimes I go and see healthcare professionals about things that are completely unrelated to the fact that I'm trans, and when they ask me about what medication I'm on or what surgery... and I tell them, they don't blink. And that's an excellent experience. That's like, I go home and I tell people, "Wow I had a really good experience in healthcare today. We didn't get a diagnosis of the thing I wanted, they don't know how to treat me, they're going to refer me from pillar to post and they've told me it's probably going to take nine months - but nobody blinked when I told them what hormones I was on!"

UK LGBTI Focus Group

This person's healthcare outcomes – "we didn't get a diagnosis... they don't know how to treat me... it's probably going to take nine months" – are not positive. However, due to previous experiences of transphobic discrimination it is seen as "a really good experience in healthcare". Due to previous minor instances of transphobic abuse ("nobody blinked when I told them what hormones I was on", suggesting that this had previously been an issue), minor instances of simply **not** experiencing abuse are internalised as positive outcomes.

3.2.5 Summary

This section has shown a number of key healthcare inequalities experienced by LGBTI people in six European Member States:

- LGBTI people identify a lack of knowledge on the part of HCPs around LGBTI-specific health issues – which are not limited to STIs;
- Trans people in particular feel that HCPs have a limited knowledge of trans lives and appropriate healthcare;
- Trans people are worried that this lack of knowledge will result in their physical harm;
- Healthcare systems are ill-equipped to deal with the increasingly-recognised complexities of gender identity;
- LGBTI people’s familial relationships are affected by laws and institutional policies;
- There are laws and policies restricting access to healthcare which is felt to be necessary by LGBTI people;
- Laws often prevent trans people in particular from accessing appropriate medical services;
- LGBTI people continue to experience discrimination in healthcare;
- The experiences and needs of intersex people were striking in their absence;
- Experiences which may be seen as minor or insignificant by non-LGBTI people can have a serious impact on LGBTI people.

3.3 What are the barriers in accessing healthcare services for LGBTI people?

3.3.1 Introduction

This Section covers specific barriers to accessing healthcare services which LGBTI people encounter. The Section is divided into four key areas: 1) Ongoing discrimination and refusal of treatment by HCPs; 2) assumptions that patient is heterosexual, cisgender and/or non-intersex; 3) diversity within LGBTI and intersectionality, and; 4) stigmatising attitudes and beliefs of wider society.

3.3.2 Ongoing discrimination and refusal of healthcare

LGBTI people continue to experience healthcare inequalities in the form of negative attitudes and discrimination from healthcare staff (see Section 3.2.4), and the wider literature shows that LGBTI people report worse treatment in healthcare setting than non-LGBTI people (Zeeman *et al.*, 2017b:17; see also Zeeman *et al.*, 2017a, 2017c). Such discrimination can become an active barrier to LGBTI people accessing appropriate healthcare services. Firstly, respondents discussed cases where they or people they knew had actually been refused healthcare due to being LGBTI. This respondent's trans friend was refused medical treatment due to previous gender reassignment surgery – note that it is not the reassignment surgery itself which was refused here, but later surgery in an affected area of the body:

PL LGBTI HCP 1: My friend that already had sex reassignment surgery from male to female - I am not sure how advanced it was - she told me that when she had laryngological problems, she was met with flouting and she was refused a treatment. Because they noticed she had an operation on her larynx to have her Adam's apple removed. She was treated really badly by at least two doctors.

Poland LGBTI HCP Interview

Another female respondent with a female partner shared a story in which, after explaining her same-sex relationship to her HCP, she was rushed out of a consultation without receiving proper healthcare for her STI:

LT LGBTI 7: Everything was written very fast. I said: "Wait, I want to know my diagnosis. Could you please write it for me on the separate piece of paper so that I could look for information online myself as you haven't explained a thing and because you are trying to get me out of this room." And then she wrote it with horrible handwriting that I could not understand... I said: "Wait, so if my current partner does not have this disease, how did it happen? Could it be inherited? Does my mum need to get checked" She replied: "Nothing, it is not possible. No." So she wrote everything and I left. Until now I am trying to resolve one problem. I am still thinking how long ago, how many years ago I had other partners as I should call them and let them know. I mean these are important health issues... I did not receive any answers and I cannot even do any research online because I cannot read what she wrote on that paper.

Lithuania LGBTI Focus Group

Despite assumptions amongst HCPs that denial of treatment based on LGBTI identity never happens (see Section 3.4.3), LGBTI respondents confirmed that open, active discrimination continues to occur and prevents access to healthcare services (for further evidence of this ongoing discrimination see Zeeman *et al.*, 2017a, and Zeeman *et al.*, 2017b).

Barriers to accessing services can also stem from other forms of discrimination, which can result in LGBTI people avoiding healthcare service altogether. Another trans respondent, this time from the UK, explained what happened the first time they told their GP that they were trans:

UK LGBTI 7: My GP went to the same church I did, and she immediately said "That's against my religion." I thought, "What?" "I can't treat you. I will not help you. You're opposing the Word of God." So I'm sitting listening to a sermon, and I said "Fine." I went away, thinking hard, what am I going to do. And then when I came into church that Sunday, a couple of deacons came up to me and said "Sorry, you can't come in." I said "Why?" Because she – my GP – has told the pastor and "Sorry, but you're excluded until you repent."

UK LGBTI Focus Group

In this situation, as described by UK LGBTI 7, not only did the GP refuse to provide healthcare services to her patient, she also unprofessionally disclosed confidential details of that patient's life and medical, resulting in the patient avoiding seeking healthcare services. Broken confidentiality and the fear this could create has been noted in reviews of the wider literature (Zeeman *et al.*, 2017b:34-35). In focus groups and interviews, LGBTI people shared experiences of multiple forms of discrimination resulting in the LGBTI patients not feeling able to seek healthcare services. Experiences of discrimination often lead to a fear or expectation of experiencing discrimination, which can itself act as a powerful barrier to accessing healthcare services for LGBTI people:

BG LGBTI: My GP has looked after me since I was a baby so I continued to go to her. She, however, continues to ask me the same question over and over again, recently she's given up asking it and began making inappropriate comments that I'm unlucky in my life (perhaps because I am single at my age). So, I have never discussed this topic with her. I've even attended some of my appointments accompanied by men for a number of reasons. I've had such moments and I can't do anything about it now. But she's a person whom I cannot trust.

Bulgaria LGBTI Focus Group

When experiencing these kinds of attitudes, whilst some LGBTI people said they felt able to confront and challenge their HCPs, others did not:

BG LGBTI: At the end of the day, you are in front of your doctor and you are vulnerable. You're not just a customer who had gone to a provider, you are dependent on that person. You depend on him for your life, for your health and with all these things. You can't just lose your temper with him.

Bulgaria LGBTI Focus Group

This last comment from a Bulgarian respondent highlights the issue of the relationship between LGBTI patients and their HCPs. When experiencing poor treatment, discrimination, or abuse, LGBTI people in focus groups and interviews often felt unable to continue experiencing it but also unable

to challenge it, resulting in their avoiding services altogether. Dependency on healthcare providers can be a matter of life or death and LGBTI respondents knew that they cannot afford to upset them.

3.3.3 Assumptions that patient is heterosexual, cisgender and non-intersex

Some LGBTI patients said that they did not want to be 'out' to their healthcare providers unless it was of clear medical, pathological relation to a health issue. However, this was not about seeing these issues as irrelevant, but more of a fear of being discriminated against or encountering stigmatising attitudes or ignorance:

LT LGBTI 9: LGBTI people don't want to be out because they fear being discriminated against. It is scary to go to see the doctor. My personal experience is that I get ready or I want to get ready to be open with the doctor, I feel like I want to finish these lies, I want to stop pretending to be someone else... I get all possible answers ready, but then when I see the doctor and tell them the truth they still don't understand me.

Lithuania LGBTI Focus Group

Much of the data from LGBTI patients suggests that it is precisely being treated as if they were heterosexual, cisgender and/or non-intersex, which makes them feel that they must avoid healthcare services:

BG LGBTI: I have been present during my female partner's medical consultations and when it comes to a gynaecological assessment they start with questions like: "Is it painful on intercourse?" etc. "You have to have more active sexual life as otherwise this and this might happen" ... It's not about discrimination, it's more about the fact that at one point you feel like you've been given an ice-cold shower. So, you immediately feel like you can't share anything with that doctor.

Bulgaria LGBTI Focus Group

IT LGBTI HCP 1: By default they somehow take it for granted that the person is cisgender and heterosexual. And then the user impacts with the protocol that does not recognise him and therefore the lack of recognition is institutional, and somehow creates the difference in status. So surely it's the protocols often that I think represent just a barrier⁵.

Italy LGBTI HCP Interview

Participants noted that problematic assumptions and phrasing used by healthcare professionals can have a considerable impact. Both of these respondents suggest that these assumptions on behalf of their HCPs puts a barrier up between them, meaning that they 'can't share anything with that doctor' and consequently will receive less appropriate healthcare (see also Zeeman *et al.*, 2017b:31; Zeeman *et al.*, 2017c:21-22). As this respondent explains:

IT LGBTI HCP 1: A gay person has different health needs from those of heterosexuals. So even the couple's relationship for example can affect medical issues but if in some way the person does not feel at ease and therefore does not declare to the operator of this relationship, the operator does not know a whole slice of the patient's life and therefore also the diagnosis might be wrong.

Italy LGBTI HCP Interview

⁵ See also Zeeman *et al.*, (2017a).

Other LGBTI respondents explained that these kinds of supposedly 'minor' assumptions can become difficult or impossible for people to deal with. This is due to their ongoing repetition throughout a person's life, or their healthcare experiences:

UK LGBTI 2: It's just too difficult to expect someone who has mental health issues to constantly explain to different areas. I can't do it anymore without it impinging on my health, so I've just given up... If they have to explain to ten different people what's wrong, over and over again, and then face different types of prejudices, depending on who you get, then they too might give up.

UK LGBTI Focus Group

LGBTI healthcare workers and patients also raised these issues as crucial barriers to seeking healthcare. One LGBTI patient explained that they would prefer to leave the healthcare service altogether, despite medical problems, rather than have to explain their sexual orientation to a healthcare professional:

BG LGBTI: The problems I was there with had nothing to do with my sexual orientation is one of the reasons... Why didn't I share any information – like it was mentioned earlier, I don't think that every doctor needs to know that. The attitude that I have received and the pressure that I have felt, on most occasions, have both created a barrier for me. It has made me think that I'd rather just pay the money, pick up my stuff, leave the consultation room and never ever come back there. I'd rather do that than sit down and give any information about myself. This is a pressure that I have felt towards me as a woman who doesn't have children, so just imagine what it would be if I go on and share any further information. So, if there have been any opportunities to avoid sharing, I have always gone with that.

Bulgaria LGBTI Focus Group

This respondent's story is supported by the existing literature, which shows a link between 'coming out' as LGBTI and receiving discriminatory treatment in healthcare (Zeeman *et al.*, 2017b:18). Additionally, these issues can impact on LGBTI people's health, not only by discouraging them from being open about their lives and concerns, but also by placing a barrier to seeking appropriate healthcare in the first place (Zeeman *et al.*, 2017c:22-23). Both of these factors can contribute to ill health. Receiving good healthcare and maintaining good health was connected by LGBTI people to their ability to be 'out' to healthcare providers:

LT LGBTI 6: Bisexual men... never tell anything to anyone including doctors. A bisexual man is seen as an HIV positive person who comes to this 'normal' world. It means that it is very hard, even more hard, to be open with a doctor when he does have some sexually transmitted diseases. I believe in this case a lot of partners remain unsafe. It must be a very sensitive topic to a lot of people.

Lithuania LGBTI Focus Group

In this example, the stigma around LGB sexual orientation leads to people not discussing crucial health issues with their HCPs, with consequential risks for not only themselves but also for others (see the story in Box 3 [below] for how the opposite can also be true). This can also be related to 'bi-invisibility' (Barker *et al.*, 2012) whereby bisexual people are regularly elided in self-described

'LGBTI' research and activism, and their identities dismissed or disbelieved by straight and gay people alike (see the following Section 3.3.4).

Box 3: 'He didn't assume I was heterosexual'

In one of the UK focus groups, UK LGBTI 4 described being alone in hospital and feeling unable to 'come out' to her consultant – or indeed to discuss anything about her sexual orientation. This was made more difficult by the pain she was in, which prevented her from communicating clearly. UK LGBTI 4 linked her improvement in health to a second consultant – a psychiatrist – who talked to her without assuming she was heterosexual:

'He heard why I was in pain and everything, but he didn't assume that I was heterosexual and then start writing whatever... Most of the consultants that I've seen previously just came with a fixed mind set about who I was just as soon as I walked in through the door'

As a result UK LGBTI 4 felt better able to discuss her issues with him, improved rapidly, and was subsequently discharged from hospital. UK LGBTI 4 linked this improvement directly to this HCP's attitude, and this kind of LGBTI sensitivity and communication has been connected to improved health outcomes (see Zeeman *et al.*, 2017c:56)

UK LGBTI Focus Group

3.3.4 Diversity within LGBTI and intersectionality⁶

Whilst LGBTI people are often treated as a homogeneous group, respondents in the focus groups and interviews emphasised the importance of differences between lesbians, gay men, bisexuals, trans people, and intersex people. Discussing these differences, a Polish respondent suggested areas of healthcare within which particular groups within LGBTI might need more support:

PL Facilitator: Do some of these groups have bigger problems than others? What do you think?

PL LGBTI 1: Access to more friendly gynaecologists for lesbians. And also for transgender men and women. I have dealt more with transgender men but women also need a kind and knowledgeable gynaecologist. Gays need friendly proctologists, urologists, gastroenterologists, and infectious diseases specialists because these are not always great.

Poland LGBTI Focus Group

This does not mean that these are the only areas of healthcare in which a person's LGBTI identity is relevant, but rather that particular issues of marginalisation, stigma and discrimination could arise here. Some other respondents discussed issues for specific sexual orientations and gender identities. Bisexuality, for example, was raised with regard to mental health:

UK HCP 5: My bi-friends, are really struggling at the moment with the amount of bi-rage and really struggling with the amount of violence and how that's affecting their mental health. I know bi-women have some of the worst mental health outcomes of anyone.

UK HCP Focus Group

⁶ For a discussion of marginalised identities and social positions which did not emerge strongly from the focus group data – including disability, asylum seekers and refugees – see Zeeman *et al.*, 2017b:36-38, and Zeeman *et al.*, 2017c:47-52.

Existing research supports this HCP's assertions and notes widespread health inequalities specific to bisexual people (Zeeman *et al.*, 2017c:31-33), who often relate the struggles of dealing with 'bi-invisibility' in all aspects of their lives as a factor contributing to such issues (Barker *et al.*, 2012). Similarly, trans people can be elided in supposedly 'LGBT' or 'LGBTI' research, despite experiencing extremely serious discrimination when accessing healthcare (Zeeman *et al.*, 2017b:19-20; Zeeman *et al.*, 2017c:38-43). However, in this research trans people and associated health issues were frequently raised and discussed in detail by participants. This may be connected to ongoing (and erroneous) assumptions that being 'trans' or intersex is fundamentally a medical condition and associations of necessitated surgical 'treatment' or intervention (see also Zeeman *et al.*, 2017b, 2017c).

