COMPARATIVE REPORT

ATTITUDES, EXPERIENCES AND TRAINING NEEDS OF HEALTH PROFESSIONALS WITH REGARD TO LGBTI PEOPLE IN FIVE EUROPEAN COUNTRIES

OPEN DOORS

Promoting Inclusive and Competent Health Care for LGBTI People

Title: **Attitudes, experiences and training needs of health professionals with regard to LGBTI people in five European countries**

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Publisher: **Università degli Studi di Brescia**

Date: **July 2020**

This publication was produced as part of the project, *Open Doors: Promoting Inclusive and Competent Health Care for LGBTI People* co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020).

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Introduction

The purpose of this comparative report is to present the main results of the research carried out within the Open Doors project following the three methods of investigation applied: desk research, qualitative research via interviews, quantitative research through online survey. The first section provides a brief overview of legislation, guidelines and policies concerning the health of LGBTI people as well as programmes and services targeting LGBTI people in the five countries participating in the project. The second section is devoted to interviews with health professionals and experts, while in the third section findings of the online survey are shown.

SECTION 1 – Open Doors Desk research

1.1 Legal framework

The consortium represents a patchwork of different legal frameworks. This paragraph includes basic information about legislation and legal provisions that may affect LGBTI people's rights in the healthcare sector. More detailed information is provided in the corresponding section of national reports.

1.1.1 Discrimination law

Legislation prohibiting discrimination based on sexual orientation and gender identity, either expressly provided for the healthcare field or indirectly applicable to it, was enacted in Catalonia,[1] Hungary[2] and Bulgaria[3]. However, while the Catalan Law no. 11/2014 includes

[1] Law no. 11/2014 to guarantee the rights of lesbians, gay men, bisexual, trans and intersex people, and to eradicate homophobia, biphobia and transphobia.

[2] Act no. CLIV of 1997 on health care (Health Care Act).

[3] Law on Protection against Discrimination, promulgated in State Gazette #.86 from 30.09. 2003, in force from 01.01.2004, and amended to include "sex change" in 2015.

reference to the rights of intersex people, sex characteristics and intersex status are not specifically mentioned in the Hungarian and Bulgarian legislation.

On the other hand, in Italy, at least at national level, the prohibition of discrimination on the grounds of sexual orientation, gender identity and expression, or sex characteristics is not covered either by specific legislation or by the Constitution, although Articles 2 and 3 of the latter could be construed to offer protection to LGBTI people's rights in the whole system, including healthcare. Also in Poland such legislation is missing.

1.1.2 Legislation on gender affirmation treatment

In Italy the possibility for gender reassignment free of charge is recognised by law although the procedure is time-consuming and quite expensive in terms of procedural costs[4]. According to the law, and its interpretation since 2015, surgery (body change of primary characteristics and sterilisation) must be considered as an option not a necessary requirement for gender reassignment. In Hungary, there is no legislation granting or limiting access to gender-affirmation treatments for trans people and various hormonal and surgery treatments are offered by healthcare providers to trans people although only a small part of these treatments is funded by the national service. A recent Act banning the legal gender recognition for transgender and intersex people was passed by the Hungarian Parliament[5].

While in Bulgaria there is no legislation on gender affirmation and none of the procedures are covered by the National Health Fund, in Poland, trans people are forced to bring a civil action against their parents to access gender reassignment surgery and to have their identity documents changed according to their gender identity.

In Catalonia, some treatments for gender reassignment are free of charge and recognised by law. Although all hormonal treatments are included in the public health services portfolio, only certain surgeries are included, and they have long waiting lists. There is a special trans health service as part of the Catalan public health system, which works fine although it is currently overloaded with cases.

[4] Law no. 164/1982 as amended by Legislative Decree no. 159/2011.

[5] Act no. XXX/2020, see Article 33.

1.1.3 Next-of-kin

In Italy[6] and Hungary[7] same-sex partners both as registered partnership and in form of cohabitation are recognized as next-of-kin, in the same way as different sex partners are. In Catalonia, like the whole of Spain, same-sex partners are also recognised as next-of-kin providing they are married or they are registered partners. Although the Polish system does not recognise same-sex partnerships, according to the Patient Rights Act[8] when a patient is unconscious a physician should inform the patient's closest person, understood by the Act itself as someone living in a committed, intimate relationship (not necessarily marital and heterosexual) with the patient. On the other hand, in Bulgaria, the status of 'next of kin' is not recognised by law to the cohabiting partner in same-sex families, with serious implications for access to health information and procedures.

1.1.4 Assisted reproduction and surrogacy

With regard to assisted reproduction in Catalonia[9] all women of legal age can have access to assisted reproduction techniques regardless of marital status and sexual orientation while Bulgarian law does not exclude single women from accessing those techniques. Despite the letter of the law cases of discrimination against lesbian women or lesbian couples have been reported in both countries.

In Hungary single women are allowed to participate in assisted reproduction[10] while women in a same sex relationship are explicitly excluded by the law[11], while in Italy[12] and Poland[13] both single women and women living in same-sex relationship are still prohibited from access to medically assisted procreation.

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[6] Law no. 76/2016 which regulates civil unions between persons of the same sex and provides rules on cohabitation.

[7] Act no. CLIV/1997 on health care (Health Care Act), see Article 3:r.

[8] Act of 6 November 2008 on Patients' Rights and the Commissioner for Patients' Rights, see Article IX

[9] Law no. 14/2006 on assisted human reproduction techniques.

[10] Act no. CLIV/1997 on health care (Health Care Act), see Article 167(4).

[11] Act no. XXIX /2009 on Registered Partnership and Related Legislation and on the Amendment of Other Statutes to Facilitate the Proof of Cohabitation, see Article XX.

[12] Law no. 40/2004 laying down rules on medically assisted reproduction.

[13] Act of 25 June 2015 on treatment of infertility.

With regard to surrogacy, it is outlawed and criminally sanctioned in Italy and Hungary and it was banned since 2019 in Bulgaria while there is no specific regulation on the matter in Catalonia and Poland.

1.1.5 Intersex minors

Despite the fact that the European Parliament[14] has repeatedly stressed the need to address violations of the human rights of intersex people by calling on Member States to propose legislation to address these issues, none of five countries of the consortium enacted binding legal provisions banning sex-normalising treatments and surgery on intersex children.

1.2 Research, programs and strategies

Overall research on the health needs of LGBTI people is quite poor in all five countries of the consortium and this prevents the development of appropriate national health strategies or plans specifically targeting LGBTI population.

National health programmes rarely take the LGBTI community into account, with the exception of those on HIV/AIDS and STIs prevention which explicitly mention MSM (men who have sex with men) and trans people in Italy[15] and MSM in Bulgaria[16], as a key population to which specific measures should be addressed.

Nevertheless a few positive examples in the opposite direction, in the sense of including the needs of LGBTI people, have been found like the implementation protocol ex art. 3 of Italian Gender Medicine Law[17] where sexual orientation is included as parameter to take into account in the assessment of pathologies and in their management and, a specific paragraph is dedicated to the wellbeing of transsexual and intersex people. In more general terms the

[14] European Parliament, Resolution on the rights of intersex people, 2019.
https://www.europarl.europa.eu/doceo/document/B-8-2019-0101_EN.html

[15] Ministry of Health, Piano nazionale di interventi contro HIV and AIDS (PNAIDS) (*National plan of actions against HIV and AIDS*), 2017.
http://www.salute.gov.it/imgs/C_17_pubblicazioni_2655_allegato.pdf

[16] Ministry of Health, Национална програма за превенция и контрол на ХИВ и сексуално предавани инфекции в Република България 2017-2020 (*National Program for Prevention and Control of HIV and Sexually Transmitted Infections in the Republic of Bulgaria for the period 2017-2020*).
http://www.strategy.bg/StrategicDocuments/View.aspx?lang=bg-BG&Id=1226

[17] Ministry of Health, Piano per l'applicazione e la diffusione della Medicina di Genere *(National Plan for the application and dissemination of Gender Medicine*).
http://www.salute.gov.it/imgs/C_17_pubblicazioni_2696_allegato.pdf

Health Plan (Plan de Salut), developed by the Barcelona Health Consortium, makes explicit reference to LGBTI people recognizing that the discrimination they suffer has consequences for their health.[18] However, the extent to which LGBTI people's health is actually affected by these plans remains to be ascertained.

In some countries, as in Hungary and Poland, an important role is played by NGOs which carried out researches on LGBTI people health needs and/or discrimination they experience in healthcare settings.

1.3 Support and services to LGBTI patients

Aside from the Catalan service for trans people health (Trànsit), there are no publicly funded health services targeting LGBTI patients in any of the five Open Doors countries. However, in some cases, like in Italy and Bulgaria, health systems work in collaboration with non-profit organisations in offering HIV and/or STIs prevention services in order to effectively reach the target population (MSM) through community-based centres where people can get consultations, free testing and/or referral to health treatment.

While a few NGOs provide specific support to trans people, including psychological counseling, assistance in the transition path, referral to trans-friendly service providers, there are no services targeting intersex people specifically. Although organisations dealing exclusively with health of LGBTI people are extremely rare, many LGBTI NGOs provide health-related services especially in the field of mental health and HIV prevention.

