Piloting the health4LGBTI training course in 6 European countries: evaluation report

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

List of abbreviations:

BE	Belgium
BG	Bulgaria
EU	European Union
LGBTI	Lesbian, Gay, Bisexual, Trans, and Intersex
IT	Italy
LT	Lithuania
MS	Member State
PL	Poland
q	question
UK	United Kingdom

Introduction to the document

This report provides the main results of the piloting phase of the Health4LGBTI training in 6 European countries.

It is divided into two parts.

The first part provides an overview of the methods and procedure used to implement and evaluate the Health4LGBTI training course.

The second part provides a description of the main quantitative and qualitative results that emerged from the piloting phase.

Questionnaires and evaluation materials can be found in Appendixes 1-5.

Note on terminology

In this manual, "trainer" refers to the person who conducts/facilitates the training and their co-trainer whereas "participants" and "trainees" refers to the people who attend the training course.

1. Background

Introduction note

Health4LGBTI is an EU funded Pilot Project aimed at reducing health inequalities experienced by lesbian, gay, bisexual, trans and intersex (LGBTI) people.

The Health4LGBTI training course named "Reducing health inequalities experienced by LGBTI people: what is your role as a health professionals?" has been developed by a consortium of 5 European partners, namely:

- EuroHealthNet (public health network-Belgium),
- Verona University Hospital (AOUI-VR-Italy),
- National Institute of Public Health – National Institute of Hygiene (NIPH-NIH-Poland),
- University of Brighton (UoB-UK),
- The European region of the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA-Europe-Belgium),

working on behalf of the European Commission.

The structure and content of the training course were elaborated on the basis of the extensive research carried out in the first phase of the Health4LGBTI pilot project. A first version of the training package was piloted in the following 6 EU Member States: Belgium, Bulgaria, Italy, Lithuania, Poland and the UK. The main methodology and results of this implementation is reported in this document. This piloting phase was crucial and served to fine-tune the Health4LGBTI training course.

However, the final version of the training package took into account also the feedback from the EC, the Health4LGBTI Advisory Board and from participants in the Health4LGBTI Final Conference.

Piloting phase aim

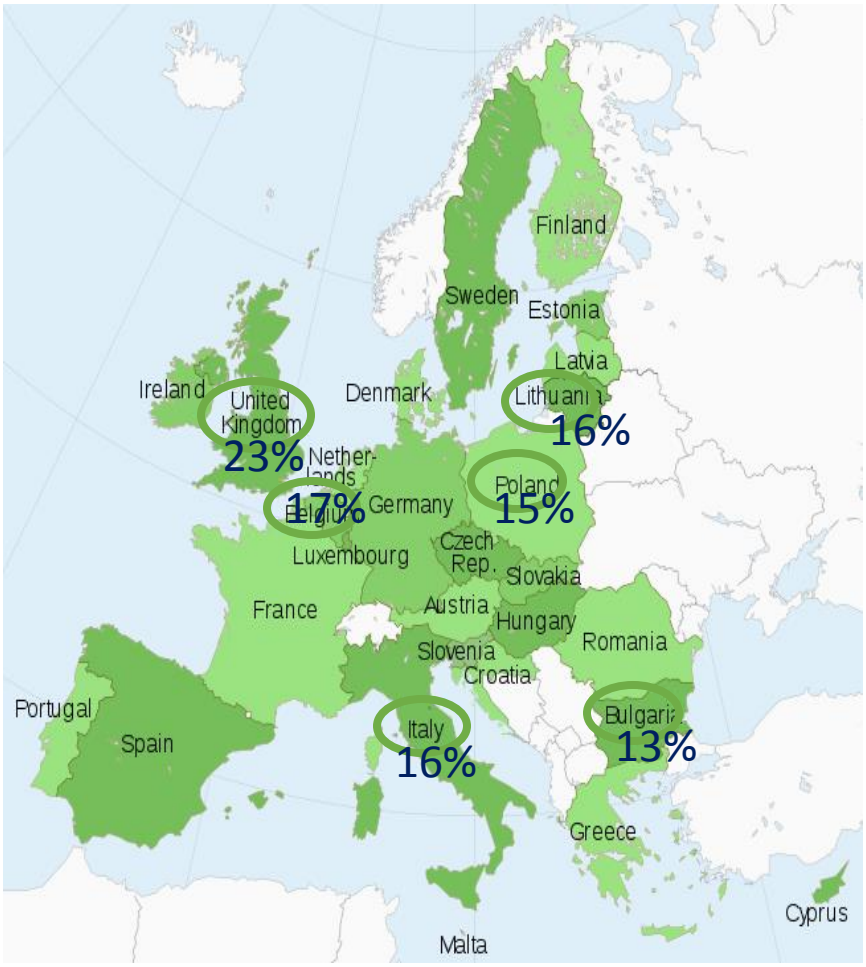
The main aim of the pilot implementation phase was to evaluate the acceptance and effectiveness of the training modules among participants with different backgrounds across potentially diverse European settings.

2. Methods and Procedure

Setting

The training course recruited healthcare professionals from 6 EU Member States: Belgium, Bulgaria, Italy, Lithuania, Poland and the UK. The training course was piloted in the following cities: Gent in Belgium, Sofia in Bulgaria, Verona in Italy, Vilnius in Lithuania, Warsaw in Poland, and Brighton in the UK. Figure 2.1 describes the EU MS involved and the percentages of participants. In each piloting site, trainers adapted the training agenda to the local needs and for this reason the training course was delivered in two consecutive half day sessions in Italy, Poland, UK or in one full day in Belgium, Bulgaria, Lithuania.

Figure 2.1. Piloting sites and percentages of participants in each country



Evaluation Procedure and Tools

The evaluation procedures consisted of five components: pre- and post-training evaluation completed by the training participants, evaluation by the trainer, site visit and follow-up evaluation (See Table 2.1 for a detailed description).

Table 2.1. Summary of the evaluation components

Evaluation Component	Instrument	Format	Timing	Completed by
Pre-training Evaluation	Pre-training Questionnaire (Appendix 1)	Paper only	Immediately preceding training	Participants
Post-training Evaluation	Post-training Questionnaire (Appendix 2)	Paper only	Immediately after completion of training	
Follow-up Evaluation	Follow-up Questionnaire (Appendix 3)	On-line	Approx. 2 months after training	
Evaluation by Trainer	Swot matrix (Appendix 4)	Electronic	After completion of training	Trainers
Site visit	Site Visit Form (Appendix 5)	Electronic	After completion of training	External Evaluators from the Consortium

Evaluation by participants

The knowledge, skills and attitudes were evaluated in the form of pre- and post-training self-administered questionnaires.

Before and after the training course, all participants were asked to complete:

- The pre-test questionnaire. This contained questions on knowledge, attitudes, behavioural intention and self-perceived skills in addition to contextual information (demographics, role in the health care system);
- The post-training questionnaire. This included the same set of questions as the pre-test questionnaire to measure the desired change in attitudes, self-efficacy, behavioural intention and knowledge. In addition, the post-training questionnaire contained questions measuring the overall satisfaction with the training, including the training organisation and logistics.

The questionnaires have been collected immediately preceding and immediately after completion of the training.

The aim of the follow-up questionnaire was to measure the behaviour change and potential difficulties that the participants may have faced in implementing the new skills in practice.

The questionnaires in English are included in the Annex 1, 2 and 3. The training questionnaires were translated by the trainers into the language of the country where the training course was implemented: Italian, Polish, Bulgarian, Lithuanian and Dutch. These versions are available on request. However, please note that translation problems were reported to the Health4LGBTI team. For example, in some countries there were multiple correct answers for question q24 and we recommend that for future use the translation is corrected to match the original.

The Evaluation Tool Annex reported in the Trainers Manual describes the methods used to develop the questionnaires. Briefly, wherever possible we used items from three existing tools, which we identified as relevant in the published literature (LGBTQ cultural competency

training[1], Sexual Orientation Counsellor Competency Scale (SOCCS) in Mental Health[2], Evaluation of a Pilot Training to Improve Transgender Competency Among Medical Staff in an Urban Clinic[3]). The items were selected, discussed and modified by the project team. The following table reports the question numbers and the area of evaluation for each questionnaire (Table 2.2). This division have been followed to organize the analysis.

Table 2.2. Questions in the final tools by intended area of evaluation

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

During the pilot phase the questionnaires were collected in a paper based form and then entered into an online form by the Consortium staff.

Evaluation by trainers

The **SWOT analysis** is a framework for identifying and analyzing the internal and external factors that can have an impact on the future of the project in question. During the piloting phase this analysis was intended to capture factors that could affect possible wider dissemination of the training module in the country.

To assist this analysis a specific SWOT matrix for trainers has been designed (Appendix 5) providing sample areas. For each piloting site at least one trainer, but often both co-trainers, jointly completed the form per training.

Evaluation by experts

Experts from AOUI-VR (Italy), ILGA-Europe or NIPH-NIH (Poland) attended the training courses (**site visits**) allowing detailed monitoring of the piloting of the training courses

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

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

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

including adherence of the trainers to the training manual, participants' reactions and group dynamics. Specific evaluation grids have been developed to collect this information (Appendix 4).

Methods

Evaluation by participants

Study group definition and exclusion criteria

The quantitative evaluation comprised the change in knowledge, attitudes and skills from before the training and after the training, which could be attributed to the learning experience.

The study group was selected from the participants attending the training. It was defined based on the target audience criteria as well as completion of both pre- and post-test questionnaires. For the target audience both doctors and nurses were admitted to the course, including those in training, but also other medical professions (e.g. psychologists, social workers, pharmacists, physiotherapists) or auxiliary medical professions (e.g. administrative support/ reception workers, medical managers, medical researchers).

The following exclusion criterion were adopted: having completed only the pre-test or only the post-test questionnaire.

Linkage of pre- and post-test records

Pre- and post-test records were linked with the provided participant ID. In case of non-matching records remaining ID were reviewed, by study site manually, according to the following procedure:

1. Removing obvious typographical errors, e.g. no hyphen, double hyphen, blanks, duplication of a letter or a number.
2. Verifying the remaining non-matches with the original forms and removing typographical errors of data entry.
3. Looking for inverted characters, e.g. switched month and day of the second half of the ID. These types of errors were corrected automatically.
4. Looking for close matches: e.g. differing by one character. These were matched only if the demographic information on the pre- and post-test matched exactly.

If no match could be found after applying the above criteria the records were classified as unmatched.

Knowledge items

The questionnaire contained 9 knowledge questions.

The intention was that a single answer is correct. Due to translational issues this was not clear in the question number 24 (Check the correct statement: 1.☐ He is homosexual; 2.☐ He is a gay; 3.☐ He is a gay man) because in some countries more than one term from the list was correct. Due to this fact this question was excluded from the analysis.

The questions were recoded into binary variables: 1 – "correct" 0 – "wrong or missing". Based on this recoding a summary variable was created, "**Knowledge score**", as a sum of the 8 recoded knowledge variables.

Sub-scores were also created as follows:

- terminology score (sum of recoded questions q23, q25, q26),

- inclusive practice score (sum of q21 and q22) and
- trans/intersex score (sum of q27, q28, q29).

Moreover, for each participant a variable describing her or his change in the knowledge item was assigned:

2 – "correct both initially and at the end";
1 – "incorrect initially but correct at the end";
0 – "incorrect both initially and at the end";
-1 – "correct initially and incorrect in the end".