Intersex people and their healthcare-related issues were rarely discussed in the focus groups and interviews⁷. In total, intersex people were only discussed specifically 15 times in the entire dataset (see also Section 2.2.1 on recruitment) and the lack of knowledge around intersex issues identified elsewhere (Zeeman *et al.*, 2017b:26) 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. One of the few detailed discussions around intersex people highlighted institutionalised problems around terminology which presented barriers to how HCPs could engage with intersex people's health issues. As with the complexities of non-binary trans identities discussed in Section 3.2.3, intersex was framed as a complex phenomenon, with difficulties around social, cultural, and medical definitions and inclusion within the term:

BE HCP 2: It's about a DSD [Disorders of Sex Development] ... Not all patients or parents find it a suitable term. I should elaborate. It's a term that allows them to understand the biological process their body is going through to put into context of the 'how does a typical gender development work and how is it different for you or the family?'. But when you ask them 'what would you call it?' then there's only a few that would say 'I have DSD or intersex'. Most of the time they'll use the name of the syndrome they're suffering from... So, there's little cohesion within our group I think... If you would call it the Intersex Clinic then the threshold is just as big.

Belgium HCP Focus Group

From this Belgian HCP we can see that intersex is perceived to be difficult for HCPs to get to grips with at an institutional level, due to the tensions existing between medical definitions, patient terminologies and self-identification, and new intersex institutions such as the clinic the HCP is developing. This can complicate HCPs' attempts to progress healthcare services for intersex people (see also Zeeman *et al.*, 2017b:20-21).

In addition to LGBTI identities, the data also reveals that intersectionality – that is, the unique issues which arise when a person inhabits two or more marginalised identities or positions – was seen by respondents as being poorly understood in healthcare services:

⁷ For more on intersex invisibility and a review of some of the health inequalities and lack of knowledge faced by intersex people, see Zeeman *et al.*, 2017b:41-42 and Zeeman *et al.*, 2017c:43-46.

UK LGBTI 4: I think one thing I found with healthcare professionals is they don't really get intersectionality at all. They just see it as one thing and then they will ... you have to try and explain that you're more than just this [one] thing.

UK LGBTI Focus Group

Intersectionality can incorporate both sexual orientation and gender identity, as well as age, class, and race/ethnicity. These aspects of a patient's life should not be seen in isolation as their 'intersection' can result in unique issues of discrimination and inequality (Zeeman *et al.*, 2017:17). Issues surrounding class and wealth were raised across the focus groups but particularly in the group of LGBTI people from Lithuania:

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

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

Lithuania LGBTI Focus Group

Private healthcare was frequently identified by LGBTI people as preferable for their healthcare – though not absent of discrimination and marginalisation, it was seen as generally more accepting of sexual orientation and gender identity. As LT LGBTI 6 notes above however, this kind of healthcare was not accessible to all, or even most, LGBTI people (see Zeeman *et al.*, 2017b:40 on paying for healthcare; and Zeeman *et al.*, 2017c:51-52 on socio-economic poverty). They also point to another issue of intersectionality here, specifically regarding age. 'Young students' in particular cannot afford this kind of healthcare. Older LGBTI people, too, were believed to experience unique healthcare inequalities:

UK LGBTI 5: The thing that scared me the most in hospital was that I was in a ward with lots of old people, and most old people had families around them that would speak up for them, and I just remember saying to my partner, God, when we're old we're not going to have anybody speaking up for us... When you're very elderly, you need somebody to speak up for you, and if you haven't got children, which not all of us will have, then that is a very scary prospect. It terrified me, actually.

UK LGBTI Focus Group

Despite assumptions that only younger people are LGBTI (Zeeman *et al.*, 2017b:38), older LGBTI people obviously do exist, and LGBTI people can and do have children. However, substantial legal barriers around LGBTI reproduction and parenting remain in place in many countries (see Zeeman *et al.*, 2017b:32) and it remains the case that most will not have children to care for them in old age – a prospect which 'terrified' this respondent, knowing the importance of children in advocating for older people's healthcare. When such advocates are not around for LGBTI people, respondents believed that problems can arise:

BE LGBTI 6: When you look around the centres, and I am talking about the elderly, where sexuality is a taboo then what do you expect? Homosexuality is an even bigger taboo of course. They don't know how to deal with it. My great aunt was in such a centre. She was 92

years old and had lived her whole life with a woman of which they were aware but the whole time she was pestered by a man.

Belgium LGBTI Focus Group

Older LGBTI people have been noted to face specific health inequalities through the intersections of age and sexual orientation, gender identity and/or sex characteristics (Zeeman *et al.*, 2017c:48-49), supporting the concerns of these respondents. Both LGBTI people and HCPs also identified race and ethnicity as a crucial factor in LGBTI people's healthcare inequalities:

BE HCP 5: The HIV-SAM project is a project for people with HIV with an African origin. They hold workshops and they talk about HIV and empowerment. They support each other, console each other and there was a gay man, in that group where they were talking about everything, well he didn't give a peep about his homosexuality. Afterwards he did tell the manager but it's a gigantic taboo.

Belgium HCP Focus Group

Despite common assumptions that HIV is inherently connected with (primarily gay men's) sexual orientation, in this case the gay man in question 'didn't give a peep' about this. Discussing this issue further, the group of Belgian HCPs identified this not just as an issue for LGBTI people themselves, but for HCPs and for those providing outreach and support services:

BE HCP 5: We clash against that in our campaigns towards gay men. Those are made for normal white middle class man. We clash against that. How can we reach the whole group that doesn't belong to this category? How do we reach them? That's what we're thinking about at the moment.

BE HCP 6: But when you look around the diversity in our own teams. In the end, we're sitting here at a white table.

Belgium HCP Focus Group

In this case, the HCPs connected their own lack of racial and ethnic diversity – that they were sitting at 'a white table' – to the 'clash' in campaigns which are primarily framed around a 'normal white middle class man'.

Finally, some LGBTI people noted that where a person lives – particularly if they are in a rural or urban area – impacts on their healthcare access:

PL LGBTI HCP 1: It is so much harder to access the healthcare services that are friendly to LGBT communities especially from smaller places that have a worse contact with the community. Sometimes they have to travel, can't afford it, they can't explain the travel to the family because they don't know. Because they haven't come out so they don't receive any help.

Poland LGBTI HCP Interview

UK LGBTI 9: I have an impression that there is a huge health disparity between rural and urban areas, like people have to move a very long way to the city to see a specific clinic.

UK LGBTI Focus Group

Rural areas are often seen as more traditional, conservative and hostile to LGBTI people than urban areas (Annes & Redlin, 2012). In this research, LGBTI people clearly felt that rural living presented its own barriers to accessing good healthcare, and the travel to the city perceived as necessary is not attainable by all (per findings regarding class and wealth, above). For further details, see Zeeman *et al.*, 2017c:47-48), and Box 4 below for a case study.

Box 4: 'A big hospital in a small town'

PL HCP 3 described working in 'a big hospital but in a small town', which they suggested was 'very conservative'. In line with popular descriptions of such areas, they suggested that all of the residents knew one another and that word travelled fast through the town – resulting in LGBTI people being 'afraid'. This was not only an issue for LGBTI people but for local HCPs, who had little to no knowledge of LGBTI issues.

Although this HCP worked with a 'really great' team, understanding from elsewhere in the hospital was limited:

'Doctors from the main hospital ring us if an unusual patient is admitted there. Once I was asked on a consultation to assess if the patient is lying! How can I tell if a patient is lying about their sexual orientation?'

Consequently, this HCP was not surprised by local LGBTI people's desire to seek anonymity in larger cities when it came to LGBTI-specific healthcare issues.

Poland HCP Focus Group

3.3.5 Stigmatising attitudes and beliefs of wider society

Throughout the data LGBTI respondents drew connections between barriers to healthcare services and wider cultural and societal attitudes towards and stigma against LGBTI people:

BG LGBTI HCP: If we're talking about visiting clinics for tests for venereal disease, for sexually transmitted diseases, for blood borne infectious diseases the main thing that would stop any person from going is simply shame. People are ashamed. The main reason for people to be ashamed is that our society tolerates and accepts a culture in which being different is something to be ashamed of.

Bulgaria LGBTI HCP Interview

In this excerpt, the respondent clearly relates their own knowledge and personal experience of wider attitudes towards sexuality in Bulgaria with whether or not a person feels they can access sexual health services. This point was raised by another Bulgarian respondent in the LGBTI focus group:

BG LGBTI: The problem is not from the use of [medical policy], it's with our society's attitudes, including our politicians. If we need something to change, we need to get our politicians on board. This is the place where we can make a difference. And our doctors should be our partners in this. I'm sorry, but I heard you speak about the doctors as our enemies and not our allies, and this is something I completely disagree with. The real problem stems from the politics in Bulgaria.

Bulgaria LGBTI Focus Group

This respondent is more specific, in that these attitudes are not simply part of 'society' but actively influenced by key figures such as politicians. By refusing to portray doctors as the 'enemy', blame shifts to politicians. This perception impacts on LGBTI people's access to healthcare services beyond just the actual healthcare service itself, and also doctors. It must be noted, that there is a danger here that doctors and healthcare services are not held accountable for their actions, and that LGBTI people are simply told to 'wait for society or politicians to improve'.

3.3.6 Summary

This section has identified what LGBTI people said were the barriers facing them when accessing healthcare:

- LGBTI people's experiences in healthcare facilities and interactions with HCPs are important to accessing healthcare, but so too are broader societal attitudes;
- LGBTI people are still being refused healthcare services;
- Experiencing discrimination results in LGBTI people feeling that there is a barrier to accessing the service;
- Not all LGBTI people feel able to push back against these barriers by challenging HCPs;
- Assuming that all patients are heterosexual, cisgender and/or non-intersex impacts on patients' ability to be open with their HCPs;
- Regular and frequent assumptions can result in LGBTI patients avoiding healthcare services altogether;
- Being open about sexual orientation and gender identity is seen as connected to experiencing good healthcare;
- Societal stigmas, 'shame' and national politics can be felt as a barrier to healthcare by LGBTI people;
- Specific barriers are encountered by groupings within 'LGBTI', particularly bisexual, trans and intersex people;
- Intersections with class, race/ethnicity and age are not well recognised by HCPs;
- LGBTI people in rural areas are believed to be particularly affected by anti-LGBTI attitudes.

3.4 What are the barriers for HCPs in providing care for LGBTI people?

3.4.1 Introduction

This section concentrates on what HCPs themselves (including some LGBTI-identified HCPs) said and believed about barriers to their access to, and provision of, healthcare for LGBTI people. We separate this section into the following areas: The assumption that there are no issues of discrimination or negative treatment for LGBTI people; the assumption that LGBTI status is not relevant in most areas of healthcare; the attitudes of co-workers, other patients and wider society, and; the legal, administrative and bureaucratic barriers encountered by HCPs.

3.4.2 Assumption of no discrimination or negative treatment for LGBTI people

Despite the narratives presented above and evidence in the broader literature (Zeeman *et al.*, 2017b; Zeeman *et al.*, 2017c) throughout the focus groups and interviews non-LGBTI healthcare professionals frequently commented on their perception that there were no issues or risks of LGBTI people experiencing discriminatory or bigoted attitudes or behaviour within healthcare services. For example, in this excerpt a Bulgarian HCP took issue with what they believed to be uncharitable generalisations about their peers:

BG HCP: I think you are mainly speaking about the older generation doctors here... Based on my personal observations, I believe that those older doctors behave very adequately when dealing with this particular group of people and demonstrate a completely normal and humane attitude towards them. On several occasions, I have been present during conversations between a same-sex couple and such a doctor about having a child and nothing there was any different than when it is any other ordinary person in there. So, it is not very nice to make generalisations about the older doctors.

Bulgaria HCP Focus Group

This HCP's own observations and personal experiences are not to be discounted. However, their use of the term 'ordinary' here serves as a reminder that same-sex couples (as well as trans and intersex) are not perceived as ordinary, even if there was 'nothing different'. Whilst assumptions such as these may be seen as challenging the existence of ongoing negative attitudes, they do not see all of their colleagues interactions and they may also be unaware of what can be experienced as anti-LGBTI by LGBTI people, as discussed in Sections 3.2, 3.3, and 3.4.3. The assumption that a neutral approach which is '[no] different than when it is any other ordinary person' is desirable, contradicts with LGBTI people's experiences detailed throughout the focus groups and interviews which demonstrates that this approach was experienced negatively (see Section 3.3.3). This latter point is developed through a comment in a separate interview:

PL LGBTI HCP 1: I think that in cases where the sexual orientation or identity is not the subject of the particular service and the person is not attracting any attention with the way they look or looking different, then the level of service is the same as any other one. But if this subject becomes important, then there are problems.

Poland LGBTI HCP Interview

This HCP acknowledges that being openly identifiable as LGBTI presents 'problems' and they also assume that so long as an LGBTI person 'passes' as straight, cisgender and/or non-intersex, there will not be problems. This points to a need for further awareness, because as has been shown above, these are the kinds of normativities that are felt to be excluding and a barrier to services.

Assumptions that there are no real problems for LGBTI patients seeking healthcare services, can place the blame on LGBTI patients for avoiding such services and subsequently damaging their health (as seen in Section 3.3). For instance, this HCP found reticence on the part of young LGBTI people baffling:

BG HCP: What I have personally observed, is that self-stigma is frequently seen as soon as they leave the hospital. These [LGBTI] children refuse to talk about this topic with their close friends and even with doctors who can provide help and support long-term. They refuse to talk about it with people who are highly intellectual and occupy professional positions, so it seems that really every case is different. I can't fully analyse their actions.

Bulgaria HCP Focus Group

LGBTI children are presented as somehow at fault or behaving in an incomprehensible manner because they do not trust 'highly intellectual' and 'professional' people not to exhibit anti-LGBTI attitudes. This draws on flawed presumptions that these 'professionals' do not ever exhibit discriminatory behaviour or hold stigmatising beliefs about LGBTI people or believe that LGBTI people are not discriminated against in ways that would cause reticence in speaking to friends.

HCPs across multiple focus groups drew on this concept of 'self-stigma', suggesting that LGBTI people were unjustifiably fearing discrimination and were thus contributing to their own marginalisation. The evidence produced for this research, including the sections above and the Comprehensive Scoping Review (CSR; Zeeman *et al.*, 2017b:18), illustrate that this attitude can cause further harm and be extensively damaging to LGBTI people's health. LGBTI people can never know for sure what experience they will have and how 'professionals' will react to their sexual orientation, gender identities, or sex characteristics. Moreover, such fears will always be justified in a world with continuing, and at times subtle and unnoticed (by cisgender, non-intersex and heterosexual people), anti-LGBTI and hetero-/cis-normative attitudes. It is precisely these assumptions – that there are no real issues for LGBTI people seeking healthcare services – which are experienced as a barrier to healthcare by LGBTI people, as shown in Section 3.3.3. Therefore, their continuance by HCPs is a barrier to their provision of good, appropriate healthcare for their LGBTI patients. However, at the same time a person's LGBTI identity cannot be read as central to all health problems that LGBTI people face, such as in the case of the 'trans cough' (see Box 5 next page).