As with services, medical guidelines and treatment protocols specific for LGBTI people are practically non-existent with the exception of two Catalan protocols, one on medically assisted reproduction[19] revised in 2016 to include lesbian women and another one for a non-

[18] Catalan Department of Health, Pla de salut 2016-2020 (*Health Plan*). https://salutweb.gencat.cat/ca/el_departament/Pla_salut/pla-de-salut-2016-2020/

[19] Catalan Department of Health, Protocol de les tècniques de reproducció humana assistida (*Protocol on Assisted Human Reproduction Techniques*), 2016. https://canalsalut.gencat.cat/web/.content/_A-Z/R/reproduccio_assistida/documents/protocol_rha_def.pdf

There is also a STI protocol, currently under review, which includes, among other actions, a new strategy for papilloma virus vaccine for boys under 25 who have sex with boys.

pathologizing trans healthcare[20], and Italian guidelines on the use of antiretroviral drugs[21] explicitly referring to MSM and trans women as persons who could benefit from pre-exposure prophylaxis (PrEP).

In the absence of national guidelines, some professional associations and some health professionals interviewed refer to international guidelines which propose the use of an affirmative framework and a non-pathologizing approach.[22]

SECTION 2 – Open Doors Interviews

Between December 2019 and March 2020, fifty in-person semi-structured interviews, following a standardized interview model were carried out in the five countries participating in the Open Doors research project (10 for each country). Selected interviewees have a key role in the healthcare sector, medical educational institutions and at policy making level. The questions included in the interview were intended to cover the same areas investigated with the survey (see *infra*), namely attitudes, experience and training needs of health professionals and to gather information on the state of the art (existing laws, guidelines, protocols, good practice that may have an impact on the health of LGBTI people) to complement the desk research.

2.1. Attitudes and experience

2.1.1 Challenges and barriers

According to the majority of professionals interviewed in this study the main challenge they face with LGBTI patients or clients is how to use appropriate and inclusive language. Most of them felt unprepared and did not know how to create a comfortable environment. Talking about their experience with LGBTI patients one interviewee stressed that the foremost

[20] Catalan Department of Health, Atenció a la salut de les persones trans (*Paying attention to the health of trans people*), 2017.
https://catsalut.gencat.cat/ca/serveis-sanitaris/altres-serveis/model-atencio-salut-persones-trans/

[21] SIMIT and Ministry of Health, Linee Guida Italiane sull'utilizzo dei farmaci antiretrovirali e sulla gestione diagnostico-clinica delle persone con infezione da HIV-1 (*Guidelines on the use of antiretroviral drugs and the diagnostic-clinical management of people with HIV infection*), 2017, p.152.
http://www.salute.gov.it/imgs/C_17_pubblicazioni_2696_allegato.pdf

[22] References made to: The World Professional Association for Transgender Health, Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People, (7th version, 2011); American Psychological Association, Guidelines for Psychological Practice With Transgender and Gender Nonconforming People, (2015); American Psychological Association, Guidelines for Psychological Practice with Lesbian, Gay and Bisexual Clients, (2011).

difficulty encountered is "how to talk about certain topics without hurting personal sensibility and making judgements. We are unprepared and untrained in terms of communication" [andrologist, Italy], while for another "which questions to ask such patients and how to ask them" [microbiologist, Bulgaria] proved to be problematic .

This feeling of inadequacy can lead to avoiding questions that would be useful to establish a fruitful doctor-patient relationship as reported by one of the interviewees "I can be too cautious, because I'm not always sure what words I am supposed to use" [psychologist, Hungary].

Factors that make access to health services more difficult for LGBTI people are mirrored by those that prevent health professionals from providing a good quality care.

Although in principle the health system guarantees, or should guarantee, equal access to all and doctors are required to treat each patient in the same way, there are cultural and structural factors that make non-discriminatory access to services deceptive. Most professionals interviewed believe that the main barriers faced by LGBTI patients, when accessing the healthcare system, are: the fear of meeting unprepared, unwelcoming and judgmental people who make patients feel even worse, discrimination and lack of acceptance as well as taking patients' heterosexuality for granted. Unwillingness to treat LGBTI patients was also highlighted by a few participants in the interview.

Fear of being discriminated against or encountering stigmatizing attitudes and homo-transphobia of health professionals, often based on previous bad experiences, can lead LGBTI people to delay or avoid accessing healthcare services and seeking treatments. As underlined by some interviewees, for fear of not being accepted "LGBTI people cannot communicate appropriately their issues, because the medical stuff is not open enough" [midwife, Hungary] and "[they] are ashamed to come with their partners for testing or consultation" [microbiologist, Bulgaria].

A serious episode of prejudiced attitude and discrimination was reported by one of professionals interviewed:

"We have had situations with an HIV patient and another HIV and hepatitis patient. And both were gay men. One of my colleagues wanted to put both patients in the same room, because as she said "gay diseases should be together". I was really frustrated and confronted her that this

is against the rules, because the HIV patient has already a compromised immune system and to put another HIV patient who also has hepatitis, which is infectious disease, is strictly forbidden. My colleague said that she cannot stand gay people and she said "I don't care if he gets infected by hepatitis". She also wanted to let him out of the hospital sooner" [surgeon, Bulgaria].

With specific regard to trans patients the health environment is even more challenging: stigma towards trans people by medical profession, impossibility or difficulty to access both hormonal treatment and surgery or to access them for free, difficulty in arranging andrological or gynaecological visits and which room/ward trans patients should stay when documents do not match with their identity are the principal barriers underlined by the interviewees. A worrying refusal to provide assistance to trans people was reported by two participants: "[T]here are doctors who do not want to deal with trans, the stigma toward trans people by the population in general and the medical class in particular is very strong" [head of medical research in a not for profit foundation, Italy]; "some institutions communicate to trans people that they don't deal with trans" [psychologist, Poland].

Obstacles can become even greater in case of vulnerable intersections especially for migrant trans as underlined by two interviewees. For example one respondent, talking about free access to antiretroviral treatment, said:

"Brazilian trans enter the country with a visa that does not allow them access to the national health system. A certain period of time has to pass before they are granted this access. If they cannot pay for treatment there is a problem of continuity of care and this is of serious concern. Nevertheless, we try to find a way for ensuring treatment and avoid transmission" [university professor in infectious diseases, Italy].

As regards intersex patients the main barrier underlined by one professional interviewed is the spread ignorance of medical profession about intersex condition. Moreover according to another interviewee "medicalized intersex people do not want to go to doctors because of the trauma suffered by unintended surgery or hormonal treatment" [sociologist and activist, Italy]. Several respondents explicitly said they did not have proper knowledge about intersex condition so they were not able to talk about it.

According to the professionals interviewed, adequate training and education is the most effective strategy that should be implemented to overcome the barriers that LGBTI people

encounter in accessing the health system and to provide them with good quality health services. Support to coming out and introduction of inclusive registry for trans people were suggested by one interviewee, while another one underlined the need to collect data on trans and intersex population for establishing suitable health policies and strategies.

Professionals have varying views on whether LGBTI people have different health needs compared to general population and many distinguish between lesbian, gay and bisexual patients, on the one hand, and trans and intersex patients on the other hand. According to some interviewees minority stress, anxiety, lack of acceptance and understanding can affect LGBTI people's health. These factors should be considered in the assessment of the health status of LGBTI patients: for this reason a more sensitive staff, capable of embracing diversity and able to overcome heteronormativity approach, would be required. However, a few interviewees do not think LGBTI people have different health needs: for instance, one professional said "I don't think LGBTI people have specific healthcare needs. Patients are patients regardless of their sexual orientation and/or gender identity" [university professor in infectious diseases, Italy], while according to another "No, I don't think they have specific needs. Nobody should be treated differently no matter sexual orientation or other features" [medical consultant, Bulgaria]. Furthermore, one respondent said that in her view "LGBTI people do not have different needs, but rather their own specificities, as in relation with risk factors" and she gave the example of a lesbian woman, which may have less risk factors in pregnancy or STIs [gynaecologist, Catalonia].

With regard to LGB patients "more health risk behaviour, higher problematic substance use, suicide and self harm rates, less physical activities" were mentioned as relevant factors to taken into account by one interviewee [general doctor, Hungary], while another respondent said "there are particular needs linked to some pathologies, for instance: increased risk of diseases to rectal apparatus for gay men, but their mapping is difficult because patients' sexual orientation is usually not investigated and many situations escape the national health system." [law researcher, Italy].

Besides a high risk of distress which has negative consequences for health, with regard to trans patients the main health needs mentioned by professionals interviewed are related to the transition path, screening for some kind of cancer (for instance, MtF may need screening for prostate cancer; FtM may need pap test or mammography) and side effect of hormonal therapy.

For intersex people some professionals stressed the importance of specialized medical staff well educated in intersex conditions that is able to evaluate when medical interventions are required and when should be avoided (as for interventions mainly performed for aesthetic purposes which often worsen rather than improve the health of patients).