Attitude and skill items

There were 11 attitude questions (q8-q20; q30-32). The responses were provided on Likert scale, from more inclusive attitude or greater skill to less inclusive attitude or lesser skill.

Evaluation by trainers: SWOT matrix analysis

After the training, each trainer (separately or in tandem) collected the opinions about the pilot training using the SWOT Matrix (Appendix 5). In the open-ended form they identified and emphasised the internal and controllable (**S**trengths and **W**eaknesses) and uncontrollable external forces (**O**pportunities and **T**hreats) affecting possible future training courses. In the next step, all findings were sorted into categories. Opinions about pilot training were summarized.

Evaluation by experts: analysis of site visit forms

The evaluation was conducted based on a prepared grid by external evaluators who were familiar with the project (Appendix 4). A qualitative analysis was carried out. Only in some cases the evaluators were speaking the language in which the training was delivered. Interpretation was provided to all of the evaluators who needed it. The interpretation focused on the context and approximation of the atmosphere and interactions and did not aim to translate everything that was said by the participants.

Ethical issues

The Ethical approval was submitted and obtained by the AOUI-VR Ethical Committee.
The questionnaires from a single person have been linked by a unique code in order to guarantee full anonymity of the individuals. Participants were asked to provide a (reasonably) unique ID code, which would also not be a threat to their anonymity. The code comprised of the 3 initial letters of the oldest parent's/guardian's first name and the day and month of the oldest parent's/guardian's birthday.

3. Results

Evaluation of participants

Exclusion criteria

During the evaluation phase data was collected from a total of 110 unique participants, 102 of whom provided both the pre- and post-training questionnaires.

The summary of the exclusion process by country is provided in the table 3.1. Most of excluded participants provided only the pre-test. These individuals either dropped out from the training or were not able to participate until the end due to previous engagements.

Table 3.1. Summary of application of the exclusion criteria on the group of participants

Country	Included	Excluded		
		Total	Unmatched: pre-only	Unmatched: post-only
Belgium	18	1	0	1
Bulgaria	14	0	0	0
Italy	17	0	0	0
Lithuania	18	0	0	0
Poland	15	2	2	0
UK	20	5	4	1
Total	102	8	6	2

Characteristics of the study population

The study group was not significantly different from all participants including those who did not provide both pre- and post-tests (Table 3.2). There was a tendency that those that did not provide both tests were more likely identifying as homosexual or bisexual and they more often reported professional experience with LGBTI people. However, it must be kept in mind that the majority of excluded individuals came from the UK and thus these characteristics may just represent the characteristics of the UK group.

The study group was composed of participants of all ages, although the age group of 51-64 years old was the least represented (18.8% of all participants). Heterosexual people were underrepresented constituting less than half of all participants (48.5%).

A range of professionals participated in the training. The three most represented professional groups were psychologists (29.7%), physicians (20.8%) and nurses (19.8%). A large proportion of the study group reported professional experience with LGBTI patients, especially with gay men (63.7%), lesbian women (52.5%) and bisexual people (44.9%). Less participants had provided services for trans people (32.3%) and only a small proportion for intersex people (7.4%).

Table 3.2. Characteristics of all participants and the participants included in the following analysis (study group)

	All participants No.	All participants Col %	Study group No.	Study group Col %
Country				
Belgium	19	17.3	18	17.6
Bulgaria	14	12.7	14	13.7
Italy	17	15.5	17	16.7
Lithuania	18	16.4	18	17.6
Poland	17	15.5	15	14.7
UK	25	22.7	20	19.6
Total	110	100.0	102	100.0
Age group				
18-30	39	35.8	39	38.6
31-50	48	44.0	43	42.6
51-64	22	20.2	19	18.8
Total	109	100.0	101	100.0
Gender identity				
Female	75	68.2	72	70.6
Male	34	30.9	29	28.4
Other	1	0.9	1	1.0
Total	110	100.0	102	100.0
Sexual orientation				
Asexual	3	2.8	3	3.0
Bisexual	21	19.3	20	19.8
Heterosexual	50	45.9	49	48.5
Homosexual	32	29.4	26	25.7
Other	3	2.8	3	3.0
Total	109	100.0	101	100.0
Medical profession				
Physician	22	20.4	21	20.8
Nurse	20	18.5	20	19.8
Midwife	3	2.8	3	3.0
Psychologist	32	29.6	30	29.7
Social worker	5	4.6	5	5.0
Physiotherapist	3	2.8	3	3.0
Student	5	4.6	5	5.0
Radiographer	2	1.9	2	2.0
Admin/management	5	4.6	2	2.0
Other	11	10.2	10	9.9
Total	108	100.0	101	100.0
Professional experience with:				
lesbian patients				
I do not know	17	15.6	17	16.8
No	31	28.4	31	30.7
Yes	61	56.0	53	52.5
Total	109	100.0	101	100.0
gay patients				
I do not know	11	10.0	11	10.8
No	27	24.5	26	25.5
Yes	72	65.5	65	63.7
Total	110	100.0	102	100.0
bisexual patients				
I do not know	25	23.6	23	23.5
No	31	29.2	31	31.6
Yes	50	47.2	44	44.9
Total	106	100.0	98	100.0

	All participants		Study group	
	No.	Col %	No.	Col %
trans patients				
I do not know	16	15.0	15	15.2
No	54	50.5	52	52.5
Yes	37	34.6	32	32.3
Total	107	100.0	99	100.0
intersex patients				
I do not know	30	29.1	28	29.5
No	64	62.1	60	63.2
Yes	9	8.7	7	7.4
Total	103	100.0	95	100.0

The participants were asked to indicate the main reasons (one or more, as appropriate) for which they took part in the pilot training. The majority of the participants indicated personal interest and need of personal development in the field (Figure 3.1).

Figure 3.1. Reasons for taking part in the training

Moreover, the participants declared inclusive attitudes towards LGBTI people. They were asked to place themselves on the attitude scale from 1 (inclusive) to 10 (negative). Only 6.8% of the participants placed themselves in the upper part of the scale (score >5) (Figure 3.2).

Figure 3.2. Distribution of all participants and the study group in terms of attitude towards LGBTI people

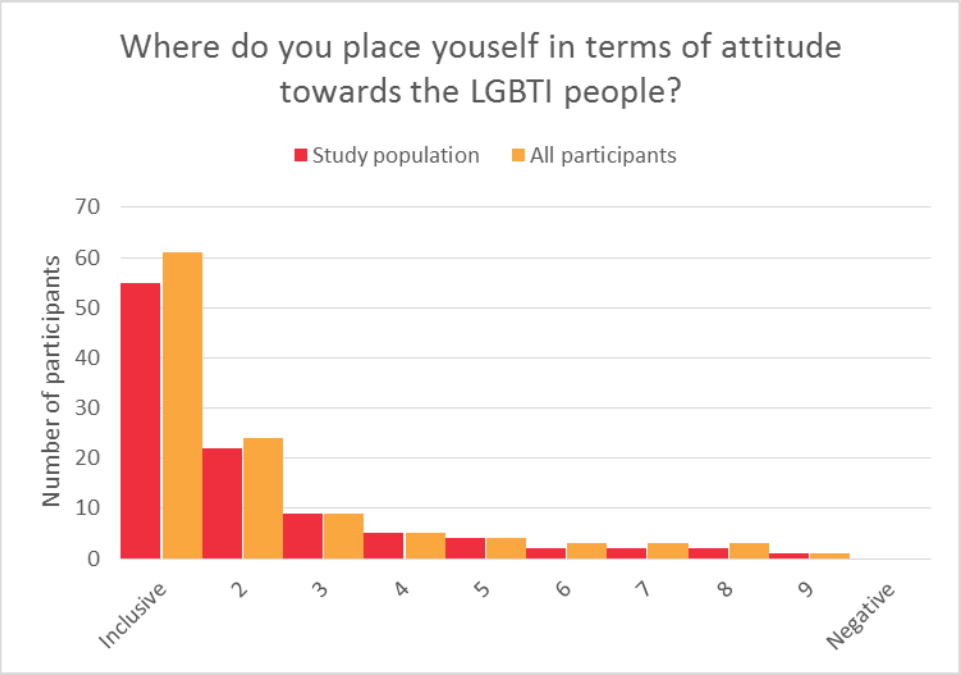


Table 3.3 provides the summary of the study group characteristics in all 6 pilot sites. The sites were variable in the demographic characteristics. As compared to the average Bulgaria, Lithuania and the UK groups were composed of younger individuals, Belgium had a higher proportion of male participants and Bulgaria and Lithuania a lower proportion of male participants, although these differences were not statistically significant. Belgium, Italy and Lithuania had a higher proportion of psychologists. Poland had a higher proportion of physicians and UK a higher proportion of nurses ($p<0.001$). The participants from Bulgaria, Italy and Lithuania more often reported to be heterosexual whereas participants from Belgium, Poland and UK reported to be homosexual or bisexual ($p=0.001$). Participants from Belgium, Italy and UK generally reported to have had more professional experience with LGBTI patients. The p-values for difference between pilot sites in proportion to the participants who reported professional experience with lesbian, gay, bisexual, trans and intersex patients were <0.001, 0.002, 0.001, <0.001, 0.166 respectively.

Table 3.3. Comparison of the study population between the pilot sites

	Belgium N(%)	Bulgaria N(%)	Italy N(%)	Lithuania N(%)	Poland N(%)	UK N(%)
Age group						
18-30	4 (22.2%)	6 (42.9%)	3 (17.6%)	10 (58.8%)	6 (40%)	10 (50%)
31-50	9 (50%)	7 (50%)	8 (47.1%)	6 (35.3%)	5 (33.3%)	8 (40%)
51-64	5 (27.8%)	1 (7.1%)	6 (35.3%)	1 (5.9%)	4 (26.7%)	2 (10%)
Total	18 (100%)	14 (100%)	17 (100%)	17 (100%)	15 (100%)	20 (100%)
Gender identity						
Female	8 (44.4%)	12 (85.7%)	12 (70.6%)	16 (88.9%)	11 (73.3%)	13 (65%)
Male	10 (55.6%)	2 (14.3%)	5 (29.4%)	2 (11.1%)	4 (26.7%)	6 (30%)
Other	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (5%)