Box 5: 'The Trans Cough'

One trans person, UK LGBTI 8, described a phenomenon known by trans people as 'the trans cough'. This is a form of, as UK LGBTI 8 puts it, 'diagnostic overshadowing' by which minor ailments such as persistent coughs can be assumed by HCPs (and others) to be related to being trans:

'It actually has some really structural issues in that doctors who really don't understand will often ... who don't understand how the systems within the NHS work will often try and refer you for gastrointestinal issues to a gender identity clinic. And the waiting lists for gender identity clinics are years long.'

Rather than having a simple cough treated by their GP then, trans people may be forced to visit a gender identity clinic for this very basic and unrelated healthcare treatment. This results in a significant barrier to treatment for trans people, as without good LGBTI-focused training HCPs may assume that 'We don't know how to work with trans people, only that clinic does.'

UK LGBTI Focus Group

A related risk, most often seen in countries with established legislative protections for sexual orientation such as the UK, is the assumption that 'everything is fine now'. This was developed by a respondent who compared sexual orientation to gender identity / trans issues, suggesting that it was the latter which was now seen to be the most pressing issue (negating the former):

UK HCP 4: I guess we're talking about trans because that's seems the latest big thing, isn't it? We feel like we've nailed the sexuality type stuff but maybe that presents later once you get to the clinician and things.

UK HCP Focus Group

The respondent notes that the assumption that 'We've nailed the sexuality type stuff' can be problematic as considerable discrimination may go unnoticed. Data presented above from the focus groups and interviews and the literature (Zeeman *et al.*, 2017a, b, c), on the other hand, confirms that LGBTI patients do continue to experience active discrimination from healthcare professionals and the healthcare systems of EU countries in general.

Following from assumptions that 'everything is fine', one HCP suggested that the provision of LGBTI-focused healthcare could be 'ghettoising' LGBTI people who are broadly speaking OK in the UK:

UK HCP 3: Is there a danger in doing all of that that you're perpetuating the 'ghetto-isation' of lesbian, gay, bisexual...? I think we've identified that this trans and intersex world is slightly different because it feels like it's some way behind, and that there clearly is a need for a better dissemination of some factual information and knowledge around there. Looking at LGB people and saying, "Right, special needs group," what about... Well there's disabled people, they're a special needs group. Homeless people, they really have shocking health outcomes and there's a really, really pressing need, and they are truly ghettoised. Is that really true for the lesbian and gay population?

UK HCP Focus Group

This HCP drew on this idea that 'everything is fine' for at least some of those within LGBTI, and questioned whether there really were issues for, at least, the 'lesbian and gay population'. Whilst in

is important to note the distinct issues facing diverse LGBTI people (see Section 3.3.4), not all HCPs held this view. Some were keenly aware of the issues faced in the UK, as well as countries seen to be 'less LGBT friendly'. One HCP responded to this suggestion of 'ghetto-isation', and reminded the UK focus group that LGB people continue to face real and serious issues:

UK HCP 5: There's a thing there about it just not being heterosexual. You know there are still people who are murdered in this country for being gay, who are being attacked, who are at increased risk for domestic violence and all the subtler forms... Bi-women have some of the worst mental health outcomes of anyone... There certainly are places outside of here where your life looks very different if you're gay or if you're bi.

UK HCP Focus Group

3.4.3 Assumption that a patient being LGBTI is not relevant

Similar to the previous Section 3.4.2, this section explores the idea that a patient fitting within the LGBTI grouping is never relevant to their healthcare. As with the idea that LGBTI people do not face problems in healthcare services, this was a regular topic of discussion in the HCP focus groups and was also raised by some LGBTI respondents. One respondent noted that some of her colleagues had questioned the inclusion of LGBTI topics in training:

BE HCP 6: I do sometimes notice an attitude from certain care providers like "Do we really need to know about such a specific theme as transgender?" ... Unfortunately, this is a theme that tends to fall by the wayside quite quickly I think as it isn't purely medical.

Belgium HCP Focus Group

In this instance LGBTI issues, specifically transgender issues, are seen as overly 'specific', and therefore not worth learning for all healthcare providers. This assumes that trans people only have specific trans related issues and not general healthcare needs, and contradicting respondents in Section 3.4.2 above, that trans people have specialist providers. Clearly, this is an obstacle to providing good healthcare for trans people and others.

As well as the assumption that LGBTI healthcare issues are minor and niche, the focus groups also revealed the idea that LGBTI identities simply should not be a factor in healthcare provision. An HCP from Bulgaria explained to the group how he dealt with sexual orientation and gender identity, as outlined in this extended excerpt:

BG HCP: I don't ask the question "What is your sexual orientation?" or "What are your problems and which group do you assign yourself to?" I can only hope that my patients trust in me will allow them to share what their problems are... I know that when a fellow colleague, let's say a dentist for example, finds out that their patient has a different sexual orientation they start asking themselves all these questions: "Is this person a carrier of an infectious disease?", "What would happen to me?". This healthcare professional begins to think only about themselves, which I think is an inadequate behaviour because when you have chosen to become a medic, a doctor, you should know and use the standard ways of protecting yourself at all times: gloves, face mask, goggles etc. Therefore, it wouldn't matter at all what is your patient's sexual orientation and whether they fall into a high-risk group of patients.

Bulgaria HCP Focus Group

Several critical issues emerge in this excerpt. First, providing good healthcare through a patient's openness, whilst important (see Section 3.3.3), is based here on 'hope' that the patient will automatically 'trust' them, linking back to understanding HCP's as 'professionals'. This automatic trust is challenged by evidence demonstrating LGBTI people's widespread lack of trust (Zeeman *et al.*, 2017c:36-37) and serious fears of experiencing anti-LGBTI attitudes and discrimination, to the point where some avoid healthcare services altogether (Sections 3.2.4 and 3.3.3; see also Zeeman *et al.*, 2017b:18). Second, this HCP portrays anti-LGBTI stigma amongst HCPs as only a matter of rationalised concerns of medical risk. This relates to an earlier respondent's belief that 'highly intellectual' people in 'professional positions' could not subscribe to anti-LGBTI beliefs or attitudes or that their professionalism would automatically override their prejudices (see Section 3.4.2). Finally, this suggests that the HCP speaking does indeed harbour their own stigmatising assumption that non-heterosexual people are an infection risk.

Across the focus groups and interviews, both HCPs and LGBTI people suggested that LGBTI issues were more clearly relevant in particular fields of medicine, such as urology, endocrinology gynaecology, and psychology. Oncology was not one of these fields, however in one of the UK focus groups a HCP told a story of treating a patient for head and neck cancer, who was transitioning from man to woman during their radiotherapy treatment:

UK HCP 5: That was quite difficult because you had no training professionally on that. Is this a man? Is this a woman? How do they want us to treat them? It was really difficult for the patient as well... It was... not caring for himself as well as he might. He wasn't shaving but was there in a skirt and that was all a bit kind of, you know...

UK HCP Focus Group

From their use of 'he' we can see the HCP misgendering this trans patient, whilst also imposing a degree of responsibility onto the patient by suggesting that the patient should shave and not worry about the skirt. The radiotherapy treatment appeared to make the transition even more difficult than it already was. Even when a person's trans identity is not the focus of medical issues, a lack of awareness in this area creates problems for HCPs and can markedly worsen a patient's healthcare experiences. As is evident from this example, this awareness needs to be in all medical fields, not simply those related to specific LGBTI health issues.

3.4.4 Attitudes of Co-Workers, Other Patients and Wider Society

HCPs do not exist in a healthcare vacuum but as part of wider society. They are also surrounded by colleagues at multiple levels of authority, and must deal with other non-LGBTI patients. Consequently, just as wider societal and cultural attitudes could impact on LGBTI people's ability to access healthcare services, so could they also impact on HCPs' ability to provide it:

BE HCP 1: When I think about all the gay men and lesbians that work within the care industry then there's lots. But when you try to discuss about how they could support such things by coming out more then they say "No better not as otherwise we might lose clients" ... Imagine, one of the people, one of the residents says "I do not want to be cared for by a gay man". How do you react to that...? They'll usually keep quiet or they might mention it to a colleague, but management will say 'make sure it stays internally'.

Belgium HCP Focus Group

Here we see that HCPs can be beholden to their patients and their prejudices, such that sameness and understanding with LGBTI patients may not be possible. This impacts not only on LGBTI HCPs but also those who wish to advocate for LGBTI people and promote an LGBTI-inclusive healthcare service. At the same time, they can also fear a management response, who are prioritising patients who would discriminate against LGBTI staff over their staff as well as other LGBTI patients. Thus, it can be problematic for HCPs to openly provide LGBTI-inclusive healthcare and this may need to be carefully negotiated within the workplace at a variety of levels. Given that LGBTI people also felt that wider societal attitudes as well as HCP attitudes were a barrier to healthcare (see Section 3.3.5), this may be an important area for LGBTI people and HCPs working together.

This idea of the influence of patients with anti-LGBTI attitudes influencing HCPs trying to be LGBTI-inclusive also emerged in other focus groups:

BG HCP: I've always tried to speak to my patients in a general kind of way – without specifying or making assumptions about their partners, whether male, husband, female etc. But many of these women would then just say: "Doctor, are you doubting my sexual orientation?" So, if you refer to their partner vaguely or in a generic way they are under the impression that you're thinking that they're lesbians... This can also be offensive to some women.

Bulgaria HCP Focus Group

Even for staff at senior levels of healthcare services, it could be difficult to challenge bigoted attitudes not just from patients but also from colleagues:

LT HCP 4: There are great specialists who are extremely open but sometimes they are not brave enough even to react to something someone said... I definitely have heard things about minorities. They said they wouldn't treat them. "There is this disgusting Jew" and so on... How can I say I don't accept this thing?

Lithuania HCP Focus Group

As with LGBTI people (see above), HCPs recognised that such wider attitudes impacted on their ability to provide healthcare to LGBTI people. For some the responsibility shifted, not to politicians as above, but to LGBTI people themselves. A number of HCPs suggested that it was the LGBTI community who should be shouldering the burden of tackling discrimination and normalising LGBTI lives in particular ways, rather than the responsibility of those who are perpetuating discriminatory practices:

PL HCP 4: What is important is that the LGBTI community should speak up, talk about themselves more. They should be able to come out in a normal, natural way. I know many couples that are together around 5-6 years. These people are middle aged; they buy two flats next to each other and don't live together. This is not the way to educate the society. We can say many things. We can try to educate but this is only a theory. The best way to see who they are is to get to know one. My son was laughing about gay people but then he met my friend. He then said he changed his outlook on gay people. My son is only 16 years old. I could not have explained it to him myself because there are too many stereotypes. That's what is missing. Showing people that this group is normal and education within LGBTI community.

Poland HCP Focus Group

As with the idea of 'self-stigma' discussed previously in Section 3.4.2, LGBTI people were expected to take on, and be successful in an environment which is hostile even to LGBTI people coming out, the difficult work of living in a 'normal' way (most likely in a conventional two-person couple way). Despite the serious risks which may accrue through visibility, such as homophobic, biphobic or transphobic violence and abuse, the blame is placed on LGBTI people who seek to protect themselves. Consequently, responsibility for the difficult, complicated task of changing the anti-LGBTI attitudes in wider society, which HCPs recognised as a barrier to their provision of LGBTI healthcare services, was placed primarily onto LGBTI people themselves.

3.4.5 Legal, administrative and bureaucratic barriers

In Section 3.2.3 of this report we outlined ways in which legal, administrative and bureaucratic issues resulted in particular healthcare inequalities for LGBTI people. Section 3.2.3 has already identified some of the legal restrictions which HCPs must operate within. In this Section we highlight how legal, administrative and bureaucratic issues can result in specific barriers to HCPs trying to provide healthcare services to LGBTI people. These issues are not only due to a lack of knowledge and training, but also to the institutionalised and administrative care pathways made available for LGBTI patients, and within which HCPs must work.

From this UK healthcare provider, for example, we can see that through the available models for staff trans people in the UK simply do not and cannot exist to the services available for pregnancy and childbirth:

UK HCP 1: I have not been able to find a single clinic, pathway, midwife, anything in the country that is doing anything for trans people. The only trans people I know who are having pregnancies are going solo and they are anomalies within the system. So they are presenting to a system and they are having case-by-case unique care packages around them or no care at all

UK HCP Focus Group

The organisation of the system of childbirth and pregnancy, in the UK with significant legislation around sexual orientation and gender identity in place, is such that it renders invisible and excludes trans people who need to go 'solo', which is a significant risk in pregnancy (see also Zeeman *et al.*, 2017c:56-57 on the impacts of missing policy pathways for LGBTI people).

A discussion in one of the UK focus groups brought together the tension between legal/bureaucratic barriers to HCPs providing LGBTI healthcare services, and the barriers produced through wider social and cultural norms and attitudes (see Sections 3.3.5 and 3.4.4). In this discussion, UK HCP 3 suggests that policy and legislation change is a crucial starting point for progressing LGBTI healthcare services:

UK HCP 3: It's no good me saying that I really think trans people should just have access. I need to go "You have to do this because it's in this document, and this document... and it doesn't matter if you don't think this is problem or you don't think it's relevant, I'm telling you that it is and you are accountable to these pieces of legislation".
UK HCP 2: You need a document first, don't you?

UK HCP 4: Well do you? I mean, god spare us from more policies or government directives - culture eats policy for breakfast. You can have those coming out of every orifice and they'd make no difference whatsoever until what you say... There is an element around how sometimes codifying things in law so, you know, race discrimination and equality and diversity legislation probably has been quite helpful, but really in order to make work on the ground it doesn't make a huge deal of difference.

UK HCP Focus Group

Here UK HCP 4 challenges the idea that legal or policy-led approaches will lead to significant change 'on the ground'. UK HCP 4 seems to feel fatigued by 'more policies or government directives'. Instead they raise the figure of institutional cultural inertia as a barrier to providing appropriate healthcare services for LGBTI people (and others). Numerous other HCP focus groups pointed out that rules and regulations may be implemented weakly or simply ignored, to the point where some suggested the need for sanctions or punishment (see Section 3.6.4). Policies, then, can be a start but a cultural shift is felt to be needed at the same time. This can be seen at a societal but also institutional and professional level, such that training in hospitals and other healthcare institutions, as well as awareness raising and other initiatives through professional bodies, can change cultures in the healthcare service. The UK focus group attests that this more localised cultural change can be different to perceptions of broader cultural change. In other words, whilst waiting for cultural change to influence healthcare cultures appears to be a default position of some HCPs, this ignores the evidence of how local and institutional cultures can be altered, and also how this affects broader cultural shifts (as well as individual and community experiences of healthcare).