Professionals do not share a common view regarding the importance to know about patients sexual orientation, gender identity and sex characteristics for health purposes. For some of them, the dividing line between relevant and not relevant is represented by the field of specialization: to know about patients' sexual orientation, gender identity and sexual characteristics is regarded as fundamental in sexual and reproductive medicine and important in certain fields like gynaecology and andrology. In the opinion of other interviewees, it is necessary to distinguish between the physical/anatomical characteristics of the patient, on the one hand, and his/her sexuality, on the other: while it is deemed important to know the former, the same is not true for the latter which concerns, instead, the intimate and private sphere of the person. However, a possible downside of knowing that a patient is trans or intersex was reported by one interviewee: "some aspects of anatomies are important to be known, but this also coexists with a tendency to over attribute certain health issues to "unexpected anatomies"... for example, many intersex people narrate that all their health problems are usually ascribed to the "intersexness" by doctors" [health promotion professional and activist, Catalonia]. The risk of facing untrained professionals was pointed out by another participant: "[I]n general health professionals are very unprepared on trans and intersex issues and that can do serious damages" [sociologist and activist, Italy].

Professionals who support the view that is important to know about patients' sexual orientation have indicated mainly two reasons for it: 1) get a more complete picture of the patient, which is essential to provide a better service; 2) identify risky habits and behaviours. However, the risk of prejudiced views (i.e. gay = STIs) was stressed by one participant [orthopaedist, Italy].

Participants who ask about their patients' sexual orientation, gender identity and sex characteristics said they do it in an indirect way mainly using neutral and inclusive language and according to one professional: "[how to ask] it is a practice that must be introduced and taught: for instance, heterosexual married is not asked if he has sex with other men /trans, but it's fundamental to know it to do prevention." [psychiatrist, Italy].

The reluctance to recognize specific needs perhaps partly related to the lack of knowledge and training but also to a different understanding of the term "health needs". The different view on

this topic is well represented in what was said by two professionals interviewed, both dealing with HIV and STIs, when asked if in their opinion it was important to know about patients' sexual orientation, gender identity or sex characteristics.

"Yes, it is important. I ask their "role" in the relationship as well, so I know from where I should take samples for the tests. My colleagues do not ask about this. It is very relevant in our field of practice." [doctor specialised in sexually transmitted infections, Hungary].

"To know about sexual orientation, gender identity and sex characteristic of a patient is important from an epidemiological point of view, but not for health purposes because human anatomy is the same. Anyway, usually our patients feel comfortable telling their sexual orientation". [university professor in infectious diseases, Italy].

2.2. Training needs

There is a broad consensus among interviewees that average health professionals are poorly equipped and do not have adequate knowledge to deal with LGBTI patients and their needs. This opinion is based on interviewees' own experience and their confrontation with students and colleagues

According to the professionals interviewed, lack of adequate training, outdated medical textbooks, as well as prejudices and people's mentality are the main reasons that prevent health professionals from treating LGBTI patients correctly. For instance, one participant in the interview mentioned a textbook, published 15 years ago, in which the term "homosexuality" is used as a synonym for buggery and sodomy.

It is a shared view that training would have a positive effect. For instance one interviewee underlined: "an adequate training would have a positive impact improving the quality and length of life of LGBTI people" [psychiatrist, Italy], while according to another "the prejudices and the mindset of health professionals" – due to the lack of appropriate training – "is what keeps them from treating LGBTI patients properly" [medical student, Bulgaria].

The dichotomy between new and old generations has been highlighted by some interviewees: "There's a generational gap and older medical staff are less sensitive to LGBTI topics, in general terms" said one professional [hospital coordinator, Catalonia], while another added "a cultural revolution is required. Doctors have to help patients and thanks to knowledge they will be able

to do it. The gap will be filled in the coming years because young people have a new mindset" [head of medical research in a not for profit foundation, Italy].

For trying to overcome their prejudices, according to one interviewee, health professionals should also undertake a psychological training: "doctors must understand what they think inside themselves on the subject otherwise they will never be able to treat patients properly" [gynaecologist, Italy].

Although the majority of professionals interviewed believe that training is fundamental for improving knowledge and attitudes, the opinion of two respondents is in the opposite direction. One underlined that training is not necessary because "it could make students feel bad" [psychologist and university professor, Catalonia], and another said that "medical textbooks and universities put enough emphasis on such topics so there is no need for additional training for medical students" [medical consultant, Bulgaria].

2.2.1 Target, content and methods of the training

A common view of professionals interviewed is that training should involve medical students, health professionals, administrative staff, and more in general anyone who has direct or indirect contact with LGBTI patients. Some participants underlined it would be useful starting training before university, as in high school or even in primary school, although it is not so easy to organize it.

A recurring suggestion is to adapt training and its content according to participating groups and their field of specialisation. Basic training is regarded as important for all and topics mainly referred to by professionals include: different definitions and terminology of sexual and gender diversity, inclusive language, minority stress and support to coming out, how to learn the correct and inclusive approach not taking the patient's heterosexuality for granted, how to build client-professional relationship, how to ask the right questions and when to do it. Some interviewees also pointed out the importance of "undoing" prejudices and stereotypes with special regard to STIs and LGBTI relationships. Further mentioned topics to be covered are psychological aspects, mental health of LGBTI people and problems due to prolonged use of drugs and hormones.

More in-depth training is considered essential for professionals working in certain fields of specialisation in the sexual sphere such as gynaecology, urology, andrology and endocrinology, although interviewees provided no indication about the content that this training should have.

Because of the crucial and sensitive role played, the need for appropriate training for general practitioners and paediatricians was explicitly stressed by some respondents.

Many and varying recommendations came up with regard to training methods. Both online and in-person training or a combination of the two are regarded as suitable tools. One interviewee suggested to use elearning for more theoretical topics and in-person teaching for workshops and case studies, while another recommended a combination of methods and techniques, depending on the target involved, repeated over time. One professional interviewed stressed that "medical specialists who mainly work with LGBTI patients should not only have specific training, but also have additional training to refresh their memory and update the information to new researches in this area" [medical student, Bulgaria].

Further suggestions from respondents included: the opportunity to discuss and ask questions; involvement of LGBTI people in the training for sharing their experiences, and training accreditation to encourage participation.

SECTION 3 – Open Doors Survey

Between December 2019 and March 2020, an online questionnaire-based survey was conducted in the five countries of the Open Doors project, namely Bulgaria, Hungary, Italy, Poland and Spain[23].

3.1 Methodology

The questionnaire was targeting professionals with a background in medicine, nursing, mental health (including psychology) or social work, including university professors; professionals with a different background currently working in healthcare; and students above the age of 18 enrolled in secondary or university programs in the above mentioned area. In order to assess whether respondents belonged to this group a set of screening questions were included in the

[23] It should be noted that despite the reference to Spain, data collection was restricted to Catalonia.

survey. Passing the screening phase respondents were asked for explicit consent to participate in the survey.

3.1.1 Questionnaire

The questionnaire was partly built upon previous studies conducted internationally or within specific states and partly developed within the consortium, and it consisted of 41 questions divided into 6 blocks. Section A was intended to collect information about the professional and/or educational background of the participants. In Section B respondents were asked about their knowledge of LGBTI issues and matters concerning health risks and needs of LGBTI people. In Section C attitudes of respondents towards LGBTI people were investigated. Section D surveyed respondents' previous experience and practice with LGBTI patients or clients. Section E was dedicated to participants' previous training experience and to assess respondents training needs and interest in taking part in future training.

In Section F basic socio-demographic data of respondents were collected including two option questions about the respondents' sexual orientation and gender identity, which were included in order to determine a possible bias.

3.1.2 Sample

1379 respondents completed the screening phase, 1137 gave their consent to take part in the survey, 951 completed at least the background section, and 722 completed the entire questionnaire, therefore the reference sample may vary across different sections and questions. The number of respondents who agreed to participate in the survey and who fully completed the questionnaire are presented below (Table 1).

Table 1 – Number of participants by country

	agreed to participate	completed questionnaire
Bulgaria	90	52
Hungary	138	75
Italy	188	132
Poland	285	189
Spain	436	285
Total	**1137**	**733**

3.2. Knowledge

The first block of questions in the Open Doors survey aimed at investigating knowledge about LGBTI issues and identities. Respondents were asked to indicate, among four options (including "I don't know"), the meaning of four statements referring to LGBTI terminology and identities.

More than 9 out of 10 respondents were aware of what the term bisexual means (93%) and more than 8 out of 10 gave the right definition for trans woman (85%). The correct understanding of "sexual orientation", "gender identity" and "sex characteristics" as terms that "mean different things, and are not necessarily related" was shown by more than two-thirds of respondents (75%) while less than half had a correct understanding of intersex (46%).

Results for specific countries differ significantly but not in uniform manner through all items investigated. While Spain scores above the average results for all items but bisexual one, Bulgaria scores under the average results for all items except for the questions on intersex where scores higher result of right answers in comparison with other countries. Results are presented in Tables 2, 3, 4 and 5 below.