	Belgium N(%)	Bulgaria N(%)	Italy N(%)	Lithuania N(%)	Poland N(%)	UK N(%)
Total	18 (100%)	14 (100%)	17 (100%)	18 (100%)	15 (100%)	20 (100%)
Sexual orientation						
Asexual	0 (0%)	0 (0%)	0 (0%)	2 (11.1%)	0 (0%)	1 (5%)
Bisexual	2 (11.8%)	3 (21.4%)	4 (23.5%)	1 (5.6%)	5 (33.3%)	5 (25%)
Heterosexual	4 (23.5%)	10 (71.4%)	11 (64.7%)	14 (77.8%)	6 (40%)	4 (20%)
Homosexual	11 (64.7%)	1 (7.1%)	2 (11.8%)	0 (0%)	4 (26.7%)	8 (40%)
Other	0 (0%)	0 (0%)	0 (0%)	1 (5.6%)	0 (0%)	2 (10%)
Total	17 (100%)	14 (100%)	17 (100%)	18 (100%)	15 (100%)	20 (100%)
Profession						
Physician	1 (5.6%)	2 (15.4%)	5 (29.4%)	5 (27.8%)	8 (53.3%)	0 (0%)
Nurse	1 (5.6%)	0 (0%)	3 (17.6%)	2 (11.1%)	2 (13.3%)	12 (60%)
Midwife	0 (0%)	3 (23.1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Psychologist	7 (38.9%)	4 (30.8%)	7 (41.2%)	8 (44.4%)	3 (20%)	1 (5%)
Social worker	4 (22.2%)	1 (7.7%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Physiotherapist	1 (5.6%)	0 (0%)	1 (5.9%)	1 (5.6%)	0 (0%)	0 (0%)
Other	4 (22.2%)	3 (23.1%)	0 (0%)	1 (5.6%)	1 (6.7%)	1 (5%)
Student	0 (0%)	0 (0%)	0 (0%)	1 (5.6%)	1 (6.7%)	3 (15%)
Radiographer	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (10%)
Admin/ management	0 (0%)	0 (0%)	1 (5.9%)	0 (0%)	0 (0%)	1 (5%)
Total	18 (100%)	13 (100%)	17 (100%)	18 (100%)	15 (100%)	20 (100%)
Professional experience with:						
lesbian patients						
I do not know	1 (5.6%)	2 (14.3%)	4 (23.5%)	3 (16.7%)	3 (21.4%)	4 (20%)
No	3 (16.7%)	6 (42.9%)	0 (0.0%)	13 (72.2%)	6 (42.9%)	3 (15.0%)
Yes	14 (77.8%)	6 (42.9%)	13 (76.5%)	2 (11.1%)	5 (35.7%)	13 (65.0%)
Total	18 (100%)	14 (100%)	17 (100%)	18 (100%)	14 (100%)	20 (100%)
gay patients						
I do not know	1 (5.6%)	0 (0.0%)	2 (11.8%)	2 (11.1%)	3 (20.0%)	3 (15.0%)
No	1 (5.6%)	5 (35.7%)	1 (5.9%)	10 (55.6%)	7 (46.7%)	2 (10.0%)
Yes	16 (88.9%)	9 (64.3%)	14 (82.4%)	6 (33.3%)	5 (33.3%)	15 (75.0%)
Total	18 (100%)	14 (100%)	17 (100%)	18 (100%)	15 (100%)	20 (100%)
bisexual patients						
I do not know	2 (11.1%)	1 (7.1%)	5 (35.7%)	2 (11.1%)	4 (28.6%)	9 (45.0%)
No	3 (16.7%)	6 (42.9%)	1 (7.1%)	12 (66.7%)	6 (42.9%)	3 (15.0%)
Yes	13 (72.2%)	7 (50.0%)	8 (57.1%)	4 (22.2%)	4 (28.6%)	8 (40.0%)
Total	18 (100%)	14 (100%)	14 (100%)	18 (100%)	14 (100%)	20 (100%)
trans patients						
I do not know	0 (0.0%)	2 (15.4%)	2 (12.5%)	2 (11.1%)	4 (28.6%)	5 (25.0%)
No	8 (44.4%)	10 (76.9%)	4 (25%)	15 (83.3%)	10 (71.4%)	5 (25.0%)
Yes	10 (55.6%)	1 (7.7%)	10 (62.5%)	1 (5.6%)	0 (0.0%)	10 (50.0%)
Total	18 (100%)	13 (100%)	16 (100%)	18 (100%)	14 (100%)	20 (100%)
intersex patients						
I do not know	5 (29.4%)	2 (15.4%)	4 (30.8%)	2 (11.1%)	4 (28.6%)	11 (55.0%)
No	10 (58.8%)	9 (69.2%)	8 (61.5%)	16 (88.9%)	9 (64.3%)	8 (40.0%)
Yes	2 (11.8%)	2 (15.4%)	1 (7.7%)	0 (0.0%)	1 (7.1%)	1 (5.0%)
Total	17 (100%)	13 (100%)	13 (100%)	18 (100%)	14 (100%)	20 (100%)

	Belgium N(%)	Bulgaria N(%)	Italy N(%)	Lithuania N(%)	Poland N(%)	UK N(%)
Self-assessed attitude toward LGBTI persons score (from *1–inclusive* to *10–negative*)						
Median [range], mean/sd	1.5 [1-8], 2.2/2.0	2 [1-4], 2.1/1.2	2 [1-5], 1.8/1.1	2 [1-8], 2.6/2.0	1 [1-9], 2.3/2.3	1 [1-7], 1.8/1.8

Level of knowledge before training

The summary of all knowledge items is provided in the table 3.4. Generally, the proportion of correct answers was high for the inclusive practice questions (q21, q22), but lower for terminology questions (q23-q26) varying from 34.3% to 66.7% and questions relating to trans and intersex health (q27-q29) from 45.1% to 74.5%.

Table 3.4. Initial level of knowledge in the study group

Question	Correct answer	Distribution of answers in the study sample	N (%)
Q21: Using a neutral language (e.g.: "partner" instead of "husband/wife", "parent" instead of "mother/father" etc.):	is one of the things that a health professional can do in order to set an inclusive environment	Incorrect/Missing	20 (19.6%)
		Correct	82 (80.4%)
Q22: When speaking with patients/clients, health professionals should:	be aware both of the medical terms and the terms preferred by the LGBTI community, but they should ask the patients themselves how they want to be addressed	Incorrect/Missing	29 (28.4%)
		Correct	73 (71.6%)
Q23: The terms "gay" and "MSM (men-who-have-sex-with-men)" are:	different, because "MSM" refers to a sexual behaviour that does not necessarily imply that the person identifies as gay or bisexual	Incorrect/Missing	34 (33.3%)
		Correct	68 (66.7%)
Q25: Intersectionality. When speaking about LGBTI people, this concept highlights social disadvantages and factors other than being LGBTI that people can face:	true	Incorrect/Missing	67 (65.7%)
		Correct	35 (34.3%)
Q26: The terms "sexual orientation",	different, and they are not	Incorrect/Missing	42

Question	Correct answer	Distribution of answers in the study sample	N (%)
"gender identity" and "sex characteristics" are:	necessarily related nor do necessarily affect/imply certain specific development of the other ones		(41.2%)
		Correct	60 (58.8%)
Q27: Corrective surgeries and other medical, hormonal and psychological treatments for intersex people are:	not always necessary, as in many cases an intersex body is a perfectly healthy body	Incorrect/Missing	26 (25.5%)
		Correct	76 (74.5%)
Q28: The fact that someone has an intersex body	will not certainly become apparent, it is possible that some intersex people never find out at all	Incorrect/Missing	56 (54.9%)
		Correct	46 (45.1%)
Q29: "Maria is a trans woman":	Maria identifies as a woman: her gender identity is female. However, at birth her assigned sex was male	Incorrect/Missing	38 (37.3%)
		Correct	64 (62.7%)

Next we considered the knowledge scores constructed as the sum of correct answers. The total score varied between 0 and 8, while terminology score from 0 to 3, inclusive practice from 0 to 2 and trans/intersex health score from 0 to 3. In order to compare the different scales on Figure 3.3 we used the knowledge score % defined as the percent of correct answers. We can conclude that apart from Inclusive practice score, the scores tended to display almost a normal distribution centring around 50%-60%.

We summarised the total knowledge score by the characteristics of the participants (Table 3.5). Most of the differences were not statistically significant although the higher scores were achieved by younger participants, males and physicians. The only notable difference was between people reporting homosexual or bisexual orientation vs. those reporting heterosexual orientation. This later group had a pre-training average score of 4.2 as compared to the score of 5.6 in the former.

Figure 3.3. Distribution of initial knowledge score % (% of correct answers) among the study population (increasing knowledge = increasing score value)

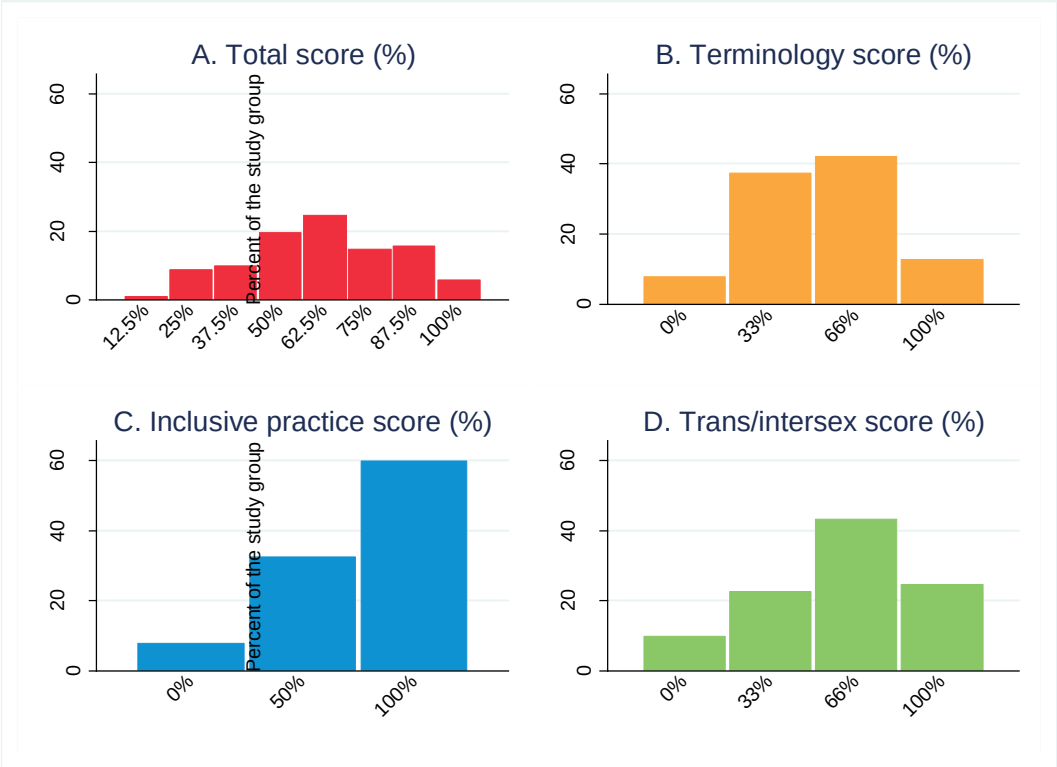


Table 3.5. Comparison of the total knowledge score before training, by demographics

		N	Knowledge score (mean/sd; median [range])
Age group (years)	18-30	39	5.2/1.8; 5 [1-8]
	31-50	43	4.9/1.7; 5 [2-8]
	51-64	19	4.4/1.3; 4 [2-7]
	p-value	0.104	
Gender identity	Female	72	4.8/1.7; 5 [1-8]
	Male	29	5.3/1.7; 5 [2-8]
	Other	1	-
	p-value	0.393	
Sexual orientation	Asexual	3	5.0/3.0; 5 [2-8]
	Bisexual	20	5.6/1.4; 6 [3-8]
	Heterosexual	49	4.2/1.5; 4 [1-7]
	Homosexual	26	5.6/1.7; 6 [2-8]
	Other	3	6.7/1.1; 6 [6-8]
	p-value	<0.001	
Profession	Physician	21	5.3/1.4; 5 [3-8]
	Nurse	23	4.7/1.7; 5 [1-8]
	Psychologist	30	4.7/1.7; 5 [2-7]
	Other	27	5.1/1.9; 5 [2-8]
	p-value	0.785	

Comparing pre- and post-training results in knowledge

Table 3.6 provides details on the change in knowledge achieved after the training.