3.4.6 Summary

The barriers faced by HCPs in trying to provide healthcare for LGBTI people matched some of those experienced by LGBTI people themselves, which may point to potential areas for collaboration. Data from the focus groups and individuals indicate that key barriers for HCPs are:

- HCPs often assume that LGBTI people do not face significant discrimination in seeking healthcare services;
- Some HCPs believe LGBTI people are contributing to their own marginalisation by fearing HCPs' anti-LGBTI attitudes;
- Many HCPs are not aware that assumptions that patients are heterosexual/cisgender/non-intersex, are experienced as barriers by LGBTI people. These assumptions can themselves be barriers for HCPs to provide appropriate healthcare services for LGBTI people;
- The idea that LGBTI issues are too niche to study or train around can result in confused healthcare staff and negative experiences for LGBTI people;
- Assumptions that whether or not a person is LGBTI is irrelevant to healthcare provision can result in LGBTI patients avoiding services;
- HCPs can find it difficult to challenge anti-LGBTI attitudes from both patients and colleagues;
- Much responsibility for changing wider attitudes was placed on LGBTI communities themselves;
- Institutional policy and care pathways can lead to some LGBTI people being rendered non-existent or incomprehensible at an administrative level, challenging HCP's attempts to provide healthcare services for them;
- Both policy-led and culture-shifting approaches are seen to be necessary to tackle existing barriers.

3.5 What kind of training do LGBTI people think HCPs need?

3.5.1 Introduction

The final two parts of Section 3 highlight findings around what kinds of training HCPs were felt to need with regard to LGBTI people. This part of the Section is focused on what LGBTI people said needed to be included in HCP training. We separate this Section into the following areas: An attitude of LGBTI-friendliness; the sense that both student and ongoing HCP training is needed; the importance of universal and mandatory training, and; how both LGBTI and non-LGBTI HCPs can offer 'informal training' to colleagues and contribute to cultural change.

3.5.2 LGBTI-friendly Attitudes

Few LGBTI people discussed visible signage (e.g. rainbow flags, pink triangles etc.) as a significant marker of good practice around LGBTI issues. Rainbow flags are not always seen as a universal marker of 'LGBTI' and trans and intersex people in particular may not see their identities or lived experiences as associated with them. In fact, some LGBTI people explicitly noted that even where such signs were present, poor healthcare experiences still occurred:

PL LGBTI 2: I am thinking about the clinic on [name of street]. When you walk in there is a rainbow flag. Great you think. You feel accepted. They also have condoms lying around. Everything is there. And the consultants are sometimes great too.

PL LGBTI 3: Not always.

PL LGBTI 4: Every time I go to the doctors I assume my sexual orientation does not matter. But I prefer not to mention it just in case the doctor is homophobic. To recognise the good doctors...

Poland LGBTI Focus Group

Whilst the clinic discussed in the Poland focus group above has the rainbow flag, which can contribute to feelings of acceptance within that particular space of healthcare provision, the respondents are less sure that they will experience LGBTI inclusive practices by the actual HCPs on the site. These people are not consistent and are only 'sometimes' great, 'not always'. Thus, more than signage is needed and as the last LGBTI speaker here notes, it is 'recognis[ing] the good doctors' which is seen as crucial. Indeed, some suggested that these visible signs could actively and somewhat cynically be used by those with no real interest or training in LGBTI issues:

BE LGBTI HCP 1: I did hear from other doctors, 'Hmm, that's a sector I haven't reached yet. Lets' put a few ZiZos in the waiting room', whilst they're not in the least bit open-minded.

Belgium LGBTI HCP Interview

'ZiZo' is a popular LGBT magazine in Belgium, and here its placement as a sign of being 'LGBTI-friendly' masks a HCP who is 'not in the least bit open-minded' and potentially leading to the kind of situation described by the Poland LGBTI focus group, above.

The search for LGBTI-friendly HCPs was a frequent topic of discussion across the focus groups and interviews, with LGBTI people sharing tips and stories of their own experiences and those of friends. This indicates that LGBTI people may seek ghettos as a response to the inequalities and barriers

experienced and these may not be directly related to LGBTI specific health issues, such as the need for gender reassignment services. In the Italian focus groups, one gay man discussed the importance of LGBTI-friendly or LGBTI-identified HCPs:

IT LGBTI 2: I wonder if the GP can manage this situation... I use drugs or sex in a certain manner... the GP is never going to be prepared to handle such a delicate thing. That creates a bit of mutual shame probably. So if you know that this stuff exists at least there you can pick up one eye, straighten the antenna, 'But I did not sleep all weekend for three days!' 'How come?'. If they know that there are certain things between LGBTI, I'm hoping that then he knows how to handle it... But sometimes it is not even there, they do not even know what happens.

Italy LGBTI Focus Group

Here we can see the importance of more than just a basic knowledge of sexual orientation, gender identity and associated terminologies, but also a simultaneous knowledge of and comfort with particular habits, practices and cultures amongst LGBTI people. Therefore, training needs to develop HCPs' attitudes towards LGBTI people as well as skills and knowledges, so that they can be identifiable as 'LGBTI-friendly' by their local communities. This Section and the previous Sections 3.3.3 and 3.4.3 demonstrated that HCPs often said that a neutral approach to accessibility was best, as opposed to being explicitly LGBTI-friendly; however, LGBTI people themselves clearly seek explicitly LGBTI-friendly and even LGBTI-identified HCPs. Negative and stigmatising attitudes persist amongst HCPs, and LGBTI-friendly or LGBTI-identified HCPs can be seen as more accepting, more knowledgeable around LGBTI issues and lives, and easier to open up to. Whilst this continues to be the case, training explicit, identifiable LGBTI-friendly HCPs can be seen as valuable.

3.5.3 The importance of training for students and current HCPs

LGBTI people's discussions around training needs focused on both student education at university, and the ongoing training in LGBTI issues needed by HCPs:

UK LGBTI 4: I think one of the problems is that you are working with a profession who historically have basically said that the LGBTQI community are mentally ill... There are some people practicing now who studied during a time when it wasn't a medical manual or something. And I think the World Health Organisation still classifies some of this as mentally ill. So I think within that context, I think something like that has to be challenged.

UK LGBTI Focus Group

LGBTI people were concerned about the ongoing use and reproduction of outdated, discriminatory medical knowledges around LGBTI lives and healthcare, particularly regarding the framing of non-heterosexual, non-cisgender and intersex people as mentally ill (see Zeeman *et al.*, 2017b:38-39). As can be seen in the quote above, this was particularly associated by respondents with older HCPs. In some cases, respondents were pessimistic about the capacity of older HCPs to change their knowledge of and attitudes towards LGBTI people's healthcare:

IT LGBTI 1: It's clear that a doctor who is now 60 years old, you are not going to make him change his mind.

Italy LGBTI Focus Group

Outdated medical knowledges were a real concern for LGBTI people, particularly in textbooks for medical students. Tackling the knowledges of LGBTI people presented in these textbooks was a must for some respondents, particularly LGBTI-identified HCPs:

LT LGBTI 1: I had psychiatry course, child psychiatry course. And I was brought and given a book. I was told: "Read it, it is our Bible". It is a bible of psychiatry. And in this text book there was a description of homosexuality... It stated it is a disease. It is a book from Soviet times and at the moment medical students still use it to study and consult teenagers brought to crisis intervention unit.

LT Facilitator: So first of all these textbooks should be sorted out, taken out from the course?

LT LGBTI 1: Yes, yes, taken out. These things should be controlled...

Lithuania LGBTI HCP Interview

The discriminatory attitudes that such knowledges were understood as leading to were also highlighted. Many respondents felt that building positive attitudes and constructive relationships with LGBTI patients was key to HCP training:

IT LGBTI HCP: I would focus a lot on the relationship that it is created, because there is a specific investment that the users make on the service, the people who work there, so the importance of creating a safe environment, recognition, where there is a positive reflection, although for many operators all this is difficult because the work is rather hard in these terms. Then on the use of an inclusive language.

Italy LGBTI HCP Interview

This kind of attitude training was often discussed directly alongside training in updated knowledges around sexual orientation and gender identity, and in fact such training for existing HCPs was framed by one respondent in a more pointed way:

BE LGBTI 9: I think that right now it's more important that there is such training at university because for probably another 20 years we'll have to re-educate the students as they never received it at university.

Belgium LGBTI Focus Group

As well as highlighting the urgency of beginning training for students immediately, here the discussion of student 'education' and HCP 'training' is flipped, such that students receive 'training' and future HCPs need to be 're-educate[d]'. This suggests that what is needed for existing HCPs is not simply the update in knowledge and skills which might be implied by 'training', but a whole new education – perhaps specifically regarding attitudes and familiarity with LGBTI identities and lives (see Section 3.5.2). 'Training' alone may not be enough (see Box 6 below). Some LGBTI respondents in Bulgaria and Poland suggested that HCP training, at a large enough scale, could contribute to tackling the problematic societal attitudes noted in Section 3.3.5 and 3.4.4:

BG Facilitator: What can improve the sensitivity and the attitudes? Anything that you can suggest, any training?

BG LGBTI: Yes, with training. Some sort of large symposia that would have a broader impact on the mass.

Bulgaria LGBTI Focus Group

PL LGBTI 1: I would like the education to be better. In all the health service (for doctors and nurses, psychologists and psychiatrists). Sexual orientation should be a mandatory subject. Maybe then we would have less homophobia in our country.

Poland LGBTI Focus Group

Whilst LGBTI people warned that wider cultural changes were not identical to changes in local cultures of healthcare services (see Section 3.3.5), they were seen as connected by some respondents and HCPs may be able to position themselves at the vanguard of wider cultural change.

Box 6: 'We've Had Training, But...'

LGBTI people were cautious of assuming that those who had received the requisite training in LGBTI issues would tackle things well in a 'real life' scenario. In the focus group with Belgian LGBTI people, BE LGBTI 3 told his story of when he called the Belgian suicide helpline '106'. BE LGBTI 3 identified himself as a trans man, and the helpline worker proved unable to help, saying 'We've had training, but...':

He himself was in a panic, and he didn't know how he could help and then he said 'Yes you can tell from my prattling on that I don't know a lot about it. We've had training in it but...'

BE LGBTI 3 explained that while he was used to HCPs not knowing about trans issues, this was a helpline for suicidal people and at that moment he 'really needed help'. Despite having training in trans issues the helpline worker panicked at being confronted with this in a real life situation. He could only suggest trying to speak to someone else at another time:

'Perhaps you could call again, but I can't help you.'

Asked by the focus group moderator to comment on LGBTI training, BE LGBTI 3 said that he felt training which provided 'basic knowledge' was not enough. Instead, as with other respondents, an open and accepting attitude and willingness to learn was even more important:

I'm a big fan of more knowledge in college or something like it, but I think that the basic training is much more important actually. I much prefer someone who says 'I know nothing about it but tell me more' than someone who knows a lot about it.

Belgium LGBTI Focus Group

3.5.4 Universal and mandatory training

Whilst cautious of the idea that training in LGBTI issues for HCPs would necessarily remove all barriers to healthcare, LGBTI respondents nevertheless generally agreed that such training was desirable. In particular, they emphasised that such training should not be undertaken only HCPs such as doctors and nurses, but by all staff:

IT LGBTI HCP: Information and training, necessarily. I thought that for example (this is the first issue) I thought the target to work on. They definitely are the health & social services operators but I was thinking also of all the technical and administrative staff which belongs to the services because even there often, at least in Italy, this is the staff that receives them...

IT Facilitator: For example, the person at the counter or at the checkout?

IT LGBTI HCP: Exactly, often these are people who collect preliminary information, they do the welcome and use the protocols.

Italy LGBTI HCP Interview

As this respondent points out, more staff than just the clinical HCPs are involved with LGBTI patients when they access healthcare services. Indeed, the very first point of contact with healthcare services is usually the 'technical and administrative staff'. Training therefore must also include these staff members too. Another respondent in the LGBTI focus group in Italy further clarified the universal (that is, for all staff) nature of the training:

IT LGBTI 1: I think I would say we would need a basic education. Also on the things that you said about GPs, for sure... But first of all we would need a vision from those who make programs that takes into account that there are differences... and peculiarities sometimes in services, a little more delicate, other times with an education on the universal, general services.

Italy LGBTI Focus Group

This respondent highlights the need for training in 'universal, general services', but reminds us that there are at times 'differences' and 'peculiarities' in some areas of healthcare (see Section 3.3.4). Therefore, multiple training programmes may be needed - some general training designed for all staff, and some more specific training tailored to specific specialisations or departments.

Another clarifying comment on the universality of training was made by an LGBTI HCP in the UK, regarding the at times complex staffing of healthcare services:

UK LGBTI HCP 1: It only takes one person, you get an agency person in or a locum in or somebody who hasn't been to training, or somebody from another department who hasn't had the training and then you can undo all that good work. Or the people who do the training they're not on the shift that day when that one person comes in.

UK LGBTI HCP Interview

This respondent points to two factors. First, all staff must be trained because 'it only takes one person' to 'undo all that good work', and it is not sufficient for working staff on any day or time not to be properly trained. Second, the respondent points out that 'agency' staff and external locums may work at that specific healthcare site such as a hospital or clinic. Thus, whilst all of that site's staff may have received excellent and comprehensive training, agency staff may not. Thus, to ensure LGBTI people do not encounter discriminatory attitudes, training must be *undertaken by all* health services staff – including private agency workers and off-site locums.

3.5.5 Contributing to cultural and institutional change

Whilst most of the discussions in the focus groups and interviews concentrated on formal training for programmes HCPs, LGBTI people also shared stories and experiences of more 'informal' kinds of training within healthcare settings. In such informal training, HCPs contributed to each other's knowledge, skills and education around LGBTI issues as well as producing cultures of LGBTI-inclusion in healthcare facilities:

BG LGBTI: Some [doctors] are extremely discriminative towards LGBTI people and some defend LGBTI rights very actively. Perhaps, they don't do that within the larger community, but they do it within their circles of friends at least. The latter ones are the people that we need to work with to change the opinions of all the other doctors. You are right to say that

doctors don't always listen to the opinions of other people, especially if they are not doctors themselves. But that's the point – we can use those that do listen to break through the opinions of other doctors.

Bulgaria LGBTI Focus Group

The idea that HCPs would not listen to advice or training except from other HCPs emerged in both LGBTI and HCP focus groups and interviews. This LGBTI respondent suggested utilising this to encourage supportive HCPs to 'break through the opinions' of their colleagues, taking on more of the responsibility for creating cultural and institutional change already noted as vital in Sections 3.3.5 and 3.4.4 This could particularly be the case for senior staff:

PL LGBTI 5: My friend joked about something and the senior registrar scolded him. He did that in front of a big group on psychiatric ward where jokes like that were not tolerated. I was working in psychiatric clinic in [area] where the sexology department had just opened. And the top person – senior registrar - told my friend off and that definitely had an influence on others.

Poland LGBTI Focus Group

Whilst HCPs suggest that even senior staff may find it difficult to challenge the attitudes of the colleagues (see Section 3.4.4), LGBTI people were keen on the idea of pro-LGBTI HCPs to use their status and connections to 'influence others', creating an environment where discriminatory jokes and attitudes 'were not tolerated'.