Tables 2-5 – Knowledge

The terms "sexual orientation", "gender identity" and "sex characteristics"...				
	mean the same thing	mean different things, but are closely related	mean different things, and are not necessarily related	I don't know
Bulgaria (N = 73)	1%	39%	60%	0%
Hungary (N = 101)	3%	37%	59%	1%
Italy (N = 163)	1%	23%	75%	2%
Poland (N = 228)	1%	18%	81%	0%
Spain (N = 386)	1%	20%	77%	2%
Total (N = 951)	**1%**	**24%**	**75%**	**1%**

What does the following statement mean? "Maria is a trans woman"	Maria identifies as a man: her gender identity is female	Maria has both male and female sex characteristics, but she has chosen to identify as a woman	Maria identifies as a woman: her gender identity is female. However, at birth her assigned sex was male	I don't know
Bulgaria (N = 73)	22%	7%	68%	3%
Hungary (N = 101)	4%	7%	89%	0%
Italy (N = 163)	10%	7%	80%	3%
Poland (N = 228)	6%	5%	85%	4%
Spain (N = 386)	8%	3%	88%	1%
Total (N = 951)	**8%**	**5%**	**85%**	**2%**

What does the following statement mean? "Peter is bisexual"	Peter has sexual relationships with both women and men at the same time	Peter has had sexual experiences with both women and men	Peter is sexually attracted to both women and men	I don't know
Bulgaria (N = 73)	11%	0%	89%	0%
Hungary (N = 101)	1%	2%	97%	0%
Italy (N = 163)	1%	2%	95%	2%
Poland (N = 228)	8%	1%	91%	0%
Spain (N = 386)	3%	4%	93%	0%
Total (N = 951)	**5%**	**2%**	**93%**	**1%**

What does the following statement mean? "Laura is intersex"				
	Laura was born with sex characteristics that do not fit the typical definitions for male or female bodies	Laura does not identify as either woman or man	Laura's assigned sex at birth was male, she has started transitioning to live as a woman, but her transition is not yet completed	I don't know
Bulgaria (N = 73)	56%	19%	8%	17%
Hungary (N = 101)	27%	40%	13%	20%
Italy (N = 163)	37%	23%	12%	28%
Poland (N = 228)	54%	21%	5%	20%
Spain (N = 386)	48%	22%	3%	27%
Total (N = 951)	**46%**	**23%**	**7%**	**24%**

After providing them with a short glossary, respondents were asked to answer another set of questions still to investigate their level of knowledge. In particular, they were asked to indicate whether a set of statements concerning the health of LGBTI people were true or false with a possibility to provide an answer "I don't know". Two questions about legislation that can affect LGBTI people's rights were also included.

In all surveyed countries the majority of respondents are aware that: LGBTI youth have higher rates of suicidality than their heterosexual, cisgender youth (average result: 82%), it is possible for a person to legally change their name and gender in their official documents (71%), gay men have an increased incidence of anxiety and depression compared to heterosexual men (70%). However, only about half of respondents know that people living with HIV receiving antiretroviral treatment are no longer able to transmit the infection if their viral load is undetectable (54%) and breast cancer can still occur after bilateral reductive surgery for female-to-male transsexuals (56%). Only slightly more than one respondent in ten is aware that lesbians are more likely to suffer from obesity than heterosexual woman (12%).

The comparative analysis shows that there are some differences between the countries, but again they are not consistent for all the topics investigated. For instance, Hungarian and Polish respondents, compared with respondents from other countries, are more conscious of the higher risk of suicidality for young LGBTI people (average: 82% HU: 91% PL: 89%) and increased risk of anxiety and depression for gay men (average: 70%, HU: 91%; PL: 86%), scoring above the

average result for right answer. But when asked whether breast cancer can still occur after bilateral reductive surgery for transgender women to men, less than half of Polish respondents gave the right answer, while Hungary scored above average with the highest percentage of correct answers, followed by Italy (average: 56%, PL: 45%; HU: 70; IT: 69%).

3.3. Attitudes towards LGBTI people

The second block of questions in the Open Doors survey covered attitudes of health professionals and medical students towards LGBTI people. Respondents were asked to provide an opinion on a set of statements including general opinions on LGBTI people and healthcare setting specific topics. The questions used a 5-point scale (agree strongly, agree, neither agree nor disagree, disagree and disagree strongly). Results are presented in Chart 1 below.

Around nine out of ten respondents in all EU member states included in the Open Doors survey agreed or strongly agreed with the following statements: LGBTI people should have the same rights as any other member of society (97%); it is important to create an inclusive environment for LGBTI patients or clients (92%); same sex sexual attraction is a natural expression of sexuality in humans (87%); and a gender identity different from sex assigned at birth should not be considered a mental disorder (87%).

When respondents were asked their opinion on whether irreversible surgical interventions on intersex children should be delayed until the person themselves can consent to the treatment, except in case of medical emergencies, average results show that more than two-thirds agreed or strongly agreed with the statement (87%)

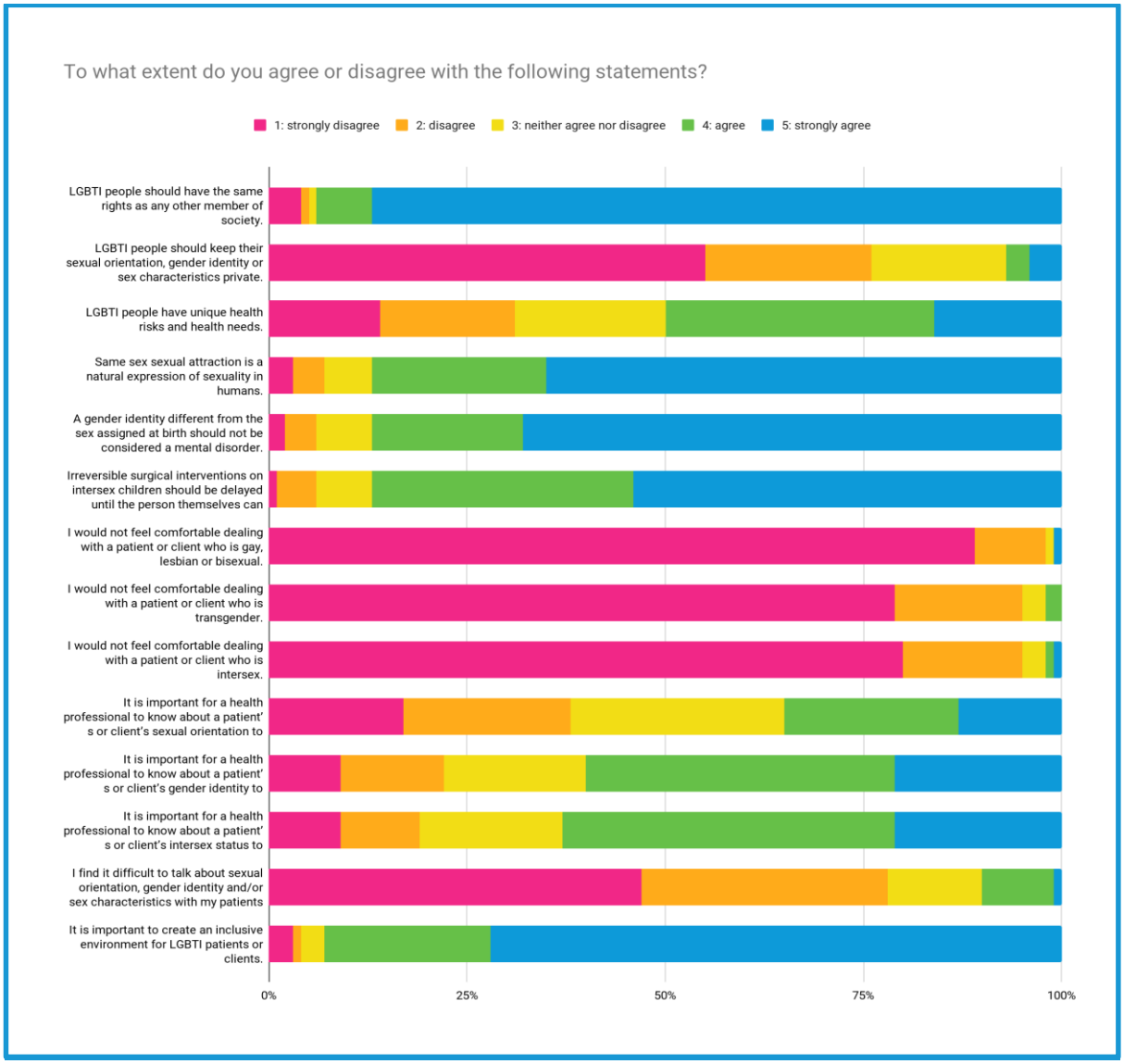
Still a large majority of respondents felt absolutely comfortable dealing with LGBTI patients, although results shown a slight lower level of comfort for trans and intersex patients compared to lesbian, gay and bisexual patients or clients (T and I: 95%; LGB: 98%).

More than seven out of ten respondents disagreed with the fact that LGBTI people should keep their sexual orientation, gender identity or sex characteristics private (76%) and did not find difficult to talk about them with patients (78%).

While a larger proportion of respondents consider it important to know if a patient is trans (60%) or intersex (64%) only around one in three agreed that it is important knowing about patients' sexual orientation in order to provide them with appropriate service (35%).

The perceived irrelevance of a patient's sexual orientation for health purposes seems somehow linked with the results concerning LGBTI people's unique health risks and needs where only five out of ten respondents agreed or strongly agreed with the statement (51%). Moreover, a similar perception is confirmed by the view of several professionals interviewed in the Open Doors project (see *supra*, pag. 20-22).

Chart 1 – Attitudes toward LGBTI people



The Open Doors survey shows general positive attitudes of health professionals and students toward LGBTI people, better if compared with other studies (Fisher 2017) and opinions collected through interviews. However, there are differences between countries in the levels of acceptance and results are not consistent through all statements. Spain is the most accepting

country and scores above average results for all items except those on LGBTI unique health risks and needs and importance to know patients' sexual orientation, gender identity and/or sexual characteristics. On the other hand, Bulgaria and Hungary score below average results for the majority of the statements (10 out of 14) while Poland and Italy are in a middle position.