We note that only a small proportion of participants for each question moved from a correct answer to an incorrect one, possibly representing a group who guessed the answer in the pre-test and remained confused or of those who misunderstood the training. The proportion of this category was the highest for the question relating to which terms to use when addressing LGBTI patients (10.8%), description of an intersex body (7.8%) and differentiation of terms "sexual orientation", "gender identity" and "sex characteristics" (6.9%). For the last two questions also the proportion of people who provided an incorrect answer both before and after training was high, respectively 31.4% and 26.5%. This points to possible areas of improvement of the training especially in light of the fact that for these two questions the proportion of those moving from incorrect to correct answer was less than the proportion staying incorrect.

Table 3.6. Comparison of pre and post test results in knowledge questions

	Number of participants	Percent (%)
Q21: Using a neutral language (e.g.: "partner" instead of "husband/wife", "parent" instead of "mother/father" etc.): Correct answer: is one of the things that a health professional can do in order to set an inclusive environment		
Correct to incorrect	3	2.9
Stayed incorrect	4	3.9
Stayed correct	79	77.5
Incorrect to correct	16	15.7
Total	102	100
Q22: When speaking with patients/clients, health professionals should: Correct answer: be aware both of the medical terms and the terms preferred by the LGBTI community, but they should ask the patients themselves how they want to be addressed		
Correct to incorrect	11	10.8
Stayed incorrect	11	10.8
Stayed correct	62	60.8
Incorrect to correct	18	17.6
Total	102	100
Q23: The terms "gay" and "MSM (men-who-have-sex-with-men)" are: Correct answer: different, because "MSM" refers to a sexual behaviour that does not necessarily imply that the person identifies as gay or bisexual		
Correct to incorrect	3	2.9
Stayed incorrect	10	9.8
Stayed correct	65	63.7
Incorrect to correct	24	23.5
Total	102	100
Q25: Intersectionality. When speaking about LGBTI people, this concept highlights social disadvantages and factors other than being LGBTI that people can face: Correct answer: true		
Correct to incorrect	3	2.9
Stayed incorrect	19	18.6
Stayed correct	32	31.4
Incorrect to correct	48	47.1
Total	102	100

	Number of participants	Percent (%)
Q26: The terms "sexual orientation", "gender identity" and "sex characteristics" are: Correct answer: different, and they are not necessarily related nor do necessarily affect/imply certain specific development of the other ones		
Correct to incorrect	7	6.9
Stayed incorrect	27	26.5
Stayed correct	53	52.0
Incorrect to correct	15	14.7
Total	102	100
Q27: Corrective surgeries and other medical, hormonal and psychological treatments for intersex people are: Correct answer: not always necessary, as in many cases an intersex body is a perfectly healthy body		
Correct to incorrect	4	3.9
Stayed incorrect	5	4.9
Stayed correct	72	70.6
Incorrect to correct	21	20.6
Total	102	100
Q28: The fact that someone has an intersex body Correct answer: will not certainly become apparent, it is possible that some intersex people never find out at all		
Correct to incorrect	8	7.8
Stayed incorrect	32	31.4
Stayed correct	38	37.3
Incorrect to correct	24	23.5
Total	102	100
Q29: "Maria is a trans woman": Correct answer: Maria identifies as a woman: her gender identity is female. However, at birth her assigned sex was male		
Correct to incorrect	3	2.9
Stayed incorrect	10	9.8
Stayed correct	61	59.8
Incorrect to correct	28	27.5
Total	102	100

Nevertheless, we note a substantial increase in the knowledge, as measured by the knowledge scores. The median total knowledge score increased from 5 (interquartile interval 4-6) to 7 (5-8) (Figure 3.4).

The least change was observed in the inclusive practice score, which was high even in the pre-test. The changes in the distribution of the terminology score and trans/intersex scores are presented below (Figure 3.5). The median terminology score before and after was 2, but the proportion reporting all correct answers increased from 13% to 49%. The median trans/intersex score increase from 2 to 3 and the proportion reporting all correct answers increase from 25% to 56%.

Figure 3.4. Distribution of knowledge score in pre-test and post-test (horizontal line represents median value, box – interquartile interval)

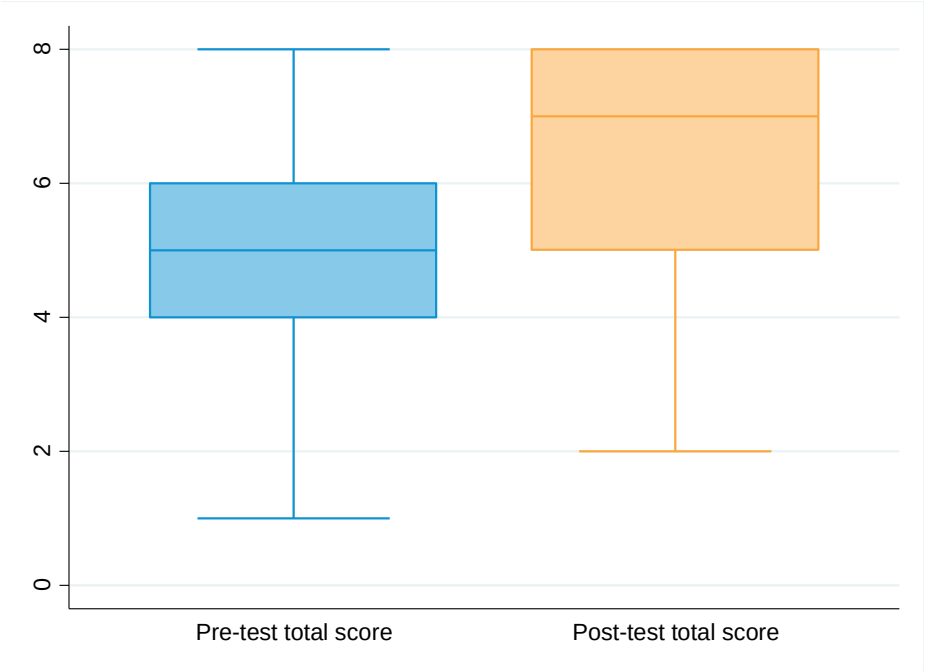
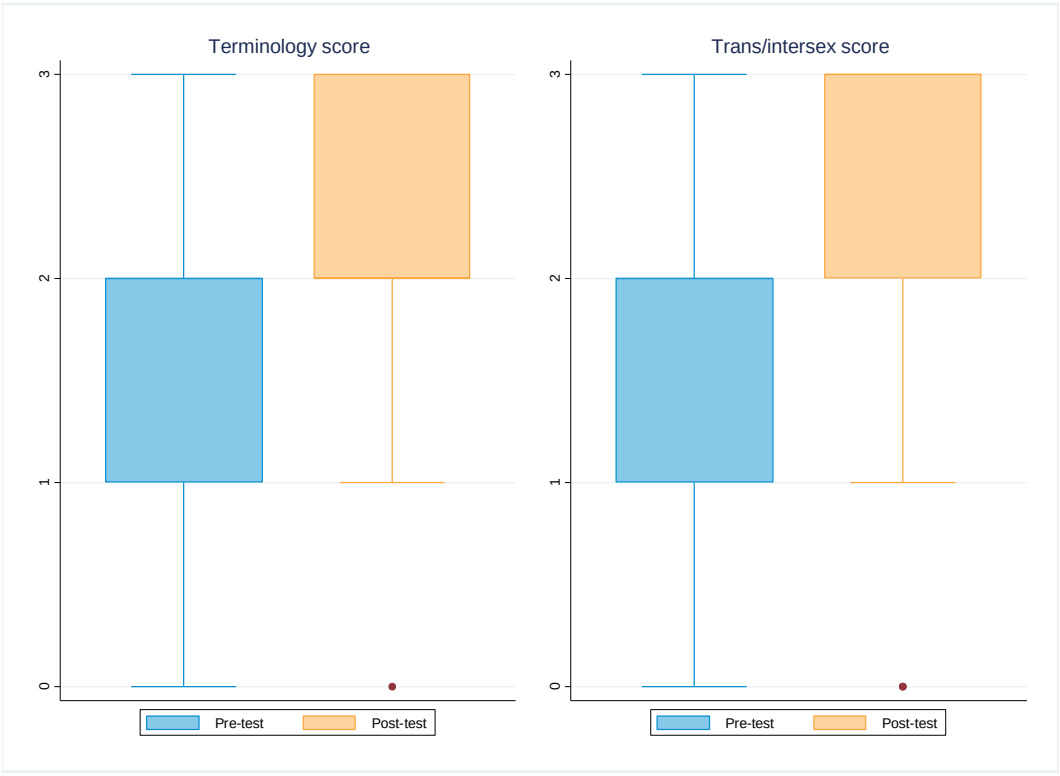


Figure 3.5. Distribution of knowledge terminology and trans/intersex scores in pre- and post-test (horizontal line represent median value, box – interquartile interval)

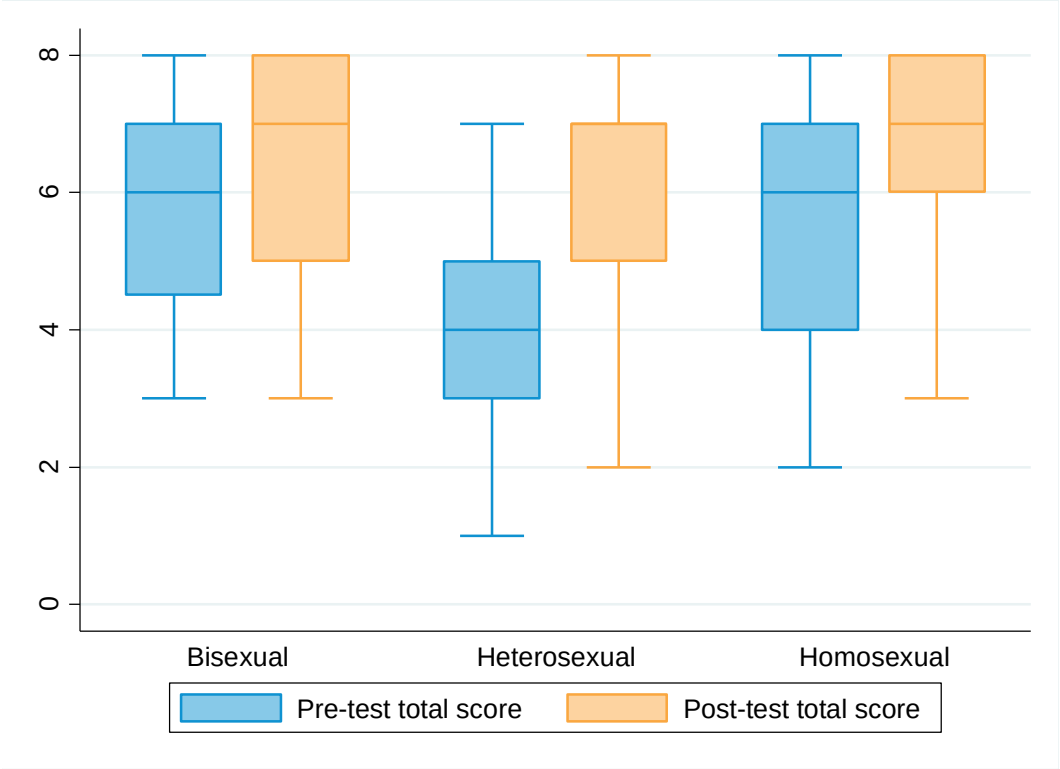


It was also considered whether the increase in knowledge score depended on the characteristics of the participants. In general the total knowledge score increased in all age

groups. Moreover, despite initial differences, the post-test median values was 7 for all age groups. Only in the oldest age group (51-64 years) a significant proportion (25%) achieved 4 or less (of 8) correct answers.