LGBTI HCPs and staff in healthcare services were noted as being potential resources in progressing positive change in their workplaces, in addition to actively being sought by LGBTI patients (see Section 3.5.2). The data shows that it is possible for LGBTI HCPs to interface between healthcare services and local LGBTI communities:

UK LGBTI HCP 1: I have a sort of a role bridging the gap between the healthcare side of things and the community organisation side of things in a sense that I am part of the [name of local trans organisation], trustee of [name of other trans organisation] which is one of the support groups in town and I'm also a healthcare professional as well. And so that has helped me have two separate hats. I can put a community hat on and I can put a healthcare hat on. And I can see where the gaps are and how we can cross that gap with other people who are interested in helping.

UK LGBTI HCP Interview

Numerous LGBTI-identified HCPs in informal training opportunities undertook similar roles, either advocating for and guiding LGBTI patients through healthcare, connecting healthcare services with local communities, or providing a kind of informal training to colleagues (see Box 7 below). Others were working more discreetly within their organisations, for example to incrementally include LGBTI issues in existing training packages:

IT LGBTI 1: We have an instructor, he never came out, but you can see. He made sure that he always infiltrates it in his lectures there, because he says 'One step at a time you can do it'.

IT Facilitator: So a personal initiative still.

IT LGBTI 1: But from above they did not tell me 'No, this is not good', and then he continues, he does all the lessons. Half an hour. Everyone has the course, in that half an hour, occasionally [he talks about LGBTI issues].

Italy LGBTI Focus Group

On this course which 'everyone' takes, the instructor 'occasionally' adds details about LGBTI issues. However, the instructor is said to be cautious about doing so. He 'never came out' and perhaps senses risk 'from above' if his approach were to foreground LGBTI issues too heavily. It is clear that LGBTI staff should not be made to feel responsible for such work, and that they can fear being identified as LGBTI in the workplace:

PL LGBTI 5: I worked in the hospital for two years as a lab assistant. Despite the fact I had connections, I was always afraid. I was always afraid to say too much, say out loud that I am dating a girl and not the boy or something like that. When I was collecting my results, I was always checking if I knew the person.

Poland LGBTI Focus Group

Box 7: 'Special information'?

UK HCP 4 described their work in the midwifery department in a local hospital, explaining that women with same-sex partners are not uncommon amongst their patients. They discussed the contributions made to the midwifery team by another midwife who identified as a lesbian.

This midwife questioned the team's practice of telling each other "Oh she's in a same sex relationship" when a mother with a same-sex partner was introduced. She explained that whilst it was a good idea to make sure other team members understood that a mother was in a same-sex relationship, the phrasing suggested that this was 'special information'. UK HCP 4, with other members of the midwifery team, learned instead simply to introduce partners by name and any other identifiers relevant to their relationship, such as wife.

'I wouldn't have thought of that, and I certainly wouldn't have thought that was an issue if that hadn't been brought to my attention by a healthcare professional who could see it from the other side.'

It is important to note that UK HCP 4 identifies as trans but not as a lesbian. While LGBTI HCPs can provide valuable guidance and 'informal' training for their colleagues, they may not be knowledgeable particularly in other areas of the LGBTI grouping.

UK LGBTI Focus Group

3.5.6 Summary

LGBTI people had numerous thoughts about what kind of training was needed by HCPs wanting to provide healthcare for LGBTI people. They also gave some direct recommendations. Their key findings from this section are:

- Healthcare sites with LGBTI-inclusive signage do not always have LGBTI-friendly HCPs;
- Some LGBTI people actively seek out LGBTI-friendly HCPs, who may be seen as more accepting and approachable;

- Some LGBTI people actively seek out LGBTI-identified HCPs, whom may be seen as more accepting and approachable as well as knowledgeable around 'in-group' issues;
- Training for HCPs should raise the importance of being visible and identifiable as LGBTI-friendly for LGBTI patients;
- Current HCPs need to be updated on the most recent literature on LGBTI issues, particularly regarding trans and intersex;
- HCP training was connected to making wider societal changes and LGBTI people believed that it could contribute to this;
- LGBTI people wanted supportive HCPs to use their connections and influence to promote positive attitudes towards LGBTI people, or at least erase open discrimination.

3.6 What kind of training do HCPs think HCPs need?

3.6.1 Introduction

This final findings Section examines the data around what kinds of training HCPs themselves said was needed by them and their colleagues. It is clear that there are significant overlaps with what LGBTI people argued for. This Section is separated into the following areas: The importance of student education; the inclusion of LGBTI people in training; universal and mandatory training, and; HCPs working together to improve institutional culture.

3.6.2 The importance of student education

For some HCPs learning about LGBTI issues is a new endeavour. This is because a number said that they received no training at all, as this Polish HCP stated:

PL HCP 2: During medical studies the LGBTI subject is not mentioned – not in sociology, gynaecology, urology, and psychiatry or in psychology...

Poland HCP Focus Group

However other HCPs raised another equally important point – that even when included in education, LGBTI issues may be framed in unhelpful or incorrect ways:

BG HCP: I joined the medical university and discovered that the textbooks say different things from what I've learnt. I've been brought up to believe that there are no high-risk groups but rather that there is high-risk behaviour. And at the time, the textbooks were all absolutely emphasising that there are high-risk groups, pardon me for speaking so passionately about this but it's very personal for me. For me this is inadequate attitude – for me LGBTI is not a high-risk group; for me, being a high-risk group would be being poorly educated, to have low level of health education, to not know how use a condom, to not know how to maintain good intimate hygiene... those are high-risk people for me and that's governed by behaviour.

Bulgaria HCP Focus Group

This respondent drew on their own education and upbringing prior to their medical studies, assessing them critically in this light. Engaging with the suggestion that LGBTI people are inherently a 'high-risk group', they critique their textbooks for outdated ideas as did LGBTI people (see Section 3.5.3). Just as LGBTI respondents attested to the need to train both existing HCPs as well as those currently studying to become HCPs, some HCPs also said that they wanted more training on these issues for current staff:

UK HCP 4: I completed my undergraduate training in 1992. It certainly wasn't in there but you know I've still got at least another 20 years of work in front of me so it's about getting to those people as well. Putting it in undergraduate stuff is important but there are a lot of people that are working in the system.

UK HCP Focus Group

This HCP points out that 'there are a lot of people that are working in the system' already, noting that they have 'at least another 20 years work'. Whilst students are important, then, HCPs were also keenly aware of the need for more and better training for current healthcare staff.

3.6.3 Inclusion of LGBTI people in training

As noted in Section 3.5.5, both LGBTI and HCP respondents often suggested that HCPs would only listen to other HCPs when it came to LGBTI healthcare and associated issues:

BG LGBTI: In reality, to reach a point where you give savvy to the medical professionals when you are not one of them – that's an absurd idea. They don't listen to anyone who isn't a doctor, especially if you are there in the capacity of a patient. They are more likely to think that they know better than you what you want.

Bulgaria LGBTI Focus Group

Whilst this was a regular refrain, HCPs did think carefully about who should undertake and present training for their colleagues:

UK LGBTI HCP 1: 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

This LGBTI HCP considers both sides of the argument, regarding whether training should be presented by an 'insider' (HCP) or an 'outsider' (LGBTI person). Mindful of suggestions that HCPs may not listen to others, the crucial suggestion here may be the idea that 'You've got a guest in'. The respondent's idea for an 'outsider' who will be paid attention to is someone who has explicitly been 'got in' – they are a 'guest' of the organisation and thus validated through it. The insider/outsider balance this LGBTI HCP presents may also point to the utility of training which incorporates both perspectives – someone who has an 'implicit understanding' of the HCP role and also someone 'who's been in hospital'. This could involve two partners, one HCP 'insider' and one LGBTI 'outsider'. Other HCPs also raised the importance of an LGBTI speaker involved in the training:

PL HCP 2: I believe in human contact. If we organise the training, then it can't be boring about theory. It should be an interactive meeting with a person that represents that group well. It should be a person that doesn't stand out much.

Poland HCP Focus Group

In this quote, the Polish HCP points to the need for real connection – 'human contact' which is 'interactive'. They suggest that the speaker 'should be a person that doesn't stand out much', perhaps denoting someone who is not 'obviously' identifiable LGBTI to put HCPs at ease or emphasise the 'normality' of LGBTI people. Whilst this may be a productive strategy to an extent, it may reproduce problematic norms of which LGBTI people can be accepted (e.g. those who could pass for

straight, cisgender or non-intersex) and those who cannot (e.g. those who are visibly LGBTI) and who may be read as bringing problems upon themselves for not fitting in in particular ways.

3.6.4 Universal and mandatory training

As with LGBTI respondents, HCPs were clear that any training around LGBTI issues needed to be both universal (for all staff) and mandatory. Some were convinced that any other approach would lead to only speaking to those who were already amenable to hearing about LGBTI issues and perhaps already know what they need to:

LT HCP 10: If the trainings were not mandatory, "Whoever wants comes", then I can guarantee that they would be attended only by the LGBT friendly medics who are interested in the topic... In our hospital there are general trainings organised every Thursday. For example lectures about communication and contact between a doctor and a patient. This is where LGBT topic should be incorporated...

LT HCP 5: I have presented in seminars for residents and they had to come to the seminar.

LT HCP 10: Yes, yes. It should be a compulsive thing, otherwise...

LT HCP 2: Yes. I wanted also to say that it should not be a choice. Every hospital has its own clinical conferences or short meetings.

Lithuania HCP Focus Group

These three Lithuanian HCPs agree that the training must be mandatory and not optional, and identify a common feature in their own healthcare sites – regular mandatory meetings – which they suggest would be a good space to present LGBTI-inclusive training in.

However, other HCPs noted that HCPs are already extremely pressed by time:

PL HCP 2: If the training in the hospital were obligatory, then it would only have to last 10 or 20 minutes because they would not have the time to leave their patients for 3 hours or more. No one would stay after hours, because most people work in other places.

Poland HCP Focus Group

Mandatory training organised in this way would be very short, according to this HCP, due to HCP's need to care for their patients. They suggested that careful planning and schedule rotation would be needed to implement truly mandatory training for all HCPs.

HCPs agreed that mandatory training should not include just HCPs including doctors and nurses but also all non-clinical staff:

UK HCP 3: Before a patient gets to me or to most professional people they've met two or three receptionists or car park attendants or whatever and how those people are with the patients really can make our job so much easier or so much harder. So they're important people to consider as well.

UK HCP 4: I've had trans [people] walk in, been misgendered, turned round, walked back out. They never even made it to the clinician.

UK HCP Focus Group

Universal in this situation then means all staff on the hospital grounds, or the site of any other healthcare facility. As HCP 4 points out, LGBTI people will encounter a number of staff prior to even meeting a HCP, and poor interactions with any of them could result in the LGBTI person avoiding the service altogether.

Sanctions or punishment for breaking rules around LGBTI-inclusion was discussed in multiple HCP groups. Whilst some LGBTI people also raised this, it was some HCPs who advocated most strongly for some form of punishment. For example, in Bulgaria these HCPs discussed 'useless rules':

BG HCP 1: These are useless rules that we can just pin to the wall.

BG HCP 2: We need to train people more and better...

BG HCP 3: Yeah, add these rules to the walls but I doubt anyone would bother reading them.

BG HCP 4: Well, if they don't read them then there should be consequences.

Bulgaria HCP Focus Group

The final HCP ends by threatening 'consequences' for those HCPs not reading rules around appropriate treatment of LGBTI patients. Whilst this could address the tendency for policies and rules not to be followed, as addressed in Section 3.4.5, other HCPs were more cautious, considering that many 'broken rules' might be well-intentioned accidents rather than malicious:

UK Facilitator: I wonder if [sexual orientation and gender identity] feels a bit of a minefield if you've got to tread around... If somebody walks in the room and you think, "Nelly gay man", or maybe you think "A really butch dyke" or maybe you think "Oh, trans person." What's that like for you in your professional practice?

UK HCP 5: If staff feel neurotic... frightened that they're going to get a step wrong, actually you don't get good assessment which is fundamental to good care, isn't it?

UK HCP Focus Group

This respondent addresses the idea of HCPs afraid to make mistakes in their interactions with LGBTI people, through accidental misgendering or assumptions of sexual orientation. Other HCPs agreed with this assessment, suggesting that it could lead to a breakdown in the HCP/patient relationship which is vital to good healthcare. Later in the same focus group, UK HCP 1 argued that rather than making healthcare staff 'neurotic' with the threat of punishment if rules are accidentally broken, that patients should be able to teach and forgive errors:

UK HCP 1: It's also about how we say to people, "Look, we're teachable. Tell us." Sometimes we get it wrong in whatever, however we talked to somebody, whatever, but if you set it up where you say, "I'm teachable, tell me how it is" people are more forgiving of things that you don't get right because they can address it.

UK HCP Focus Group

This respondent advocates for an approach whereby LGBTI patients are afforded an element of control by being able to explain their own situation to a careful listener, and HCPs get the opportunity to develop and learn from mistakes (see Section 3.5.2).

3.6.5 Working together to improve institutional culture

In Section 3.5.5, LGBTI respondents discussed the importance of HCPs working with colleagues and using their status within healthcare organisations to push for cultural change, and to contribute to a more informal style of training around LGBTI issues. The findings in this present Section reveal that HCPs' thoughts were in line with these LGBTI respondents. For example, in the Belgian HCP focus group the respondents talked about forging connections with colleagues:

BE HCP 6: I've worked with some fantastic GPs but I don't think you should be your own partner. It's essential to work together. Rather it's about informing each other about your work and to also refer in a friendly warm way. I've had GP's of where I think 'oh boy'. You first make contact to help your client and after speaking just a few times, you'll get the idea if the GP is on board or not. The boy will also feel more comfortable when he visits his GP because the GP is aware he needs to allow for more time and that it's not about your usual medical problem. We could make a difference if we were to cooperate more but it's not always easy.

Belgium HCP Focus Group

This respondent liaised with GPs of LGBTI patients. Here she acts as an interface between a young man and his GP, to establish whether the GP is 'on board' and to ensure that the patient is 'more comfortable' due to her intervention. She notes, however, that 'it's not always easy' to forge these connections between HCPs and work together to promote LGBTI-inclusivity, and other discussions reflected on the time, effort and risk for HCPs attempting to push the boundaries in this way. However, the mutual support between HCPs attempting to improve LGBTI-inclusivity was a theme which emerged repeatedly in the focus groups and interviews. Senior staff were seen to play a vital role:

UK HCP 4: People look to us as clinicians and professionals for providing leadership, and there is something about leadership and modelling behaviours which people do learn from. So, you know, if I behave in a certain way then the people around me will see that and know that the couple of experiences that you're talking about stop happening, because it just becomes part of the culture of where you are. "That's not how we behave here."

UK HCP Focus Group

As a senior staff member, this HCP was clear about their capacity in influencing change amongst their colleagues simply through leading by example – behaving 'in a certain way'. As well as this more informal culture-shifting work amongst HCPs, a respondent in the UK HCP focus group highlighted a more formal implementation of this mutual support amongst HCPs:

UK HCP 1: We up-skilled GPs who had patients, you know, we sensed a small cohort of them, provided extra training and then they would support each other. So you can set up networks, can't you, in low incidence places.

UK HCP Focus Group

Even where available numbers of staff are small and universal training cannot feasibly be implemented despite the desirability of this, it may be possible to give specialised training to

particular HCPs, especially those struggling with LGBTI patients, who could then contribute to developing their colleagues' knowledges, skills and attitudes around LGBTI issues.