For example, while as many as 93% of Spanish respondents agree that same sex sexual attraction is a natural expression of sexuality in humans, only slightly more than two-thirds (69%) of respondents in Hungary share this view, followed by Bulgaria (73%), Poland (85%) and Italy (89%). Same order repeats for statements like: "A gender identity different from the sex assigned at birth should not be considered a mental disorder" or "Irreversible surgical interventions on intersex children should be delayed until the person themselves can consent to the treatment, except in case of medical emergencies".

But when considering other statements the order of countries changes. For instance Hungarian respondents were the strongest supporter of the fact that LGBTI people should not keep their sexual orientation, gender identity or sex characteristics private. In this case Hungary scores far above the average results and Bulgaria is "better placed" than Italy and Poland (average result: 76% – BG: 74%; HU: 89%; IT: 71%; PL: 63%; SP: 82%).

3.4. Experiences and practices

Section D of the Survey consisted of 11 questions intended to investigate experience and practice of respondents with regard to LGBTI patients or clients.

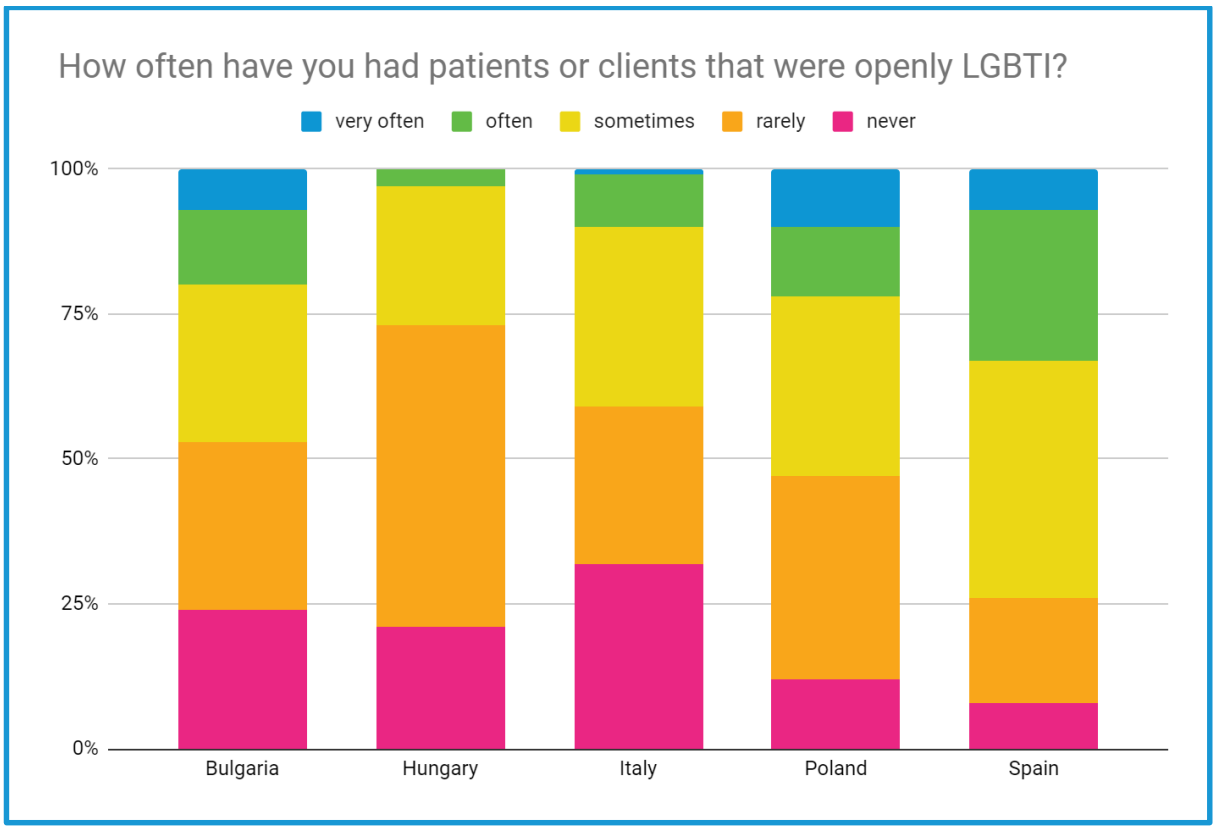
In the first group of questions (6) respondents were asked to indicate on a 1-5 points scale (never, rarely, sometimes, often and very often) how often they have had patients openly LGBTI and how frequently they have witnessed situations of discrimination, derision and mockery against LGBTI people during their studies or at work. It was possible to provide an answer "I don't know".

201 out of 819 respondents were not aware how often they encountered patients openly LGBTI and among those who knew it less than one-third said it happened often or very often (22%).

Overall the experience of respondents is rather limited. Looking at results by country Spanish respondents were more familiar with patients openly LGBTI (often or very often: 33%), while at

the opposite end there are Hungary and Italy with a proportion of participants, which dealt often or very often with patients openly LGBTI, of 3% and 10% respectively.

Chart 2 – Experience with LGBTI patients/clients

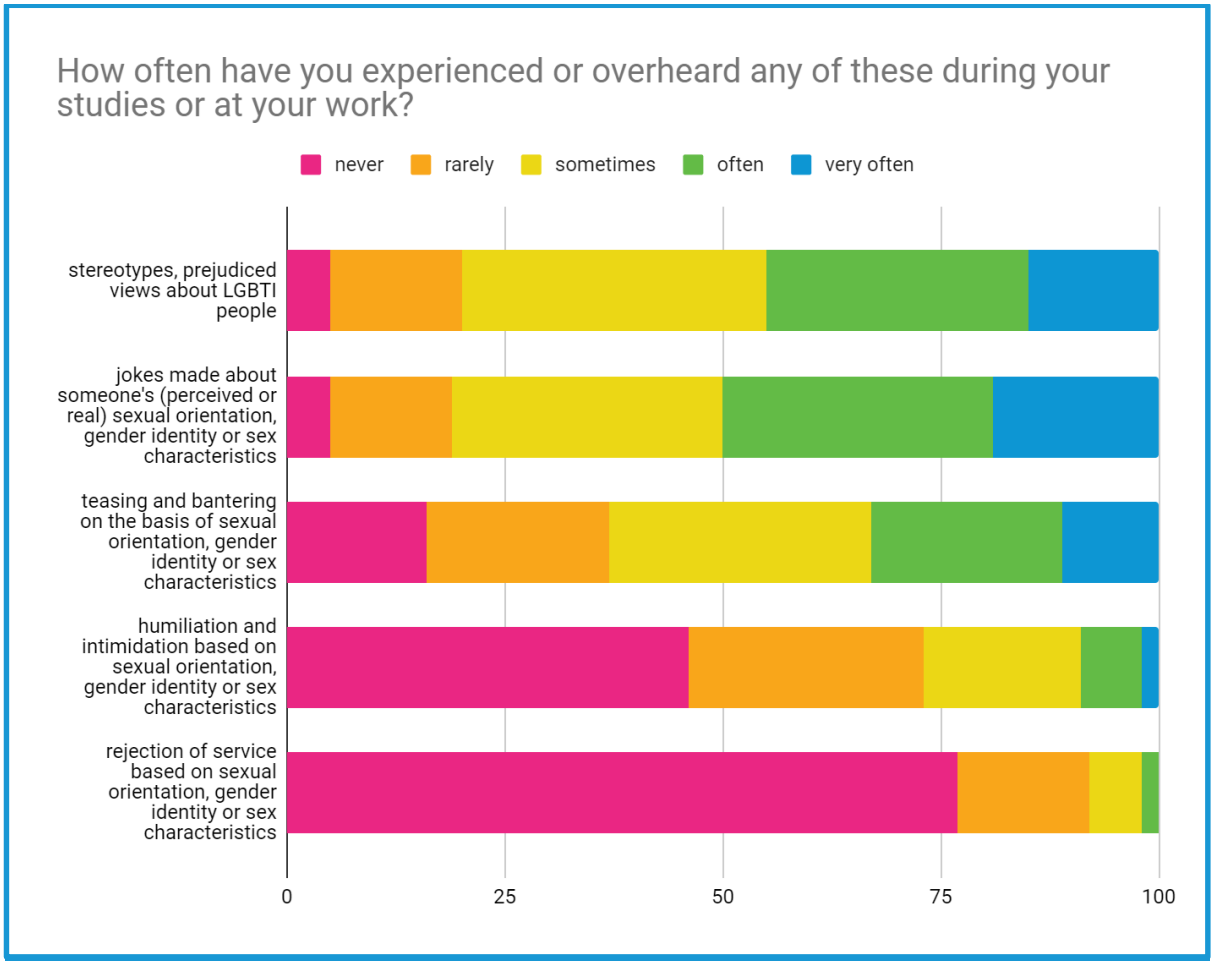


Almost a half of respondents experienced or overheard often or very often stereotypes, prejudiced views about LGBTI people (45%) as well as jokes made about someone's (perceived or real) sexual orientation, gender identity or sex characteristics (50%).

Teasing and bantering on the basis of sexual orientation, gender identity or sex characteristics were often or very often witnessed by one-third of respondents (33%) while around one out of ten participants experienced or heard often or very often humiliation and intimidation of LGBTI people (9%).