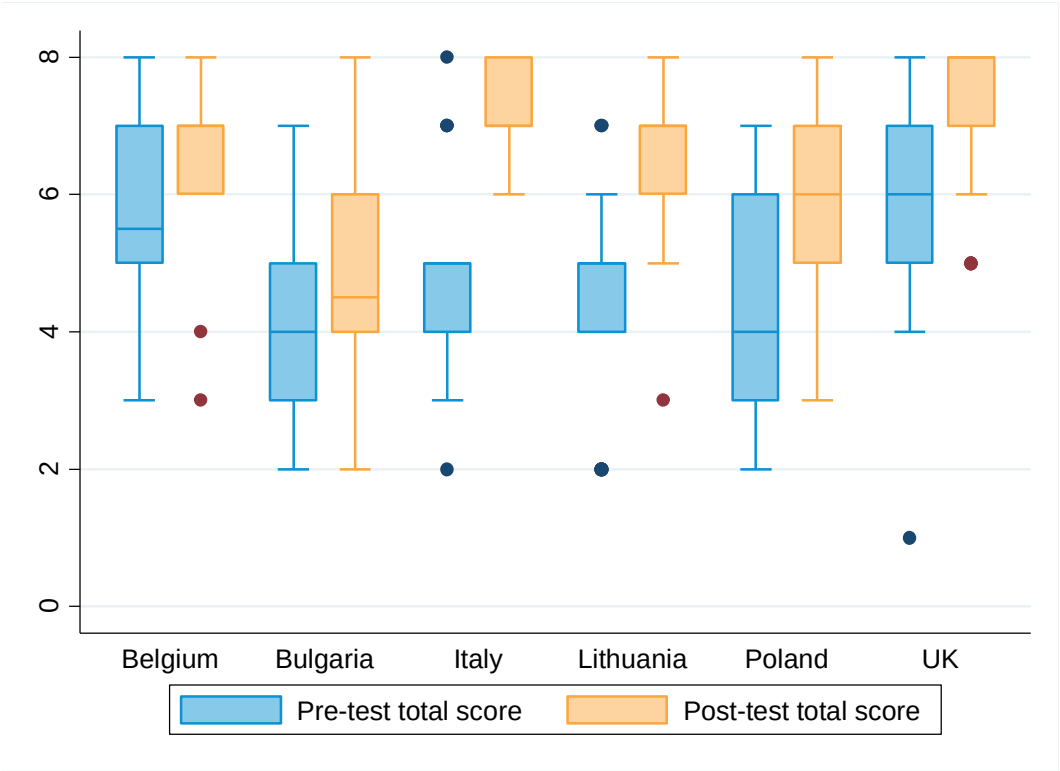
There were no specific differences by gender identity, both women and men reported substantial increase of knowledge score while differences emerged according to sexual orientation of the participants where the most marked increase occurred among heterosexual people (Figure 3.6).

Figure 3.6. Distribution of knowledge score in pre-test and post-test (horizontal line represent median value, box – interquartile interval), by sexual orientation of the participants



Importantly, the increase in knowledge occurred in all pilot countries (Figure 3.7). There was some variability and some pilot sites performed better that the others, which can be explained by many factors including the participant mix but also personal competence of the trainers.

Figure 3.7. Distribution of knowledge score in pre-test and post-test (horizontal line represent median value, box – interquartile interval), by pilot country



Attitudes and behaviors before training

The aim was to assess the baseline attitudes of the participants in particular focusing on the awareness of health inequalities affecting LGBTI people, willingness to create more inclusive practice and self-competence to provide service for the LGBTI people (Table 3.7).

Although the participants declared that they would like their patients to know that they care about specific needs of LGBTI patient (86% agreed or strongly agreed) and would be comfortable to change practice in providing services to LGBTI people (78% agreed and strongly agreed), they often were not clear on whether knowing that a person is lesbian, gay, bisexual, trans or intersex has an effect on how they perform they work as medical staff (40% agreed or strongly agreed to this statement). Half of them also believed that LGBTI people have the same access to medical care as any other patient (50% agreed or strongly agreed).

Moreover, at the time of training only half of the participants felt competent to provide care to LGBTI people and some reported difficulties in talking about sexual orientation, gender identity and/or sex characteristics with patients/clients (13.4% agreed or strongly agreed). Almost all (93%) agreed that training in LGBTI issues should be part of general medical education.

Table 3.7. Awareness, willingness to create inclusive practice and self-competence before the training

Question	Scale	Distribution of answers N (%)
"I would like my patients/clients to know that I care about the specific needs of LGBTI patients/ clients."	Strongly agree	52 (52.0%)
	Agree	34 (34.0%)
	Neither agree nor disagree	13 (13.0%)
	Disagree	1 (1.0%)
	Strongly disagree	0 (0.0%)
	Total	100 (100%)
"I do not see how knowing that a person is lesbian, gay, bisexual, trans or intersex might affect my role at work."	Strongly agree	19 (19.0%)
	Agree	21 (21.0%)
	Neither agree nor disagree	23 (23.0%)
	Disagree	24 (24.0%)
	Strongly disagree	13 (13.0%)
	Total	100 (100%)
"I think it is better if patients/clients keep information on their sexual orientation, gender identity and/or sex characteristics for themselves."	Strongly agree	2 (2.0%)
	Agree	6 (5.9%)
	Neither agree nor disagree	34 (33.3%)
	Disagree	29 (28.4%)
	Strongly disagree	31 (30.4%)
	Total	102 (100%)
"Generally speaking, in my country LGBTI people have the same access to health care as any other patient/client."	Strongly agree	13 (12.7%)
	Agree	38 (37.3%)
	Neither agree nor disagree	19 (18.6%)
	Disagree	20 (19.6%)
	Strongly disagree	12 (11.8%)
	Total	102 (100%)
"I think that LGBTI perspective should be an integral part of the medical staff education curriculum."	Strongly agree	57 (56.4%)
	Agree	37 (36.6%)
	Neither agree nor disagree	6 (5.9%)
	Disagree	1 (1.1%)
	Total	101 (100%)
"I would be comfortable to change my practice in providing services to LGBTI people."	Strongly agree	36 (35.6%)
	Agree	43 (42.6%)
	Neither agree nor disagree	18 (17.8%)
	Disagree	3 (3%)
	Strongly disagree	1 (1%)
	Total	101 (100%)
"At this point in my professional development, I feel that I have the competences and skills to provide service to LGBTI patients/clients."	Strongly agree	10 (10%)
	Agree	41 (41%)
	Neither agree nor disagree	30 (30%)
	Disagree	17 (17%)
	Strongly disagree	2 (2%)
	Total	100 (100%)
"It's difficult to talk about sexual orientation, gender identity	Strongly agree	3 (2.9%)

Question	Scale	Distribution of answers N (%)
and/or sex characteristics with my patient/client."	Agree	11 (10.8%)
	Neither agree nor disagree	29 (28.4%)
	Disagree	45 (44.1%)
	Strongly disagree	14 (13.7%)
	Total	102 (100%)

The vast majority of participants reported that they are likely to intervene if they were to witness a stigmatizing or discriminatory behaviour against LGBTI patients (Table 3.8). However, only 36.2% of the participants were likely or very likely to ask about the sexual orientation, gender identity, and/or sex characteristics of a patient/client and 57.5% to use neutral language.

Table 3.8. Reported behaviours prior to the training

Question	Scale	Distribution of answers N (%)
How likely are you to intervene if you witness a stigmatizing or discriminatory behavior against an LGBTI person at your work place?	Very likely	56 (55.4%)
	Most likely	34 (33.7%)
	Somewhat likely	7 (6.9%)
	Not very likely	3 (3%)
	I do not know	1 (1%)
	Total	101 (100%)
How likely are you to ask about the sexual orientation, gender identity, and/or sex characteristics of a patient/client?	Very likely	18 (17.6%)
	Most likely	19 (18.6%)
	Somewhat likely	21 (20.6%)
	Not very likely	42 (41.2%)
	I do not know	2 (2%)
	Total	102 (100%)
How often do you use the word "partner/spouse" instead of "boyfriend (husband) / girlfriend (wife)" when asking all your patients/clients about their significant other, or "parent" instead of "mother/father" when asking about the family relations?	Very often	34 (33.7%)
	Often	24 (23.8%)
	Somewhat often	29 (28.7%)
	Not very often	11 (10.9%)
	Not often at all	3 (3%)
	Total	101 (100%)

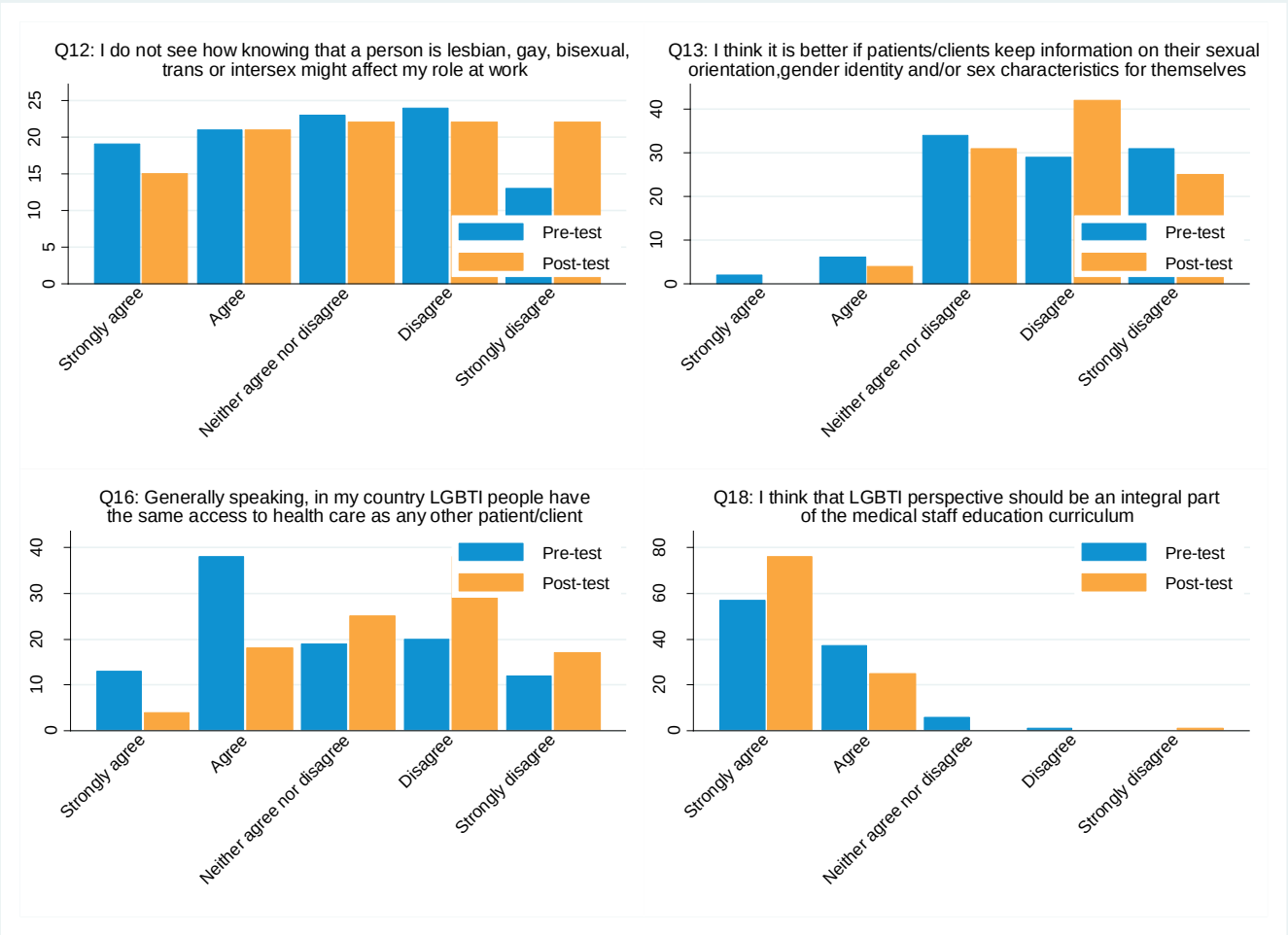
Comparing pre- and post-training attitudes