3.6.6 Summary

There were significant overlaps between the kinds of training HCPs thought was needed around LGBTI issues, and the kinds of training LGBTI people thought was needed:

- Some medical students receive little to no training in LGBTI issues at university;
- Some textbooks used in medical training reproduce outdated or discriminatory material and HCPs thought it was crucial to challenge this;
- Whilst student training was seen as extremely important, some existing HCPs will be working for several decades to come and also need training;
- Although many respondents suggested that HCPs would only listen to other HCPs, in fact many believed that LGBTI people could *and should* be involved in delivering training;
- Exclusion of some LGBTI people may inadvertently creep into training focused around presenting 'normal' LGBTI lives;
- HCPs agree that training on LGBTI issues needs to be mandatory or those who need it most will not attend. However, there may be issues in fitting such training in with staff schedules.
- Training should be universal and include all staff on the healthcare site;
- HCPs are keen that staff should abide by training and subsequent policies, however some suggested that staff should be open to learning from mistakes;
- HCPs broadly agree with LGBTI people on the importance of colleagues improving attitudes to LGBTI people in their healthcare institutions;
- Senior staff were seen to have an important role in leading by example;
- Small numbers of staff with additional formal training in LGBTI issues could support less-trained colleagues.

SECTION FOUR: Conclusions and recommendations

4.1 Introduction

This report has explored the key findings from the two qualitative research studies as set out in Task 2 of the Health4LGBTI project. As a reminder, the overall aim of Task 2 was to conduct two focus group studies to map the **barriers** faced both by LGBTI people and health professionals in six European Member States including Belgium, Bulgaria, Italy, Lithuania, Poland, and the UK. In doing so, it aimed to gain a better understanding of the specific **health inequalities experienced by LGBTI people**, focusing in particular on overlapping inequalities stemming from discrimination (also unintentional) and unfair treatment on other grounds (e.g. age, disability, socioeconomic status, race and ethnicity). Moreover, building on the outcomes of Task 1 (see Zeeman *et al.*, 2017a), the findings from these focus groups are intended to **inform the development of the training** modules for Task 3 and Task 4 of the project as well as identify key areas for further research beyond this European pilot study.

In this final Section, conclusions based on the findings of the focus groups and individual interviews are presented under two headings stemming from the aims of the Health4LGBTI project: 1) Inequalities and barriers in LGBTI healthcare, and; 2) Developing training for HCPs around LGBTI healthcare. Each section identifies areas of consensus and difference between LGBTI respondents and HCP respondents.

Finally, a series of recommendations are presented briefly and thematically including suggestions for areas where future research is needed.

4.2 Inequalities and barriers in LGBTI healthcare

LGBTI people reported believing that many HCPs were not as knowledgeable of LGBTI-specific health issues as they should be. The assumption that most or all LGBTI health issues were related to STIs was seen as a common stereotype, and this stereotype was repeated by some HCP respondents. Lack of knowledge around healthcare for trans people was seen to be a particular area of concern, with some trans people worried that they would experience serious physical, psychological and social harm through ignorance on the part of HCPs attempting to treat them. Trans and intersex people, and others, noted that existing pathways of healthcare are not sufficiently well-equipped to deal with gender identity and sex beyond a simplified binary framework – into which many trans and intersex people do not fit.

Legal and institutional inequalities and barriers remain in place for LGBTI people. This means that some cannot access the healthcare they need. The data showed that this does not impact only on LGBTI people themselves, but also on their families and romantic and sexual partners.

Whilst many HCPs believed that outright discrimination and refusal of treatment for LGBTI people no longer exists, LGBTI people related experiences suggesting that it does. LGBTI people and HCPs alike noted that whilst individual attitudes towards LGBTI people amongst HCPs were important, this did not outweigh the significance of wider social and cultural attitudes. Societal stigma could present real barriers to LGBTI people seeking healthcare.

When LGBTI people did seek healthcare, fears of negative experiences (often based on previous discrimination) meant that some felt unable to be open and honest with their HCPs. Whilst some negative experiences – such as jokes or accidental misgendering – may be perceived by non-LGBTI people as minor, these could have serious implications. A number of HCPs suggested that LGBTI people were complicit in their own marginalisation by avoiding services due to such fears and experiences. They advocated a ‘neutral’ policy through which a person’s LGBTI identity (or lack thereof) was not relevant. However, LGBTI people said that it was precisely the assumption that a patient was heterosexual, cisgender and/or non-intersex which impacted on their ability to be open with their HCP. This could have consequences for receiving appropriate healthcare, including LGBTI people avoiding healthcare altogether.

Whilst HCPs who participated in focus groups wanted to support LGBTI patients, they encountered their own problems through reactions of other patients and of their co-workers, as well as wider societal attitudes. They also indicated limited institutional and legal (in)flexibility was a challenge to providing appropriate healthcare services to LGBTI people. As such, both LGBTI people and HCPs agreed that changing cultures (at the local as well as societal scale) should take place alongside legal and administrative changes.

Specific groupings within ‘LGBTI’ – particularly bisexual, trans and intersex people – encountered their own specific barriers relating to their sexual orientation, gender identity and/or sex characteristics. Bisexuals and intersex people were only rarely mentioned in the data, which can serve to render their lives and needs less visible. Intersectionality across class, race/ethnicity, age and geography was not considered to be well-recognised by HCPs, though some HCP respondents did identify these as important areas where much more dedicated work is needed.

4.3 Developing training for HCPs around LGBTI healthcare

The findings indicate that LGBTI people do desire and actively seek out explicitly LGBTI-friendly or even LGBTI-identified HCPs. This is counter to most HCPs who responded that a neutral or general approach was best. However, it was pointed out that appropriate signage, such as rainbow flags and LGBTI magazines were not sufficient and more needed to be done to make the services accessible for LGBTI people.

Teaching medical students about LGBTI issues was seen as important throughout the focus groups and interviews. HCPs and LGBTI people alike were concerned about outdated, stigmatising information being taught to medical students through university textbooks and lecturers. Ensuring that students as well as existing HCPs were provided with up-to-date and inclusive information was seen as vital, especially regarding trans and intersex issues. Existing HCP training should include LGBTI people in it as well as HCPs.

HCPs and LGBTI people agreed that any training for students or existing HCPs should be mandatory, and that it should cover all staff on healthcare sites (including administrative and support staff). HCPs were often keen to stress that there should be consequences for breaking rules around LGBTI inclusion; however others suggested that staff needed to be open to learning from their mistakes.

LGBTI people believed that HCPs should influence their colleagues and the institutional cultures of healthcare services to be more inclusive of LGBTI people, and HCPs pointed to a number of instances

where they had achieved this – in particular through examples set by senior staff. LGBTI staff were seen as having a potentially important role in contributing to this change and to a more informal training of their colleagues around LGBTI issues – however it was clear that this can be risky for LGBTI staff. Finally, it was also believed by LGBTI people and HCPs that lower scale institutional change could contribute positively to wider cultural change.

4.4 Recommendations and future research

4.4.1 Frequency and organisation of training

- HCPs need ongoing training to bring them up to date with the most recent LGBTI issues as well as addressing attitudes towards LGBTI people;
- Training is needed throughout an HCP's education and working life. This should begin at the undergraduate level education, and should be revisited regularly during postgraduate education and during practice. There should be a requirement to update training around LGBTI issues every few years.

4.4.2 Organisation of training

- As patients may come into contact with a variety of staff members when seeking healthcare, any LGBTI training should include, and be mandatory for all staff – including clinical, administrative, estates, and support staff.

4.4.3 Content of training

- Whilst there is a lack of knowledge and awareness around LGBTI issues in general, training around trans and intersex issues is particularly needed;
- LGBTI people feel that they cannot be open and honest with HCPs, or even trust them, without being 'out' about their sexual orientation, gender identity and/or sex characteristics. Training should stress the importance of LGBTI people being able to be 'out' for providing and receiving good healthcare;
- Training should stress that LGBTI issues are important and relevant in all areas of healthcare;
- Training should address the importance of wider societal and cultural beliefs, attitudes, stereotypes and stigmas;
- Training should address the ongoing existence of serious discrimination against LGBTI people despite policy frameworks designed to tackle this being in place;
- Training should address the impact of assumptions of patients being heterosexual, cisgender and/or non-intersex;
- Even seemingly 'minor' or 'insignificant' experiences of LGBTI stigma or erasure can have a serious impact on LGBTI people's healthcare experiences. Training should address the impact of these experiences;
- Training should highlight the importance of both legal/policy change and cultural/institutional change.

4.4.4 Changing institutional cultures

- HCPs should support one another and work together to influence and ultimately change institutional cultures. LGBTI HCPs may have an important role to play due to their knowledge and experiences, but should not be expected to take on this potentially risky work or to be experts in all LGBTI issues;
- Senior staff should lead by example to change institutional culture.

4.4.5 Future research directions

- Dedicated research is needed around overlooked issues such as trans and intersex people's experiences of healthcare, along with further research that specifically focuses on intersectional experiences of being LGBTI and seeking healthcare (including disability, age, class, race/ethnicity and rural isolation);
- A detailed scoping review is required of how sexual orientation, gender identity and LGBTI issues are currently included within medical student education across the EU;
- Further dedicated research and dissemination activities are required on LGBTI experiences of healthcare provision including areas where change can be seen, good practice identified, and areas for improvement.

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Appendix – Additional Selected Quotes for Training Packages

Healthcare inequalities facing LGBTI people

Lack of specialist healthcare and knowledge around LGBTI-specific health issues

BE LGBTI 6: I had to do some interviews at the [hospital] and one of them had formerly been an administrative assistant... And she'd worked there for a while as an administrative assistant and the head of department had organised a training day. It was amongst other things about the fact that intersex is not the same as transgender. The information was totally new for them and she said 'Yes it does help me in my work because sometimes we receive notifications and we think that it's for the Transgender team and it's actually for the intersex team'.

Belgium LGBTI Focus Group

BG Facilitator: Did you tell her that this question made you feel uncomfortable? Did you tell that to the medical specialist?

BG LGBTI: No, not really because the specialist opposite me wasn't a psychologist to explain this to them. If it was a psychologist and I tell them that something is making me feel uncomfortable, they will start digging into it to find out why; if I had told her, I would have just been met by a blank face and hopeless blinking – it would have been a complete waste of time.

Bulgaria LGBTI Focus Group

PL LGBTI 1: I had gonorrhoea. The doctor honestly thought it was resulted from being gay.

PL LGBTI 2: This is not true of course. Total bullshit.

PL LGBTI 1: He didn't think I was punished with having gonorrhoea for being gay. He though I was gay so I probably had so much sex which resulted in catching it.

Poland LGBTI Focus Group

BG LGBTI 1: One of my friends wanted to change his GP so, I sent him to mine. He had a specific problem – he was HIV positive and he wanted to find a doctor with whom he could share about his sexual orientation and health problems. There are certain common infections out-there that, if accompanied by HIV diagnosis, require a more specific approach. So, I referred him to my GP by saying that she is very good, that I'm extremely satisfied and have been with her for a long time etc. Sometime later, he shared with me that he only saw her once and never went back because she had referred him to a quacksalver. She'd told him that the quacksalver will do something and he'd get rid of the AIDS.

BG LGBTI 2: Doctor?

BG LGBTI 1: Yes, a doctor! This is clearly a superstition, a belief which is part of the conspiracy that AIDS doesn't actually exist; that AIDS is a method of taking our money etc.

Bulgaria LGBTI Focus Group

IT LGBTI 1: We tried to do training especially for first aid, especially of transgender prostitutes that when they arrive in the emergency room. It's is a disaster... They come in dramatic circumstances maybe after beatings and stuff like that, they have documents or sometimes they don't, anyway immediately once the situation is spelled out the nurse gets all confused, the doctor gets all confused, this woman gets even more agitated. It would take training in particularly in first aid, on how to handle [this]. They do not know where to put them, they put them in the room here or there.

Italy LGBTI Focus Group

Legal, administrative and bureaucratic inequalities

BG LGBTI: The endocrinologist said "You have to change your documents etc, and then you can come to see me" which was ridiculous.

Bulgaria LGBTI Focus Group

BG LGBTI: I think that it is the hardest for trans and intersex people to access healthcare, as they lie outside of the standard model. Starting with simple things such as stating your gender on a document, they very quickly get themselves in a situation where they don't want to be in.

Bulgaria LGBTI Focus Group

BG LGBTI: At some point the following starts to happen – for example, you need that procedure which has the potential to disrupt your childbearing ability. And you need to give your consent in whatever form for this procedure to take place. However, on the other hand, the court forces you trans people to undergo this procedure – i.e. if you want your documents changed, you sign everything, lie down, get castrated and then maybe you could get your documents changed.

Bulgaria LGBTI Focus Group

PL LGBTI 1: You have to give a specific person [next of kin], give the relationship to that person to make decisions or to receive your medical documents...

PL LGBTI 2: Really? Do doctors ask you that questions?

PL LGBTI 1: Yes, always they ask the relationship to that person.

PL LGBTI 3: I've never come across that.

PL LGBTI 1: I answered it's none of your business. I answered: a lover! Have you got a problem with that? And straight away the conversation changes, often I had to change the specialist. But what if there is only one specialist in the whole country? But if the doctor is homophobic, you cannot explain anything. They often keep making comments about it. And it doesn't matter that later on they will say there were joking. They won't apologise.

Poland LGBTI Focus Group

Poor treatment and active discrimination from HCPs and associated workers

BG LGBTI: I have been having treatments for depression for the past 17 years. I could complain about every single one of them but my GP.

Bulgaria LGBTI Focus Group

BG LGBTI 1: I came across the most reputable gynaecologist, who everyone recommended. He told me that once I get better, once I am cured and then if I want to have a baby, to come to him. So really...

BG LGBTI 2: What do you mean be cured. Cured from homosexuality?

BG LGBTI 1: Yes. When I'm cured and want to have a baby to come to him.

Bulgaria LGBTI Focus Group

BG LGBTI: I feel humiliated so I don't complain to receive a good service. The aim of the visits is to receive a good health service, so even if the doctor is homophobic, I don't say anything. I don't feel strong enough for that.

Bulgaria LGBTI Focus Group

UK LGBTI 7: Throughout that transition I had support, sometimes grudgingly, from the support services. Complete lack of understanding, even when I was waiting for the operation. The nurses were okay, very supportive. But the cleaning staff were hostile, absolutely hostile, to the point where they treated us as objects... That particular cleaner treated me with icy disdain – there's no other word for it. I was a thing, she would avoid eye contact, clean, minimal cleaning, done. But I thought, is this the way it's going to be?

UK LGBTI Focus Group

LT LGBTI 2: If you went to any public policlinic and revealed your sexual orientation, I don't think that every doctor would reacts positively, even in the reception you would be perceived as stupid or something.

Lithuania LGBTI Focus Group

PL LGBTI: I think as soon as you come out the experience turns bad. Before I come out, as long as I live following the 10 commandments, it's ok. But as soon as you come out... During the past 16-17 years of psychiatric and psychologist treatment I haven't met one psychiatrist nor psychologist that would treat this subject with respect. I'm not even saying with understanding, but just respect. So every time I had to change the therapist.