Rejection of service based on SOGISC was often or sometimes witnessed by 8% of respondents. Results are presented in Chart 3 below.

Chart 3 – Experience of discrimination against LGBTI people



Results show that the healthcare environment in the surveyed countries is far from being inclusive towards LBTI patients, albeit with no negligible differences across the five surveyed countries.

As with attitudes, Bulgaria, which achieved below-average results for all items considered in this section, is at the bottom of the ranking with the least inclusive health environment while Spain is placed at the top. For instance, almost two-thirds of Bulgarian respondents have witnessed often or very often (62%) jokes made about someone's (perceived or real) sexual orientation, gender identity or sex characteristics against 43% of Spanish respondents. Even considering the possible bias due to the small size of the Bulgarian sample, it seems significant that almost one fifth of the participants witnessed (often or sometimes) service denial to LGBTI people.

In the second group of questions for this section, respondents were asked to evaluate, on a 0-4 points scale, how likely they would ask about a new patient's sexual orientation, gender identity and sex characteristics as well as about likelihood to use neutral language and address patients with their preferred name and pronouns.

About half of the respondents were unlikely or very unlikely to ask about a new patient's sexual orientation (58%), gender identity (49%) and/or sex characteristics (53%).

As pointed out in the previous section on attitudes, despite the fact that only one out of ten respondents found difficult to talk about sexual orientation, gender identity and/or sex characteristics with their patients results for this section show that for respondents asking about a new patients SOGI and sex characteristics is not so frequent (likely or highly likely: SO = 26%; GI = 31%; SC = 26%).

It would be interesting to investigate deeper the reasons behind this practice of "not to ask". Arguments for not asking questions expressed by health professionals interviewed are varied and include the idea that to know about a patient's sexual orientation, gender identity or sex characteristics is not relevant to health or only relevant in certain fields of medicine, but also that it concerns intimate and personal matters and therefore there is a fear of breaching privacy (see supra).

More than eight out of ten respondents said it is likely or highly likely that they would use neutral language when asking about a patient's family relations (82%) and would address patients by their preferred name and pronouns (87%).

Poles are most likely to use inclusive language (91%) followed by Spanish participants while less than two-thirds of Hungarians are likely to do so (57%). The ranking continues to be the same with regard to the likelihood of addressing patients by their preferred name and pronouns (likely or highly likely: PL = 97%; SP = 92%; HU = 72%). Results by countries are presented in Charts 4 and 5 below.

Chart 4 – Use of neutral language

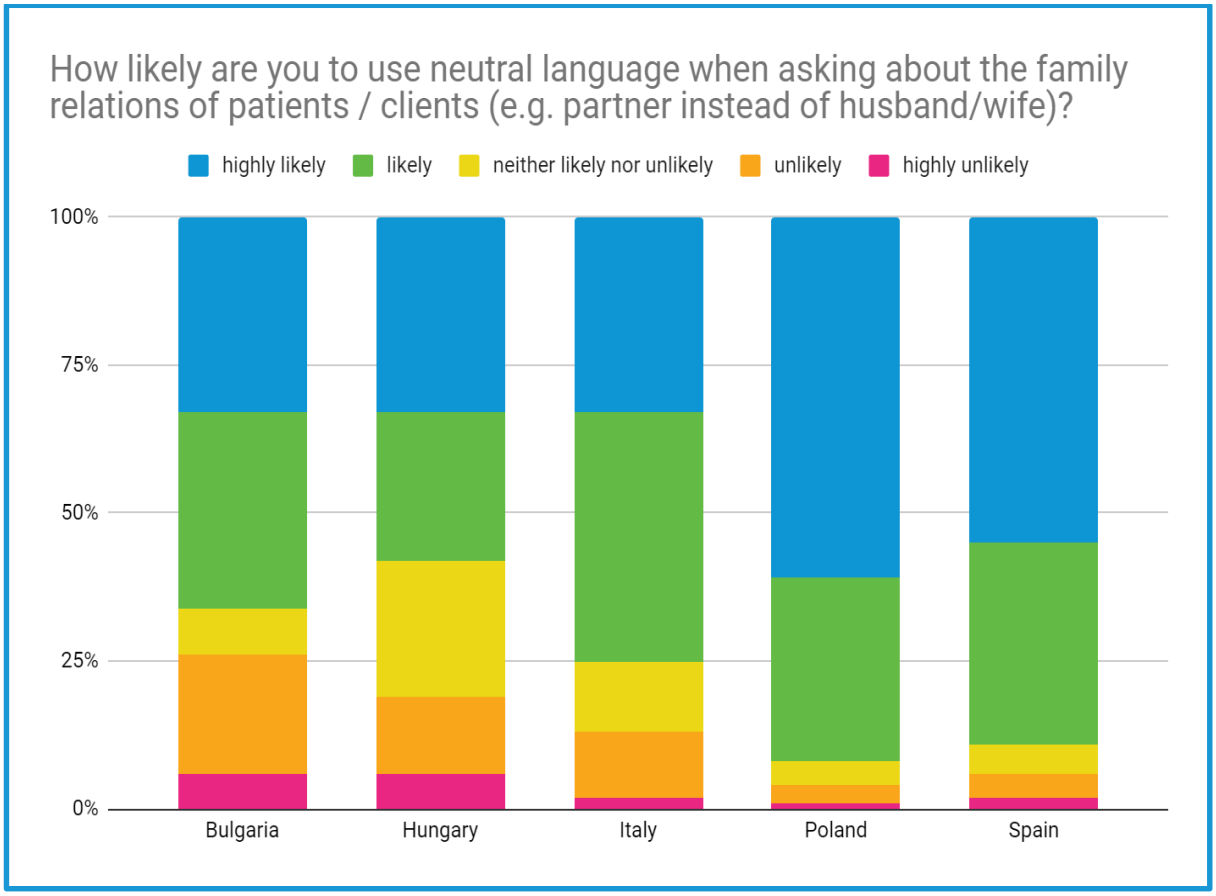
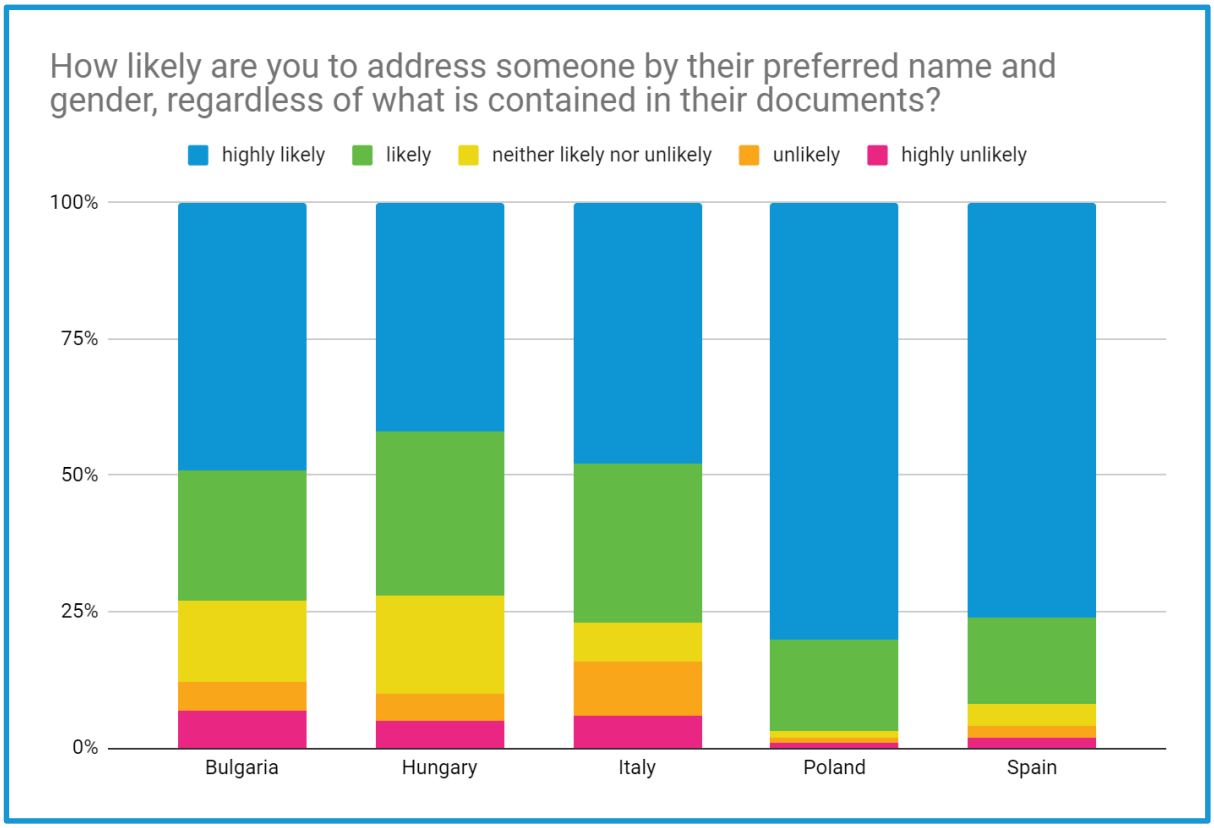


Chart 5 – use of preferred name and gender



3.5. Training

The last block of questions in the Open Doors survey was related to training.