As evident from the figure 3.8 the largest change occurred in being aware of the barriers in health care access that are faced by the LGBTI people (q16) and acknowledging the importance of inclusion of LGBTI perspective in the medical staff curriculum (q18). The distribution of answers to the questions regarding disclosure of LGBTI status and whether such information is useful for medical staff did not display an important change after the training.

In terms of awareness of health inequalities (q16) the increase did not depend on demographic characteristics of the participants, although we note that at the baseline a smaller proportion

of participants in the oldest age group disagreed and strongly disagreed to q16 (age group 51-64: 19%; 31-50; 34%; 18-30: 36%).

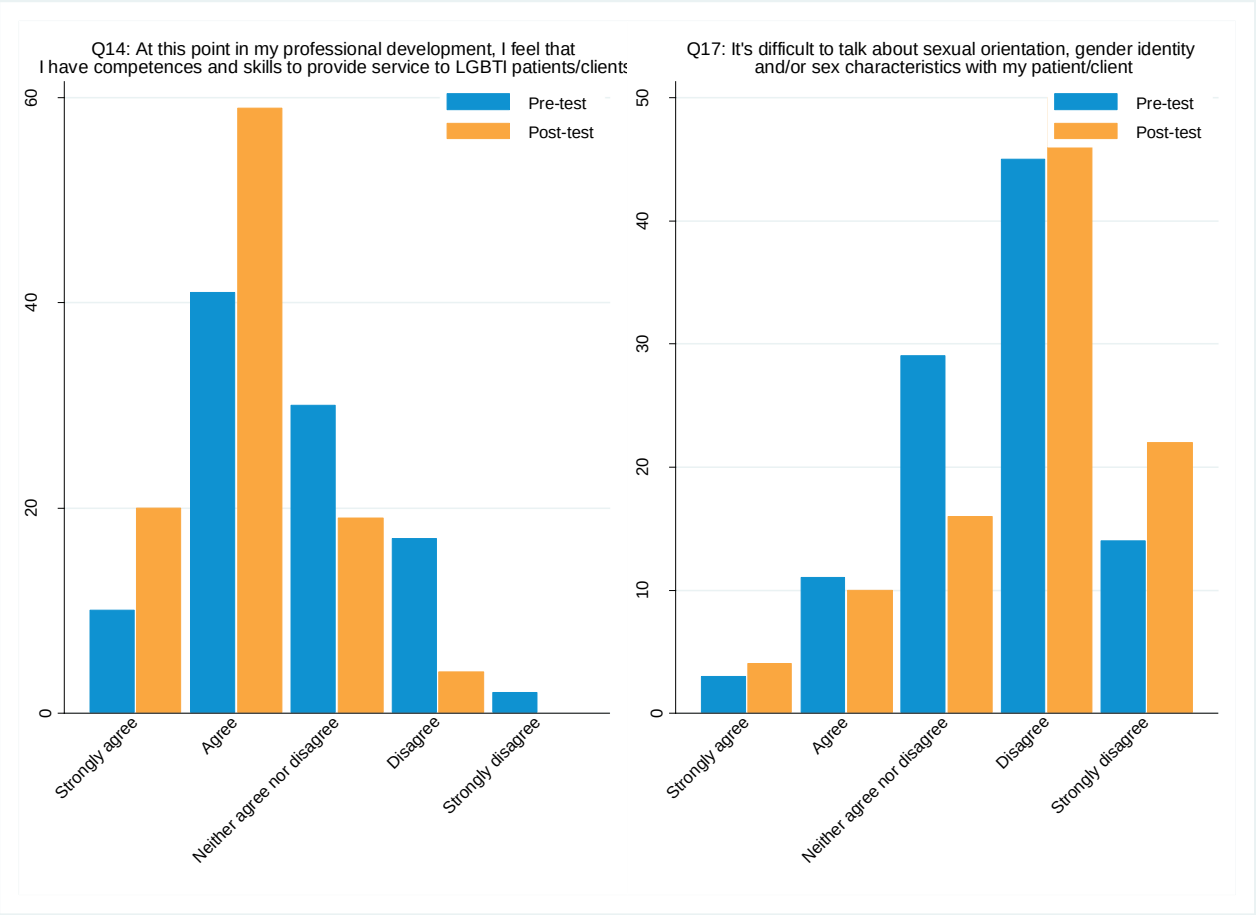
Figure 3.8. Awareness of health inequalities faced by LGBTI people



After the training, the participants felt more competent to provide services to LGBTI people (q14) and also perceived less difficulties in discussing sexual orientation, gender identity and/or sexual characteristics with their patient or clients (q17) (Figure 3.9). This change was the most pronounced in the youngest age group, who were the least confident at the baseline (e.g. the percent agreeing or strongly agreeing in q14 increased from 41% to 69% among those aged 18-30 as compared to an increase from 63% to 75% in the oldest age group). We note that despite the increase in self-confidence, the percent of agreeing or strongly agreeing to q14 remained significantly lower among heterosexual people (pre: 37.5%; post: 61.5%) than among LGB people (pre: 65.5%; post: 94.2%). There were no significant differences by professional group. Moreover, there were some differences with regard to whether the LGBTI perspective should be included in medical curriculum. Although almost everybody agreed to q18, the proportion *strongly* agreeing was higher among LGB people (pre: 74%; post: 85%) than among heterosexual people(pre: 37%; post: 65%). Interestingly, this proportion

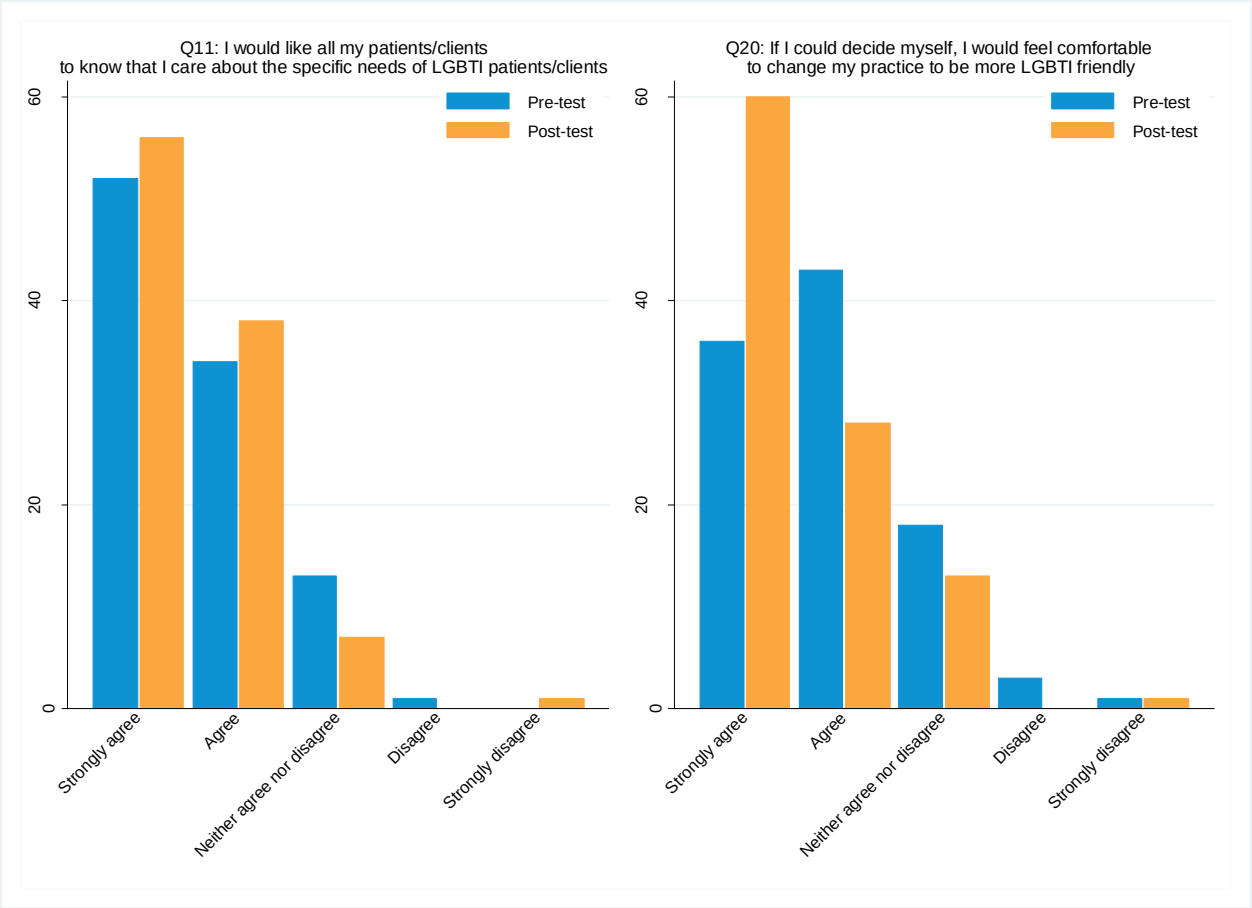
increased the most among nurses (pre: 61%; post: 96%), less so among psychologists (pre: 47%; post: 70%) and even decreased among physicians (pre: 59%; post: 50%).

Figure 3.9. Self-confidence in service provision to LGBTI patients



Finally, even if the participants were, from the beginning, willing to implement changes to make their practice more inclusive towards LGBTI people, this attitude increased even further after the training (Figure 3.10). The increase was similar across different participant groups although the proportion of participants strongly agreeing to q20 was lower among heterosexual participants (pre: 22%; post: 48%) than among LGB participants (pre: 47%; post: 71%).