Poland LGBTI Focus Group

Barriers in accessing healthcare services for LGBTI people

Ongoing discrimination and refusal of healthcare

UK LGBTI 8: I was in bed. I'd had a lumbar puncture, and it's the worst headache ever. You can't even sit up. And we just were hugging, and some visitors to the patient in the bed next to us complained about behaving inappropriately... On that occasion it was about other members of the public, other visitors to patients... What, do you think it's erotic to be in a hospital bed, do you think that's really what's going on? You just feel like ... It's a different kind of assault. It felt really like a violation at the time, I was so upset.

UK LGBTI Focus Group

LT LGBTI 5: For a long time I was afraid to go to the doctor because I was expecting a negative response and negative reaction.

Lithuania LGBTI Focus Group

LT LGBTI 6: When I was pregnant and when I had to see a doctor. I was hiding my sexual orientation in every possible way because I wanted my child to receive appropriate healthcare.

Lithuania LGBTI Focus Group

PL LGBTI: Back then my hair was cut short – I looked stereotypically like a lesbian. During the health questionnaire the doctor started making comments about how the times have changed, because there are so many perverts around, so many homosexuals. I told her I was a homosexual and I did not want to listen to her comments. Straight away she backtracked her comments, but it left me feeling really low. I even told her she had no right to say things like that in the doctor's office even if these were her private beliefs. Especially that in 1994 the World Health Organisation removed homosexuality as an illness. So she probably got scared and that's why she backtracked her comments. She said she was only kidding. But afterwards I was talked about behind my back in the hallway – I know because the nurses and other doctors were whispering "She's the one".

Poland LGBTI Focus Group

PL LGBTI: Recently urgently I had to go to hospital. I couldn't use my connections so was seen by a consultant in A&E. She treated me horribly, labelled me from the beginning. Later on my friend arrived who showed some sort of feelings towards me. The doctor's attitude got even worse. When I was discharged, the doctor did not even say one word. Later on the staff were pointing fingers at me.

Poland LGBTI Focus Group

BG LGBTI: I have a health problem that is recurrent. It's not serious but it's worrying in the sense it's considered a pre-cancerous state. It's been treated unsuccessfully numerous times and I have informed myself about the different ways that this can be treated/removed invasively. I have been refused any intervention on the basis that I have never given birth. They told me that. We're talking about a pre-cancerous state that is recurrent. In a summery,

they are telling me: "get cancer, unless you give birth to a baby I will not remove this for you".

Bulgaria LGBTI Focus Group

Assumptions that patient is heterosexual, cisgender and non-intersex

BE LGBTI 7: I want to be treated just like everyone else. But I demand from every doctor, every psychologist, every carer, that they a minimum basic knowledge. And that starts by simply saying 'how's your partner' and when he starts talking to me about my wife then it's a fail from me.

Belgium LGBTI Focus Group

PL LGBTI: I would like the doctors not to automatically assume I am heterosexual. I am sick of that. I have an experience with gynecology from the labour ward. Every time they assume there is a father. Even if there isn't one, they still ask.

Poland LGBTI Focus Group

UK LGBTI 5: Everything is so heterosexualised in the hospital, so everybody you're with in the wards and everything, it's just geared to heterosexual people, and so ... and when you're there long term, that can become quite wearing... It's just not geared up, really, hospitals or any of those services, for people who aren't heterosexual, in the long term. And I think that becomes quite an issue I think. So for me it was my emotional wellbeing.

UK LGBTI Focus Group

BG LGBTI: When there is the presumption of heterosexuality over us, we're all stereotyped from this point of view and if we're not married with children etc. there must be something wrong with us.

Bulgaria LGBTI Focus Group

LT LGBTI 6: I have also made a decision to be open thinking that it is enough of these lies. But they never ask me in a way allowing me to come out. For example one time when I was married but at the same time I was dating women... For them my marital state was enough of information; hence, they never asked me any questions. I never dared to say it first because in my life people have reacted to this topic inadequately as if this kind of information was absolutely unnecessary.

Lithuania LGBTI Focus Group

LT LGBTI 9: It is a very heteronormative thinking... People have this default thinking that everyone is hetero, unless you tell them you are not...

LT LGBTI 3: However, if you are not heterosexual and you don't want to have children, there are a lot of health problems that can occur and doctors need to keep it in mind.

Lithuania LGBTI Focus Group

Diversity within LGBTI and intersectionality

BG LGBTI 1: Patients going to see the doctor should know that he is there for them. Not the other way round. If that changes then patients would have the courage to speak up.

BG LGBTI 2: But you still have to have some sort of expertise. I think.

BG LGBTI 3: You have to be privileged in some way.

BG LGBTI 2: Yes, privileged.

BG LGBTI 3: Yes and those privileged people should start speaking up, doing something. Otherwise no one else will. The less privileged won't.

BG LGBTI 2: I think you just have to be white male from [town].

BG LGBTI 1: And rich one.

Bulgaria LGBTI Focus Group

UK LGBTI 7: People who are excluded: homeless LGBT people for a start. They find it very difficult to get into the healthcare system. You have to have an address. I've been supporting homeless people, several hundred people in the LGBT community over the last year or so. Just advocacy with the council. And yet, and this is something, because homeless people tend to have the worst health problems.

UK LGBTI Focus Group

UK LGBTI 9: I think they just have to be aware of LGBT issues, instead of oversensitive... In terms of the intersectional approach... I actually responded to my counsellor [who said I was stressed because of LGBT issues]. I said, why didn't you think it could be because I'm Chinese so that I feel stressed. And he said, erm, because you speak English. And I was thinking, so actually, you are not culturally sensitive, you are only LGBT sensitive, which makes you oversensitive on this.

UK LGBTI Focus Group

PL LGBTI 1: I think the mentality should change, the way they treat women in general. Not only LGBTI. If that doesn't change, then we can't expect a lesbian to go to the doctor and to say: Hey, I've got a girlfriend. It's great. Gays still have it better than lesbians.

PL LGBTI 2: Exactly. Women have it 5 times worse.

PL LGBTI 3: Women are discriminated against.

Poland LGBTI Focus Group

LT Facilitator: Which LGBT group people are the most vulnerable in the healthcare context? Is it women? Bisexual people? Transgender people?

LT LGBTI 6: I would say that this is not some sort of 'oppression Olympics' where we compete for more oppressed status....

Lithuania LGBTI Focus Group

Stigmatising attitudes and beliefs of wider society

LT LGBTI 5: For a long time my GP was also my parents' GP. And when I haven't come out to my parents, at the moment I have only come out to my mom, but not to my father. However, when there is this circle of people knowing each other, I am afraid that somehow my parents will get to know it.

Lithuania LGBTI Focus Group

PL LGBTI: We need a reliable portal with information maybe a separate one for gays and lesbians where we could find information about doctors, specialists, different diseases. Sometimes you can be embarrassed to say something about the illness.

Poland LGBTI Focus Group

BG LGBTI: What do you expect to be different when beliefs such as, "you can catch homosexuality through contact with homosexuals", dictates the common attitudes? So, when you have a doctor with that idea in their head, how do you expect them to show interest in dealing with LGBTI people – he'd most likely be afraid. And if he's not so much afraid of catching it, he'd be afraid of what other people might say, what his colleagues might say – "if he's treating these people then he must be one of them! Why are you taking them to your consultation room? What are you doing there all night or all day?". This fear is rooted in our society which also lacks tolerance - these two factors vitiate any attempts at tackling this problem before they've even been made.

Bulgaria LGBTI Focus Group

LT LGBTI 6: [HCPs] learn exactly as every other Lithuanian: from TV, from [specific homophobic politician], and so on. Maybe some positive information from the internet or so reaches them. I believe that it is naïve of us to expect support and understanding from our doctors who are not taught about LGBTI people, if we don't expect the same from our society.

Lithuania LGBTI Focus Group

IT LGBTI 1: The only problem we had was with the ward priest who walked into the room, making the usual rounds of the rooms, without even knowing who temporarily lived there. He arrived the day after giving birth... [My partner] was slumped over me and she was crying, really all the tears of the universe and he came and asked us ' Why are you here?' To me. I said 'Because we lost our daughters, our girls' and he looked up and I think he understood immediately. And so a little brusque, he tells me 'We who?', looking at the empty bed next to me. I say 'Us, because we are two moms and we lost our daughters' and he was immediately angry and said ' I'm sorry but I cannot pray neither for you or for the baby girls'. He took the door and left.

Italy LGBTI Focus Group

Barriers for HCPS providing care for LGBTI people

Assumption of no discrimination or negative treatment for LGBTI people

BE HCP 2: When you need care and you end up in a care centre that should become my home and you think 'that one around the corner is planning a whole campaign against me. I can't imagine you feel like fighting too much when you're ill. We see that a lot. People go back into their closets. So, I think care providers underestimate it. They think it's not really a problem anymore.

Belgium HCP Focus Group

BG HCP: The place where I work, I work in a hospital, I have numerous encounters with [LGBTI] people. To date, I have not been in a situation where these people weren't cared for exactly like any other patient in the hospital was cared for. Maybe a different attitude was present after the patient has left the hospital – there might be comments regarding what that patient was like. More often, they are related to the appearance of that patient more than anything else. At least, I have not seen any negative attitudes expressed by the doctors or by any of the visitors who were coming to the hospital. I believe that our nation has really taken a step forward and I don't believe that [LGBTI] people encounter major difficulties in this area. More likely, they encounter difficulties in other areas of their lives, not so much in the hospitals. After all, the hospital is a humane place where it doesn't matter what you are like.

Bulgaria HCP Focus Group

BG HCP 1: I think the problem with access to healthcare lies with the fact that the patients avoid going to the specialist because they worry that the doctor will have a negative attitude towards them.

BG HCP 2: I think that this is a very old-fashioned perception. People, nowadays don't do that.

BG HCP 1: Well, [the moderator] said that this has clearly come up in the LGBTI focus group?

BG HCP 3: I have the feeling that we all think that clinical care is this sterile, objective field which we provide to anyone – black, white, LGBTI or straight – and that this is some kind of bottled science that we pour to everyone's glass. Actually, the fact is that the treatment is not a standard, sterile, one-fits-all approach. It's usually a package of things...

BG HCP 2: I think that these people receive adequate care and attitudes. That's what I believe and I will continue to hold this belief because this is what I see in my practice, I don't see anything different.

Bulgaria HCP Focus Group

PL HCP: Maybe I am a bit naïve. I work with a lot of patients that are homosexuals or bisexual. For our medical staff it is not odd. We treat them like any other patient. If a nurse, doctor have enough empathy, any ill patient should be the same. The medical staff is there to help others. It should not matter whether they are gay or not. What matters are diagnosis and the treatment. Where I work, every patient is treated that way.

Poland HCP Focus Group

PL HCP: I really don't think this problem exists. Most of LGBTI people are open to show their private parts because they are really important to them.

Poland HCP Focus Group

UK HCP 5: May I pose a question? I completely recognise it around trans and I-people but I simply don't recognise within the LGB group that there is difficulty accessing healthcare. My question is how real is that and how much is it a perception thing? Am I alone in not recognising that is a challenge?

UK HCP Focus Group

Assumption that a patient being LGBTI is not relevant

BG HCP: I haven't been interested in asking about their sexual orientation because this is not part of my personal relationship with that patient. I do believe that this is a personal choice. But in my professional relationship I would always find out about her sexual partners, whether her partners are at the same educational/social level as she is etc. These are the questions I ask to enable me to provide information about sexually transmitted diseases, about the fact that both of them, or the three or even four of them might have to be treated. So, I ask about her sexual activities and not about her sexual orientation.

Bulgaria HCP Focus Group

LT HCP 5: I believe that nobody should be discriminated because of some reasons. And the terms should not be mixed. I think that the most relevant field is psychiatry as in other medical fields sexual orientation is less relevant...

LT HCP 7: It is really important to know about the social and psychological environments of the patient. I believe that sexual orientation, in case of LGBT individuals, is a very significant thing, same is in the field of psychiatry. We shouldn't disregard psychological and social environments when treating somatic diseases. Majority of somatic diseases are affected by the patient's environment, where he/she lives, who he/she lives with, what is his/her lifestyle and what he/she does... I think it is as important for a GP as it is important for a psychiatrist.

Lithuania HCP Focus Group

UK HCP 7: It's good to have that knowledge that that is relevant information if you're caring for people, you know, to bear in mind. That's a high percentage and that may inform how you provide care, to be more aware, more nuanced about what you're looking for in your patient, which is complicated ... which thing am I looking at? Am I looking at somebody who's really nervous because of this or because of a social thing? I think that's relevant.

UK HCP Focus Group

UK HCP 3: Sometimes their sexuality is key to who they are and other times it's irrelevant and that sometimes one thing is ... we live complex, complex lives and we are all operating a Western system where we've separated brain and body and don't see them together and we've separated that person. We take them out of their culture and social context and put them in a hospital and that is very ... that's not how we live. That's not how we live anywhere else.

UK HCP Focus Group

BG HCP: I just can't stop thinking about the conversation about the different races in the USA. The conversation began with "I don't see colour – whether you are black or white – it doesn't matter to me". This conversation proved to be insufficient for a number of reasons. But what the people with a different skin colour said was: "Actually, I want you to see my colour so you can communicate with me better". Without saying that the two things are the same, we could exchange the phrase "person of colour" with LGBTI we can achieve the same. You can't provide equal opportunities to healthcare if you don't see who the person is. This is why I don't believe that we have something sterile like science that we can just give to anyone, especially in Bulgaria.

Bulgaria HCP Focus Group

Attitudes of co-workers, other patients, and wider society

BE HCP 2: I think that if the government doesn't get involved or nudges the door open then people won't take any action. You notice the same with HIV. You have an ageing HIV population and it happens that they need go permanently in to a care home. When the families contact the various institutions then they get to hear that they're not ready for it. It's been going on for 30 years and you're not ready? So yes, I think the government needs to help. They need to create the right climate and set expectations.

Belgium HCP Focus Group

Be HCP 2: I remember an elderly gay man and he had to go into a care home. They'd asked me to go and see him as he needed to talk to someone... He was talking about his far-flung holidays and I thought everything is fine here so I try to talk to him but he signals that he does want to talk to me but not right now. He was talking about how he'd made those holidays with his wife. Now that man has never had a wife. When I talked to him afterwards he said he was struggling a bit because he still wasn't over the death of his partner, 'Yes I'm going to look for a woman who accepts I'm gay'. When I said 'But you've never had a woman' he said 'Yes but a gay relationship is unacceptable in society'.

Belgium HCP Focus Group

BG HCP: The Bulgarian reality - when you care about a patient and if you even remotely suggest that they might have a different sexual orientation you place yourself in the position where LGBTI might think: "What the hell? He thinks I am gay and am I really making it that obvious? Why is he talking to me like that"; However, if you don't show interest at all, LGBTI might think: "Oh, he's not interested in me at all. Why is he talking to me this way?".