The first set of questions aimed at investigating which topics on LGBTI issues were covered in the basic training of the respondents or in a specialized service training course, how they rate the quality of training received and if they feel professionally prepared to deal with LGBTI patients/clients.

The second series of questions, on the other hand, aimed at identifying which topics respondents would like to be addressed during a training on LGBTI issues as well as the preferable format and methods of an ideal training.

3.5.1 Previous learning experience

The Open Doors survey results combined with desk research and health professionals interviews show that national core curricula for the training of doctors, nurses and other health professionals do not focus on LGBTI issues.

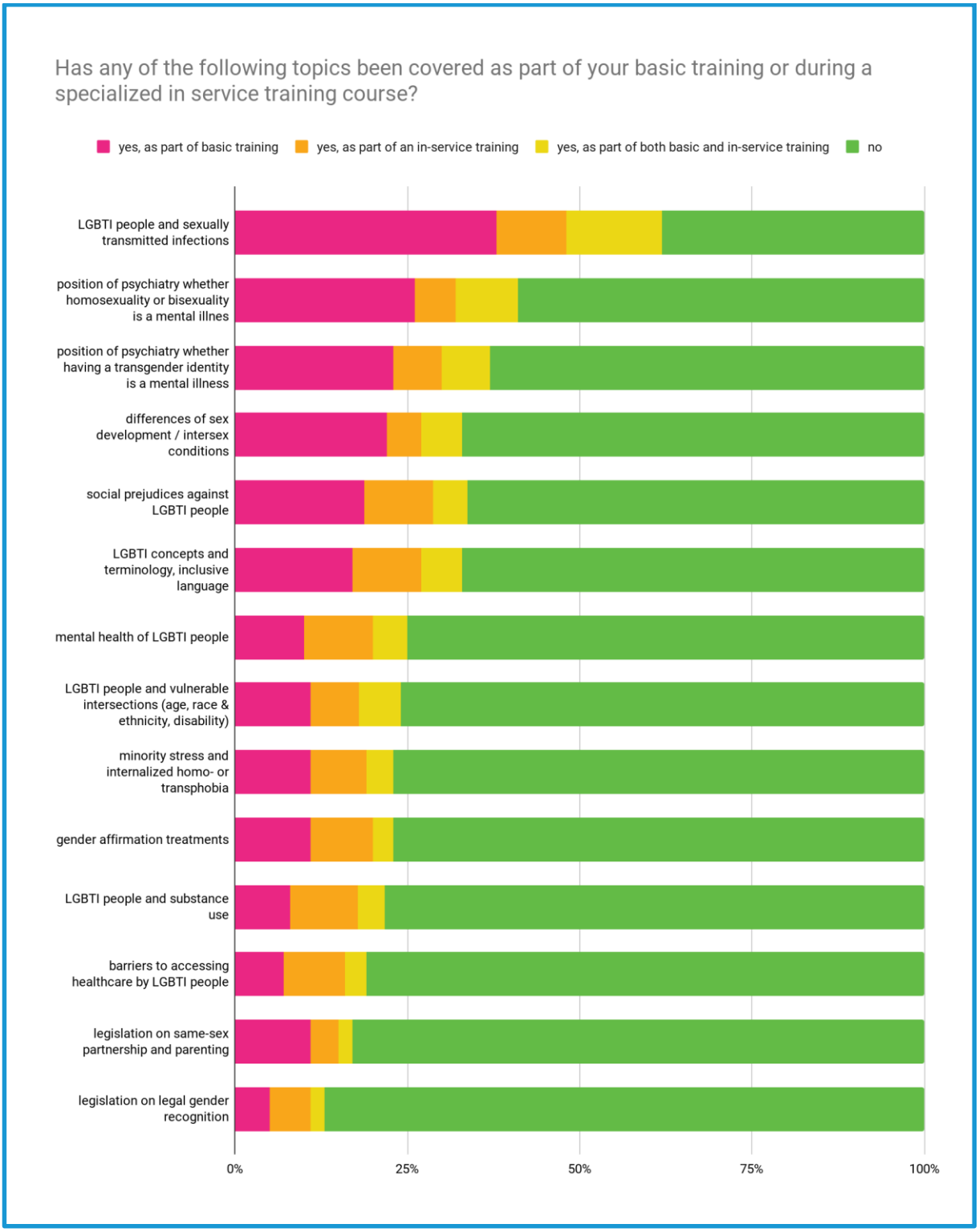
In fact, when respondents were asked to indicate whether a range of topics were covered as part of their training (basic, in-service, or both), only a minority of them responded in the affirmative.

More than seven out of ten participants did not learn about barriers to accessing healthcare by LGBTI people (81%), legislation on same-sex partnership and parenting (82%), legislation on legal gender recognition (87%), minority stress and internalized homo or transphobia (77%), mental health of LGBTI people (75%), LGBTI people and substance use (78%), LGBTI people and vulnerable intersections (76%) and gender affirmation treatments (77%),

Still between two-thirds and more than a half of respondents did not receive any training about, differences of sex development / intersex conditions (67%), social prejudices against LGBTI people (66%), LGBTI concepts and terminology, inclusive language (67%), position of psychiatry whether homosexuality or bisexuality is a mental illness (60%), and position of psychiatry whether having a transgender identity is a mental illness (63%).

According to survey data the only topic that has been covered during the training by the majority of respondents is "LGBTI people and sexually transmitted diseases" (38%: as part of basic training; 10%: as part of an in-service training; 14%: as part of both basic and in-service training).

Chart 6 – Topics covered in respondents training



Looking at results by country Italian respondents are those who received the poorest training while on the opposite side there is Poland whose respondents are the most trained. The training gap between these two countries is particularly marked for some topics. For instance,

when asked if the position of psychiatry whether homosexuality or bisexuality is a mental illness was a topic covered in their training, less than two Italian respondents in ten said yes versus almost seven out of ten of Polish respondents (any training on the above mentioned topic: average result = 60%; IT = 83%; PL = 31%).

3.5.1 Training quality

When respondents were asked to rate the quality of the coverage of LGBTI health issues in the education received on a scale 0 to 10 (0 totally unsatisfactory – 10 totally satisfactory) the majority of respondents found it very unsatisfactory (0: 28%; 1: 12%; 2: 15%). There are no significant differences between countries in the degree of satisfaction/dissatisfaction.

3.5.2 LGBTI perspective – Skills and knowledge to provide good services

More than eight out of ten respondents deemed it important to include LGBTI perspective into educational programmes (83%: agree or strongly agree with the statement "LGBTI perspective should be an integral part of the educational curriculum of all professionals working in the field of healthcare") with significant differences among countries: Spanish respondents are the main supporters for inclusion of LGBTI perspective, followed by Poles, Italians and Bulgarians. The smallest proportion of respondents who agreed with the statement is recorded for Hungary (BG = 77%; HU = 69%; IT = 81%; PL = 82%; ES = 90%).

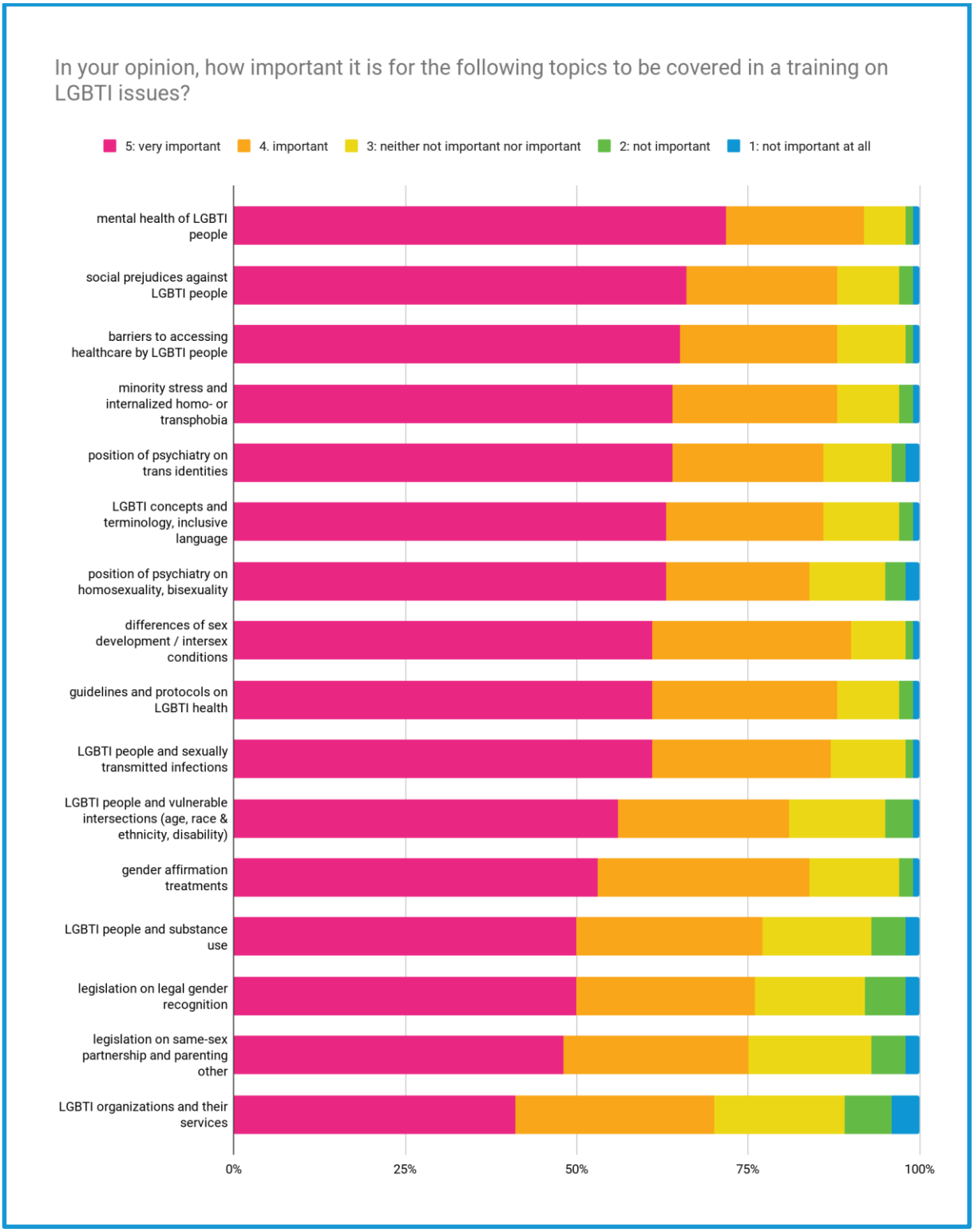
Less than half of the participants felt they have the knowledge and skills to provide appropriate and good quality services to LGBTI patients or clients (45%: agree or strongly agree with the statement "I have the knowledge and skills to provide good quality services to LGBTI patients or clients." On the country level Italian participants felt less prepared when compared to respondents from the other Open Doors countries: this seems to be coherent with the above results according to which they are also the least trained. On the opposite side there are Bulgaria and Poland with the larger proportion of respondents who believe that they are capable of providing adequate and good quality services (BG = 64%; HU = 47%; IT = 28%; PL = 62%; ES = 43%).