Figure 3.10. Readiness to implement inclusive practice

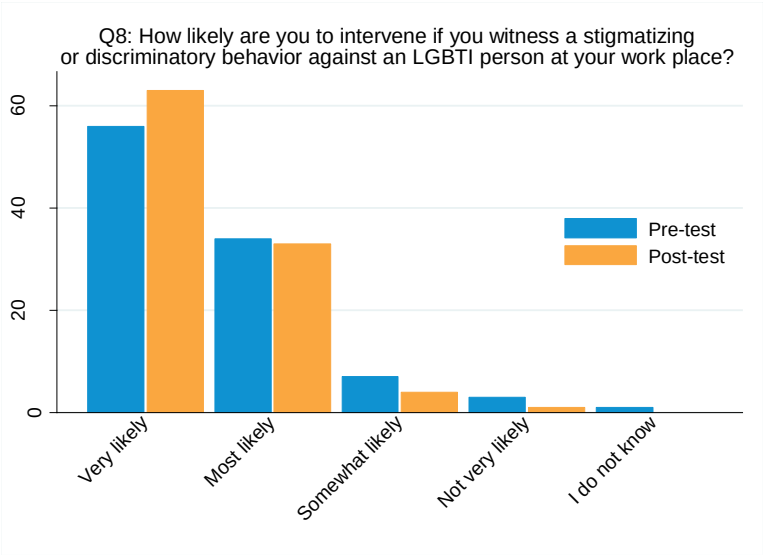


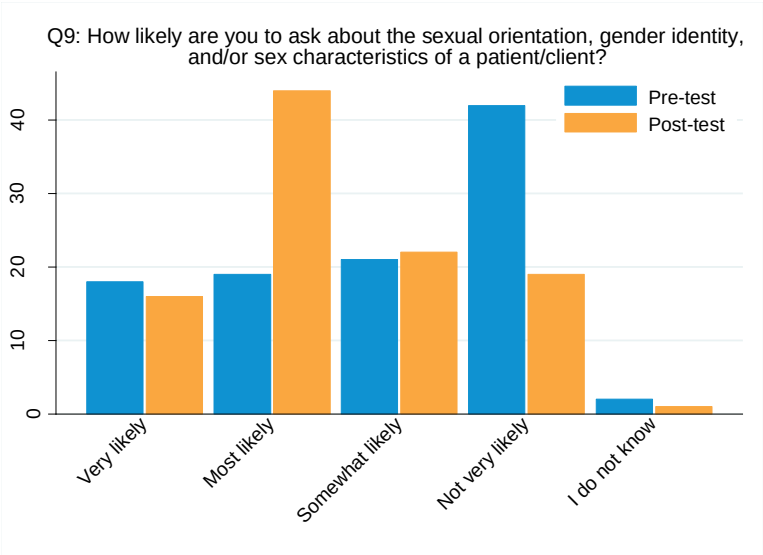
Behavior and intended behavior

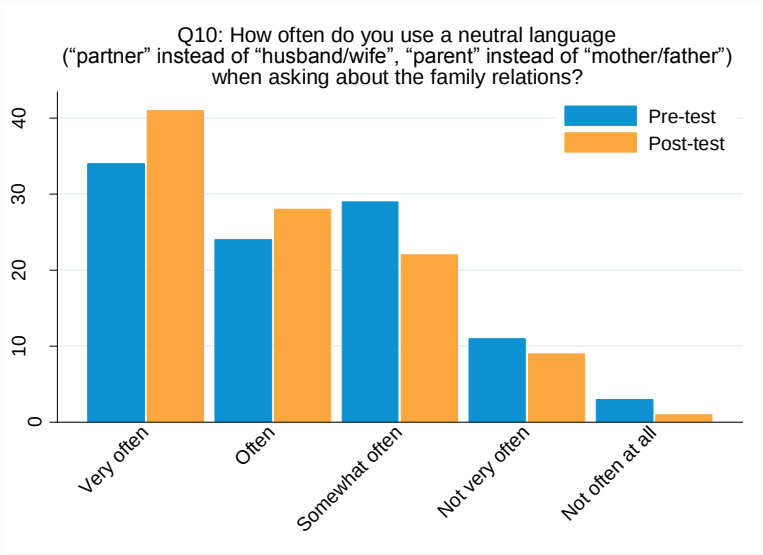
The intended behaviour after the training was more inclusive as compared with the usual practice of the participants before the training. Despite the fact that participants did not change their attitudes on whether knowing the LGBTI status affects their role as medical staff, they afterwards intended substantially more often to ask about sexual orientation, gender identity or sexual characteristics. This was the biggest shift in terms of behavioural intention, as before the training the majority of the participants (64%) were not very likely or only somewhat likely to ask this question. This change was present among all age groups and did not depend on gender identity, sexual orientation or professional group.

There was also a shift towards using neutral language more often and more often intervening when facing discriminatory or stigmatising behaviour.

Figure 3.11. Behaviour prior to training and intended behaviour after the training



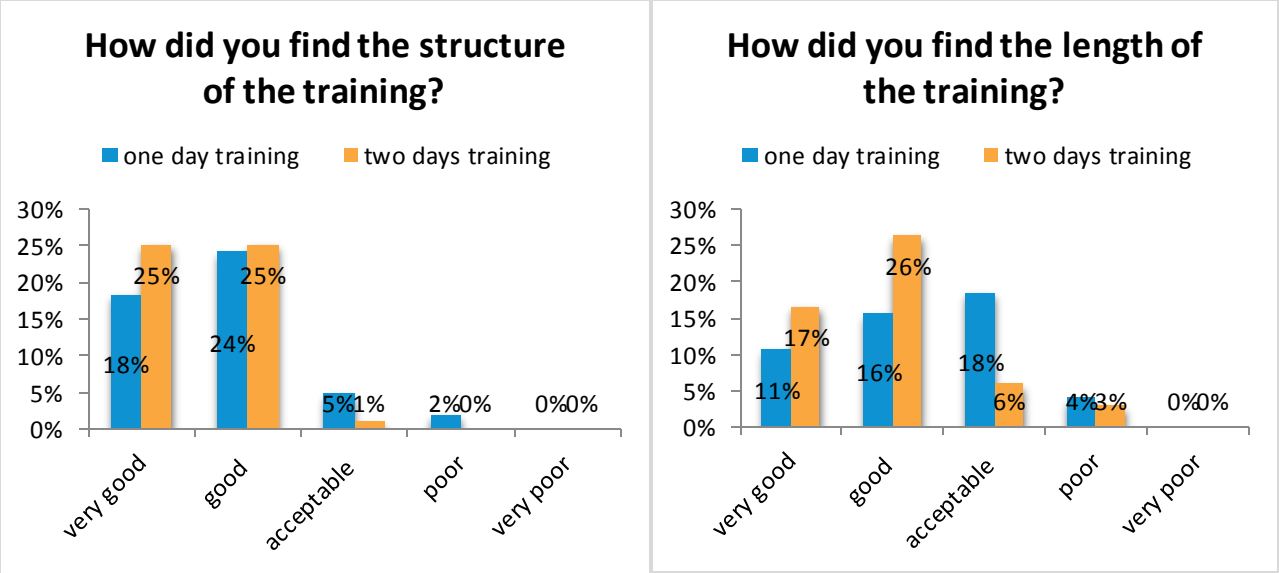




Satisfaction with the training course and relevance to practice

The participants received the pilot training well. The majority of the trainees considered the training structure and the length of the training as good or very good (Figure 3.12; q35-36). The scores were higher for the two half day sessions. Relatively higher proportion thought the length of training was acceptable (25%) or even poor (7%), these opinions were more often shared by participants of the one-day training (see also the summary of open-ended questions feedback below).

Figure 3.12. Satisfaction with length and structure of the training.



With regard to the teaching methods more than half of participants found group discussion, case studies, videos and brain storming as very useful (the highest score 5) (Figure 3.13; q37). Less than half of participants found lectures as very useful (score 5), but taking together two highest scores - 4 and 5, 83% of the participants found the lectures useful.

All participants felt confident about applying their learning from the training in their job role (Table 3.9; q32). The participants expected that they will use often (38%) and somewhat often (36%) the training in their everyday work (Table 3.9; q33). Only 13% will be able to apply their learning in job "very often" and "not very often".

Figure 3.13. Evaluation of the training methods by participants

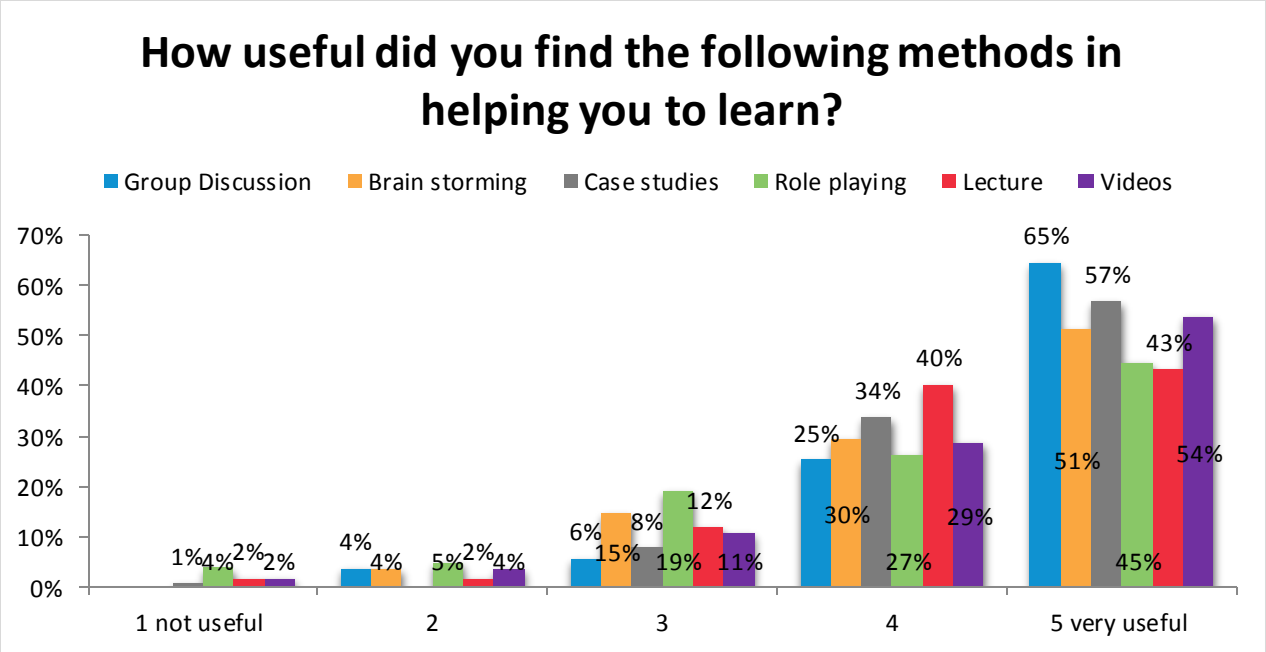
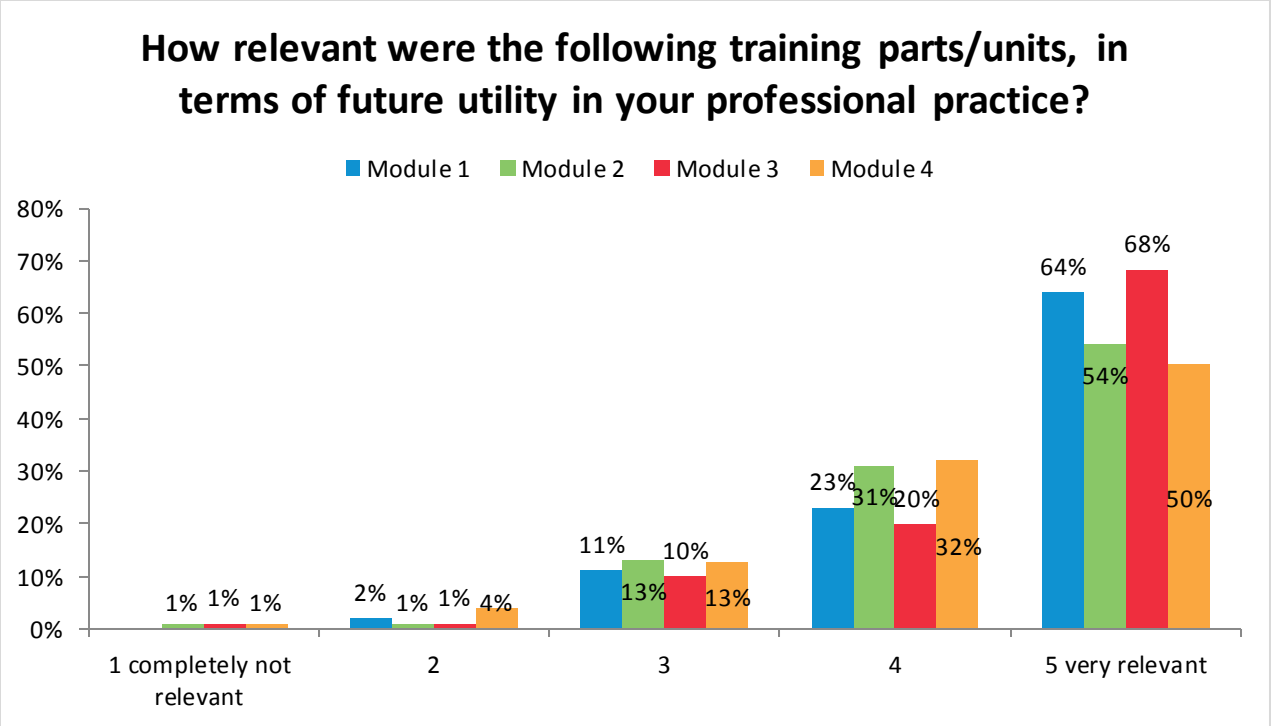