Bulgarian HCP Focus Group

PL HCP: We can't start with recognising same sex partnerships straight away. First we need to accept these people. We need to show that these people are normal people, our friends, and our work colleagues. Until then we won't be able to change the law.

Poland HCP Focus Group

LT HCP 4: People should react to information and information about these social groups should be promoted and providers of the information should be supported. A lot of it is about being brave enough to talk about it. There are great specialists who are extremely open but sometimes they are not brave enough even to react to something someone said... I definitely have heard things about minorities. They said they wouldn't treat them. "There is this disgusting Jew" and so on. And naturally I get anxious. How can I say I don't accept this thing?

Lithuania HCP Focus Group

Legal, administrative and bureaucratic barriers

BE HCP 2: Something we get confronted with in my field is that doctors don't seem to have the time. They have 20 minutes per patient, I'm talking about doctors who work in an AIDS reference centre, and they know they should make more time but often it's just the technical side like looking at blood and liver results, etc. so that there's no time for the other things. So, I think an important aspect of being a care provider is to be able to make a difference. How much time do you take for your clients or patients?

Belgium HCP Focus Group

LT HCP 4: Talking about endocrinologists... They cannot legally prescribe hormone therapy to transgender individuals as it is not approved by the law. If a doctor prescribed hormones, he/she could lose his/her license.

Lithuania HCP Focus Group

LT HCP 4: I would like to say that the current healthcare system – everyone has a very heavy workload. GPs are probably in the first place with the numbers of patients coming to see them during the day. What is the number?

LT HCP 10: I don't know, 30...

LT HCP 4: Yes yes, it is one of those...

LT HCP 9: It is the same in cases of other specialists.

LT HCP 4: Oh, specialists too... Specialists have to have a certain number of patients in a month. There is a lower limit and administration... I know they count the lowest number of patients and doctors have to do whatever they want to get patients. Administration doesn't give us freedom to choose how much time to spend with a patient. Maybe one of them needs half an hour and another one needs just five minutes when during a check-up you see there is nothing wrong with him/her... It is pathology of the system...

Lithuania HCP Focus Group

PL HCP 1: There are roughly around 40% of parents that accept the transgender children. And they try to work with psychologists, psychiatrist. They paid for the visits.

PL HCP 2: I am going to interrupt here. A friend, she's a psychologist, told me recently that the parents of transgender children are subject to the biggest stress because of the law. The transgender person to change the gender has to take their parents to court.

Poland HCP Focus Group

UK HCP 1: I also think the equalities legislation has been very helpful because when you work across agencies, increasingly working in charities or independent partners, it's often the providers, different sorts of care, you need the equalities legislation so that it becomes a priority for every organisation and then you tap into the passion of the individuals.

UK HCP Focus Group

What kind of training do LGBTI people think HCPs need? LGBTI-friendly attitudes

BG LGBTI: I have my GP who is aware of my sexual orientation. She never charges me anything, even when I'm there to receive my hormonal injections. Although it might be an isolated case, she and the nurse working with her are both wonderful. Both of them have very poor knowledge in this area but they have always told me: "Whatever you need, we'll do it" which is always better than nothing. It's definitely better than the other scenario where you have people with a lot more knowledge on the subject and well-established prejudice.

Bulgaria LGBTI Focus Group

BE LGBTI 3: More than just teaching that basis attitude it should also be clear that the institute who teaches it, has that basic attitude... I only want to prevent them saying 'ok we have to go but we'll add a diversity box'. That doesn't solve it because you forget about that box.

Belgium LGBTI Focus Group

Importance of training for students and current HCPs

BG LGBTI: The aim of this gathering and this discussion tonight is to gather and educate people; We don't need to educate, we need to lock these people somewhere and ram all these things in their heads. All these things that they hadn't managed to ram in their heads whilst they were at university. How did they even let them out of that university?

Bulgaria LGBTI Focus Group

BG LGBTI 1: Why any of the lecturers are not chastised for their comments or their behaviour? Or fired?

BG LGBTI 2: But the universities are independent.

BG LGBTI 1: If we want to change things from the outside, we don't stand a chance. Let's start from inside. When it's 50/50.

BG LGBTI 2: Sure.

BG LGBTI 1: And the young students see that the lecturers are not accounted for their actions. That they are not punished. There is no responsibility for their beliefs or gestures.

Bulgaria LGBTI Focus Group

BE LGBTI 3: I think the strength of the person I'm with now is that not only does he have academic knowledge but also because they actively working on it. With the whole non-binary thing. If you've only read the books, then I don't think you can really understand it. You probably think you know, but pure academia is not enough in my opinion... In general practice, it is true that during their course work, the students spend a week in a disadvantaged neighbourhood. Internships for what they don't see in the books, so they come into contact with it. I can't see that being the case for all doctors, that all future doctors should spend a week with the transgender team.

Belgium LGBTI Focus Group

Universal and mandatory training

BG LGBTI 1: Those that are [like blocks of wood], there's nothing you can do there.

BG LGBTI 2: For them you create strict rules and make sure that they follow them. Those that have arranged for this study to take place live in the far west from our country. They need to understand that just simple group discussions with a few doctors are productive but somewhere west of [border control site]). In Bulgaria, you have to create directives for the doctors and if they don't follow them, they should then be fined. I'm largely against these good-willed attempts to just sit them down and talk about it.

BG Facilitator: So, your suggestion is to have stricter rules that are associated with fines, if not adhered to?

BG LGBTI 2: Yes. That's what's needed in Bulgaria.

Bulgaria LGBTI Focus Group

BG LGBTI: I think this should matter for nurses and rehabilitators as well, as they are part of healthcare services. We're talking about communication, adequate thinking and avoiding discrimination and they should all be included in this. Especially, the nurses.

BG Facilitator: Yes. Actually, if you are admitted to a hospital you are primarily dealing with nurses and not so much with the medical specialists.

BG LGBTI: We need a protocol for communication.

Bulgaria LGBTI Focus Group

IT LGBTI 2: The staff should not only be informed but must be educated: from the consultant all the way down.

Italy LGBTI Focus Group

Contributing to cultural and institutional change

BG LGBTI: What we could do, the least we could do, is not to complaint but also to contribute to the process leading to change.

Bulgaria LGBTI Focus Group

BG LGBTI: Maybe inform the LGBTI people about their rights as patients; about the laws that exist against discrimination.

BG Facilitator: To inform them better?

BG LGBTI: Well, yes. This would enable them to make complaints and submit them to the relevant regulatory bodies because there is a law against discrimination after all.

Bulgaria LGBTI Focus Group

UK LGBTI 5: I think, because they don't really focus on those sort of issues that we're dealing with so much. So I think that could be one way forward, making people aware that they could be part of that inspection team.

UK Facilitator: So empowering LGBTI people.

UK LGBTI 5: Yes.

UK LGBTI Focus Group

IT LGBTI 4: In [city] there is a friend of mine who is completing a specialisation in surgery of breast reconstruction, both for cancer patients and those who are making the transition Male-to-Female. And she told me that they are equipped to make their own courses of specialisation for trainees, to learn how to manage their own language, the pronouns and all this with regard to the trans patients they have. And she is very happy, she says it's one of the few centres in [region] which has this type of service.

Italy LGBTI Focus Group

What kind of training do HCPs think HCPs need?

Importance of student education

BG HCP: By trying to normalise these conversations [about being LGBTI] with all women and worrying whether you might or might not offend some of them highlights the lack of good communication skills that would allow you to adequately address these issues. The worst thing is that these communication tools exist and can be learnt but they are not integrated in our educational system at the [university] and you have not been taught. Our educational system is very poor and I don't believe anyone who is saying that our healthcare specialists are well-trained and that our medical professors are wonderful. There's so much more that they can all improve.

Bulgaria HCP Focus Group

BG HCP: The medical textbooks [are] extremely outdated. All medical textbooks talk about the "ill" person but not everybody is "ill", not all problems are diseases... Unfortunately, our medical textbooks are authored by professors who have graduated from medical universities in the 1960s so they are old-fashioned.

Bulgaria HCP Focus Group

LT HCP 2: Everything depends on education. It would make it easier for everyone to live. We prepare specialists; hence, there should be changes in the program. And I am thinking here, so many years in psychiatry field gender disorders were mentioned so vaguely, they were simply listed somewhere as if we needed to know only that they exist. Other thing, this topic came up and was discussed only during lectures of medicine ethics. It was good as discussions were focused on human rights and medicine ethics and there also was one workshop that in my experience had positive effects. In my group some people changed their minds or were at least surprised. For example, there were 12 people who were indifferent towards intense discussions during the workshop but in the end some of them changed their opinion. Additionally, those who were very negative about LGBT social group were surprised by the fact that other people could have completely different views to them. They started to listen to others. However, it was only one workshop during late studies.

Lithuania HCP Focus Group

PL HCP: I had a situation like that in A&E in my hospital. There was a transgender person admitted to A&E, he was undergoing the gender correction. Everyone panicked. They didn't know what to do with that patient. The doctors didn't know how to talk to him. It comes from lack of education during the medical studies. There is no education included as part of medical university course. Everyone was scared to deal with that patient. They were looking for a volunteer. The patient attempted to commit suicide... We did not know how to act, what to say, what to ask. No one taught us. Now I work in a place where I have a lot of contact with LGBTI community. I am used to it. But for an average Joe...

Poland HCP Focus Group

PL HCP: In psychiatric studies the sexology subject was non-existent. The only lecture that was connected to sexology was the subject of erectile dysfunction. And that was only one lecture. So how are the young people supposed to learn how to deal with those people? How are they supposed to know anything about human sexuality or what is the sexual orientation, sexual identity? This is not covered.

Poland HCP Focus Group

UK HCP 2: I think HIV actually put sexual orientation on the agenda and I think there is some work around that and our [organisation] is actually putting on some training at the moment about sexual orientation and is including people who are transitioning and intersex. But... I don't think there's much very much for undergraduates. I don't think there is in the training for postgraduates. I think it's just coming up as an issue now. I think it's just beginning to be recognised.

UK HCP Focus Group

Inclusion of LGBTI people in training

UK HCP 1: The commissioner has kind of asked me to develop a pathway for transgender people. So I'm very, very excited because I found this co-design way of involving the young people for the service users and staff, whoever wants to be ... you know people who maybe struggle and people who are very pro. So you interview the young people first so they really feel they get their say and they get to choose the care pathway and they go along with it and then the staff, you know, they get interview. Then they all kind of come together and they're all equal so they're being heard, they're being understood, they're being valued and young people are empowered and then they actually have a way of, you know, focus groups. You build it and then there are sub-groups and then come up with the main themes. What has their experience been? What would they like it to be? What's realistic? You know it's all going to be in the pot and hopefully it's going to come out with a lovely [region]-wide transgender pathway.

UK HCP Focus Group

BE HCP 6: Sometimes I think it depends on the lecturer if the theme gets talks about. In my project, I have the ex-partner of someone transgender who lectures, and she says she spends a lot of time on the transgender theme. But that's mainly because she experienced it in her own life so in a way it's in the hands of the lecturer I think.

Belgium HCP Focus Group

BE HCP 4: But we should also have them on the board of directors so, like you said, so we can take them into account and to teach us where the sensitivities lay. I think it's a very important challenge. Definitely as otherwise we might miss the boat.

Belgium HCP Focus Group

UK HCP 4: As a trans person myself I'm currently pushing a lot of this stuff locally and apparently nationally because nobody is having this conversation in midwifery at all, about trans people accessing maternity care.

UK HCP Focus Group

Universal and mandatory training

LT HCP 9: In case of working healthcare professionals, I would start with those in leadership roles. If there is a conflict between you and other specialists you usually go to see the head of a department or so in order to solve it. So I think they are the ones that should have the right information. In order for patient rights to be promoted we need to focus on these doctors. I don't know, special teaching, I don't know what principle to use but we have to start with those in the leadership positions so that they can stand for a patient if something happened because physically it is impossible...

LT HCP 5: I would like various professionals to be taught as some individuals in the leadership positions, and then we see that between the medics thinking differently... I would teach everyone, including leaders, doctors and the head of the department...

Lithuania LGBTI Focus Group

PL Facilitator: What should the training look like? Who for? Who should lead it? How to do it so that it is effective?

PL HCP 1: For everyone - from the top to the cleaners.

PL HCP 2: Exactly.

PL HCP 1: For everyone, led by competent people. We had that in our hospital. We have to remember that cleaners spend the most time with the patients.

PL HCP 3: Yes, but now often the cleaning staff is outsourced.

PL Facilitator: Can this be a barrier to the training?

PL HCP 3: The outsourced personnel have no right to access any medical information. It is really difficult to organise for them to clean the doctor's offices and not to be able to see any medical files. The legal aspects make it very difficult.

Poland HCP Focus Group

Be HCP 6: The frontline needs to be able to receive them. I find that very important. It's something I see when I talk to care centre management that within their personnel they'll have someone who's completely homophobic and they do not know how to handle that. I also hear from the elderly that they'll get bullied by the personnel. So then I do wonder what you're doing working within the care sector. Shouldn't you be doing some caring? I think being educated in this is very important.

Belgium HCP Focus Group

UK HCP 1: I work at the local hospice. So we kind of were health but then we got a whole set of stuff that is set up to support us to be able to deliver on the health and for us it's important ... you know we need to engage with the local community on every level, really, both as funders, supporters, volunteers, staff, patients... I mean obviously our primary focus is patients but you know when we need the money then our focus depends on what your job is really...

UK HCP 2: Your volunteers are just as important.

UK HCP Focus Group

Working together to improve institutional culture

BE HCP 5: When I was teaching, the headmaster's son was gay so he had a much greater involvement in it. When something arrived from the government it immediately went in the main room. This happened 20 years ago, but a lot depends on the personal involvement of the person and that applies to all themes. Those are the goals.

BE Facilitator: Are you saying that personal involvement is important for the person giving the training or teaching?

BE HCP 5: It always stays important.

Belgium HCP Focus Group

UK HCP 1: I think that would be a really good space for space for something for LGBTI, and for [an LGBTI HCP] like yourself, you know, a champion of good practice, to come along and just open our eyes up to it a little bit more.

UK HCP Focus Group

PL HCP 1: The example: The patient is being admitted to A&E. They have to give a next of kin, so that another person could also see the medical records for example. At that moment in time the medical receptionist forces that patient to reveal the relationship with that person, which is not needed by law. You can name your next of kin regardless of the relationship.

PL Facilitator: Why do you think this happens?

PL HCP 1: I think it's because of the old times.

PL HCP 2: I don't think it's because of the old times. I think if the employer trained their staff properly and enforce it, it would not happen. It's not because of the old times. We are here to learn and to educate others. If I work with someone who behaves this way, I would go to their supervisor. If we won't start reprimanding each other, then we won't change anything.

Poland HCP Focus Group

UK HCP 3: I would say the staff probably represent the population of Brighton and Hove reasonably well if you include from your consultant to your cleaner and don't ignore them or, you know, actually they're your future patients. What are the issues that they face? They're here. They're in the hospital so you could use those people a little bit more to understand their difficulties.

UK HCP 4: Something about role models, isn't there? Actually the organisation is scattered with people like me. Maybe it's not so scary.

UK HCP Focus Group