3.5.3 Training needs

The last section explored the respondents' training needs about LGBTI issues, the ideal content and format of such a training and their willingness to participate in it. First of all, respondents were asked to rate the importance for a list of topics to be covered during a training on LGBTI

issues. The question used a 5-point scale where 1 means not important at all and 5 means very important. The results are presented in Chart 7 below.

Chart 7 – Topics for future training



12 out of 16 listed topics were considered important or very important to be covered by more than four-fifths of respondents. Mental health of LGBTI people and differences of sex development/intersex conditions were rated as the most important topics (91% and 90% respectively) while LGBTI organizations and their services (70%), legislation on same-sex partnership and parenting (75%), and legislation on legal gender recognition (77%) attracted less interest, although were still regarded as important or very important by more than two-thirds of participants.

As regards the comparison between countries, Spain has the highest percentage of respondents who consider training for 11 of the 16 topics important or very important followed by Poland. At the other end there is Hungary which scores below average results for all topics envisaged. For example, while as many as 96% of Spanish respondents think that the theme of social prejudices against LGBTI people should be covered in a training, 70% of respondents for Hungary share this view (average result = 88%; BG = 78%; IT = 85%; PL = 87%). Similar results for "minority stress and internalized homo- or transphobia" topic (average result for important/very important = 88%; BG = 75%; HU = 73% IT = 92%; PL = 86%; ES = 95%).

3.5.4 Interest in participating in a training on LGBTI issues

Participants were asked whether they are interested in participating in training on LGBTI issues and under which conditions.

The large majority of respondents said that they would be interested in participating in such training in any case regardless of credits recognition (82%). While the potential cost of the training is a factor that may affect participation. In case a fee was due, one respondent in five would participate anyway (25%) and three in five depending on the cost (62%).

On the country level Spanish and Polish respondents are the most interested in participating in the training no matter of credits, while the Italians, on the other hand, give more weight to the recognition of credits, followed by Hungarians and Bulgarians ("Would you be interested in participating in a training on LGBTI issues?" – yes: BG = 73%; HU = 69%; IT = 67%; PL = 90%; ES = 89% – yes, but only if credits are awarded: BG = 17%; HU = 21%; IT = 27%; PL = 4%; ES = 5%). More than two-thirds of the respondents for Italy and Poland would subordinate their participation depending on the cost, while Hungary and Bulgaria score the highest proportion of respondents who would not participate if a fee was due ("Would you participate in such a training if you or your organization had to pay a fee for it?" yes: BG = 28%; HU = 20%; IT = 18%;

PL = 17%; ES = 36% – yes, depending on the cost: BG = 51%; HU = 55%; IT = 72%; PL = 73%; ES = 52% – no: BG = 21%; HU = 25%; IT = 10%; PL = 10%; ES = 52%).

3.5.5 Ideal format and training methods

With regard to the ideal format of the training, in-person teaching (31%) and a combination of e-learning and in-person teaching (32%) were the preferred solution over e-learning considered alone (22%), but with significant differences among countries. Bulgarian respondents are the strongest supporters of the combined format (47%) but the least interested in in-person teaching alone (18%). On the opposite side, Hungary and Italy score the highest preference for in-person teaching (HU = 43%; IT = 36%) and the lowest for e-learning (HU = 16%; IT = 16%). Smaller differences in preference percentages between the three different formats are recorded for Spain and Poland.

Regarding methods respondents showed a clear preference for debating contested questions (72%) followed by discussing case studies (66%) and presentation of research results (63%). For more than half of respondents training methods should include meeting with LGBTI people (58%), while less than one-third expressed a preference for brainstorming (32%) and role-play (26%). However, looking at results by country, notable variations can be observed. For example, while as many as 83% of Polish respondents choose presentation of research results as preferred method to be used in the training, only slightly more than half (53%) of respondents in Spain have the same opinion. Role play is the least preferred method in Poland and in Italy chosen by about one in five respondents (PL = 18%; IT = 22%), while in Hungary almost half of the participants expressed a preference for it (HU = 49%). Brainstorming is regarded as a suitable training method by more than two in five respondents in Bulgaria and in Poland (42% in both countries), while only 23% of Italians share this view. Results by country are presented in tables 6 and 7 below.

Table 6 – Ideal format of the training

	e-learning	in person	combination	doesn't matter
Bulgaria (N = 49)	25%	18%	47%	10%
Hungary (N = 67)	16%	43%	26%	15%
Italy (N = 115)	16%	36%	35%	13%
Poland (N = 178)	25%	28%	30%	17%
Spain (N = 264)	26%	31%	30%	13% -
Total (N = 673	**23%**	**31%**	**32%**	**14%**

Table 7 – Methods to be used in the training

	Presen-tation of research results	Debating contested questions	Discussin g case studies	Role-play	Sharing experi-ences	Meeting with LGBTI people	Brain-storming on future activities
Bulgaria (N = 52)	65%	71%	75%	36%	61%	56%	42%
Hungary (N = 75)	61%	83%	71%	49%	40%	69%	25%
Italy (N = 132)	58%	71%	61%	22%	45%	61%	23%
Poland (N = 189)	83%	65%	75%	18%	58%	58%	42%
Spain (N = 285)	53%	76%	60%	27%	56%	55%	32%
Total (N = 733)	**63%**	**72%**	**66%**	**26%**	**53%**	**58%**	**32%**

Conclusions

This report outlines the main findings of the Open Doors research, which provides insights into knowledge, attitudes, experience and training needs of health professionals towards gay, lesbian, bisexual, trans and intersex people as members of society and patients or clients accessing the healthcare system.

Although research and studies have shown that LGBTI people face a range of health inequalities, barriers to access to care and discrimination based on sexual orientation, gender identity and expression and gender characteristics, in none of the five countries of the consortium are there comprehensive plans or policies to overcome these inequalities that directly address LGBTI people and their health needs. Proper services provided by the national health systems are lacking and where they exist are very limited in their scope. The few good practices that exist are not formally adopted and depend on the initiative of individual health professionals, which makes their future uncertain and their transfer to other healthcare providers uncommon.

Results both from the interviews and the survey reveal that health professionals have a low awareness on LGBTI issues and the specific needs of LGBTI patients. This lack of knowledge, due to lack of training and outdated medical curricula and textbooks, often combined with prejudices against LGBTI people by healthcare providers, represent a significant barrier for building an inclusive and non-discriminatory healthcare for LGBTI people.

Two closely related results of the Open Doors research would deserve to be explored further in future studies: the fact that knowing the patient's sexual orientation, gender identity and sex characteristics is not perceived as relevant in order to provide patients with good quality service by the majority of respondents, and the unclear opinion about the specific health needs of LGBTI people.

Two encouraging findings of our research are worth reporting. The first one is positive attitudes of participants in the survey towards LGBTI people: although other studies go in the opposite direction, showing the existence of homo- and transphobia by health professionals (Fisher 2017, Sabin 2015, Fidelindo 2016), our results give hope for a change of mentality by the new generations of health professionals.

The second positive fact is the awareness of health professionals of the need for training on issues involving LGBTI people and their health, and the willingness to participate in such training.

Appropriate training for health professionals is an important step in the direction to create an inclusive and comfortable environment for LGBTI people. In addition, national governments should take adequate health policy measures to identify the needs of LGBTI people, improve their health and access to the health system and effectively address discrimination.

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