Table 3.9. Evaluation of the training learn and the future using the training by participants in their job role

Question	Scale	Distribution of answers N (%)
How confident do you feel about applying your learning in your job role?	very confident	27 (26.2%)
	confident	61 (59.2%)
	somewhat confident	15 (14.6%)
	not very confident	0 (0.0%)
	not confident at all	0 (0.0%)
	Total	103 (100%)
How often do you expect to be able to apply your learning in your job role?	very often	14 (13.5%)
	often	40 (38.5%)
	somewhat often	37 (35.6%)
	not very often	13 (12.5%)
	not often at all	0 (0.0%)
	Total	104 (100%)

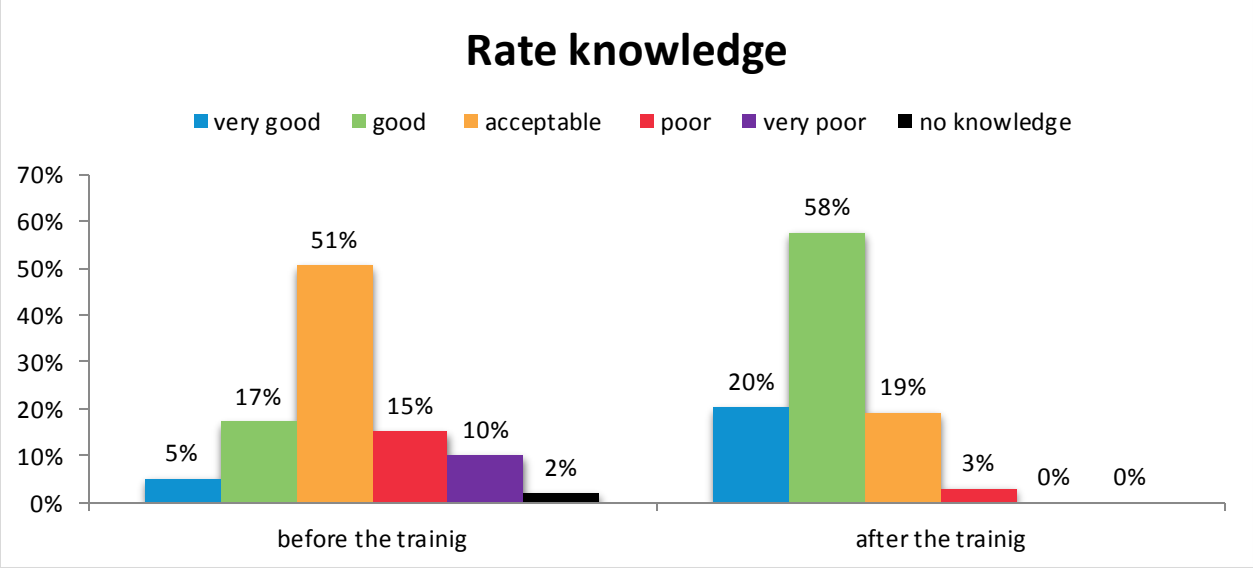
In the opinion of participants, all four training Modules were very relevant (Figure 3.14; q34). *Module 3 Communication & practice* (68%) and *Module 1 Introduction, Awareness Raising, Concepts & Terms* had the highest ratings (64%). The participants found *Module 4 Trans & Intersex Health* and *Module 2 Health & Health Inequalities* as less relevant (but still more than half of participants evaluated these modules as "very relevant").

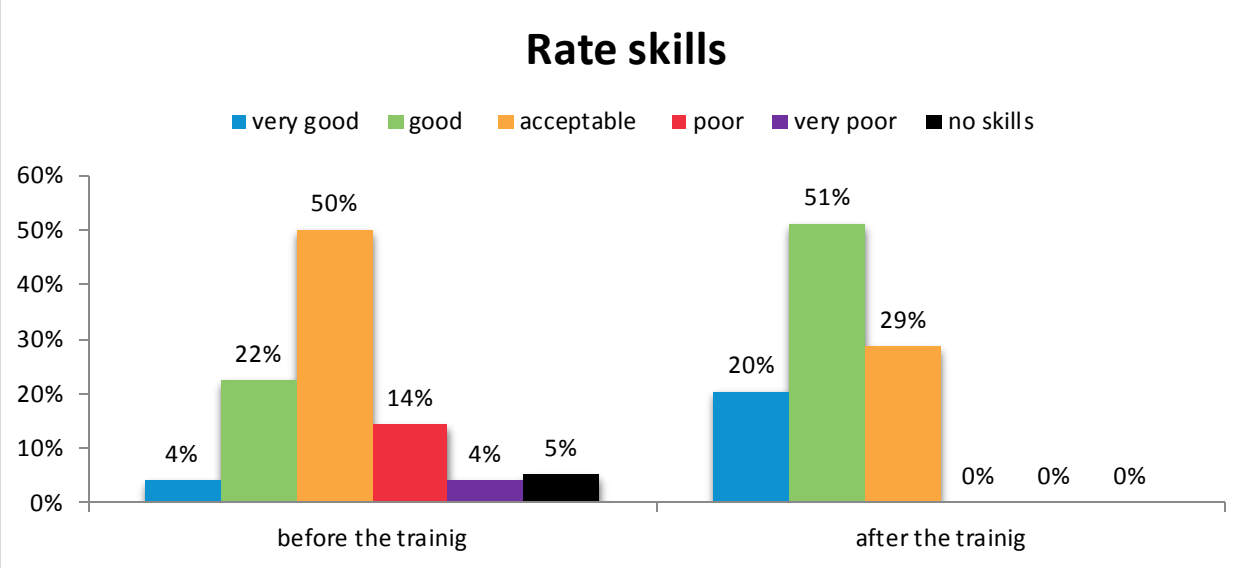
Figure 3.14. Evaluation of the training modules



More than half of participants evaluated both knowledge and skills in the level before the training as acceptable (51% and 50%, respectively) (Figure 3.15; q30-q31). Only 17% and 22% of participants rated their knowledge and skills before the training as good and 5% and 4% respectively as very good. Both knowledge and skills rates were positively changed after the training. More than half of participants evaluated their knowledge and skills as good (58% and 51%) or very good (both 20%). Only 29% and 19% of trainees still rated their skills and knowledge as acceptable.

Figure 3.17. Evaluation of the knowledge and skills by participants, before and after the training





In the open-ended post-test questions (q41-q44) 58 participants added opinions about the training, which were generally positive (98%). In the evaluation of trainees the content of training was clear and easy to comprehend, engaging and very well prepared.

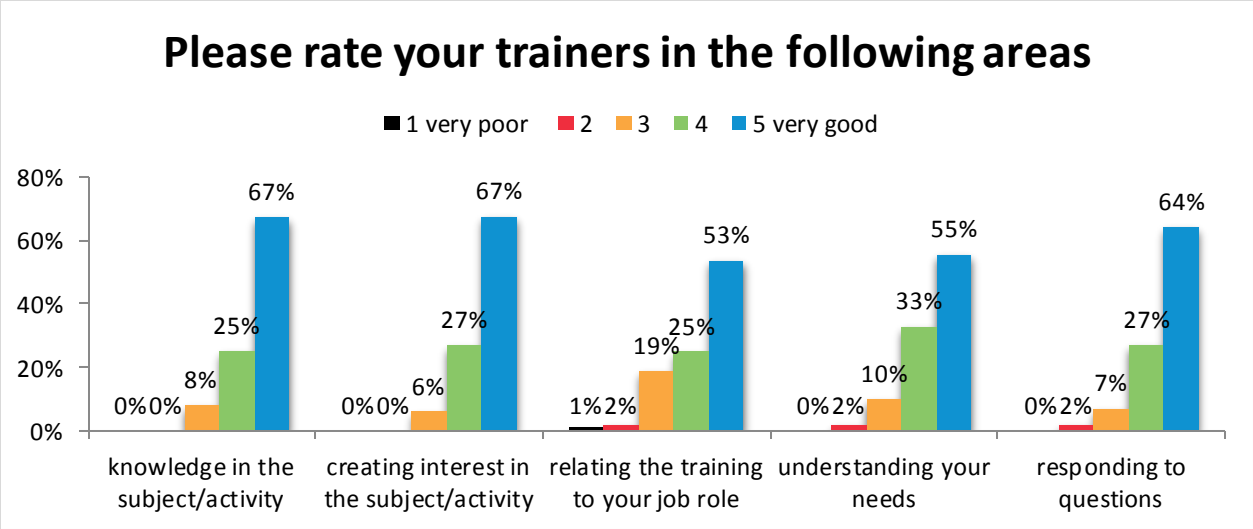
Participants also reported some suggestions for improving the training. They added comments about:

- content of training (very relevant, but maybe it would be possible to limit the number of topics and slides covered during the lectures)
- methods (preferring active learning methods over lectures)
- time of training (was a bit too long)
- certificates (very useful to obtain official accreditation)
- take home tool (printed slides will be a good tool)
- venue/room/catering (the location of the training venue and also training room/catering are very important for trainees)

The trainers, according to the participants, knew the subject and were very communicative (Figure 3.16; q38). In all the evaluation areas there were scores as very good or good by the vast majority of participants. The only area with a slightly higher proportion of scores between 1 and 3 was "relating the training to the job role".

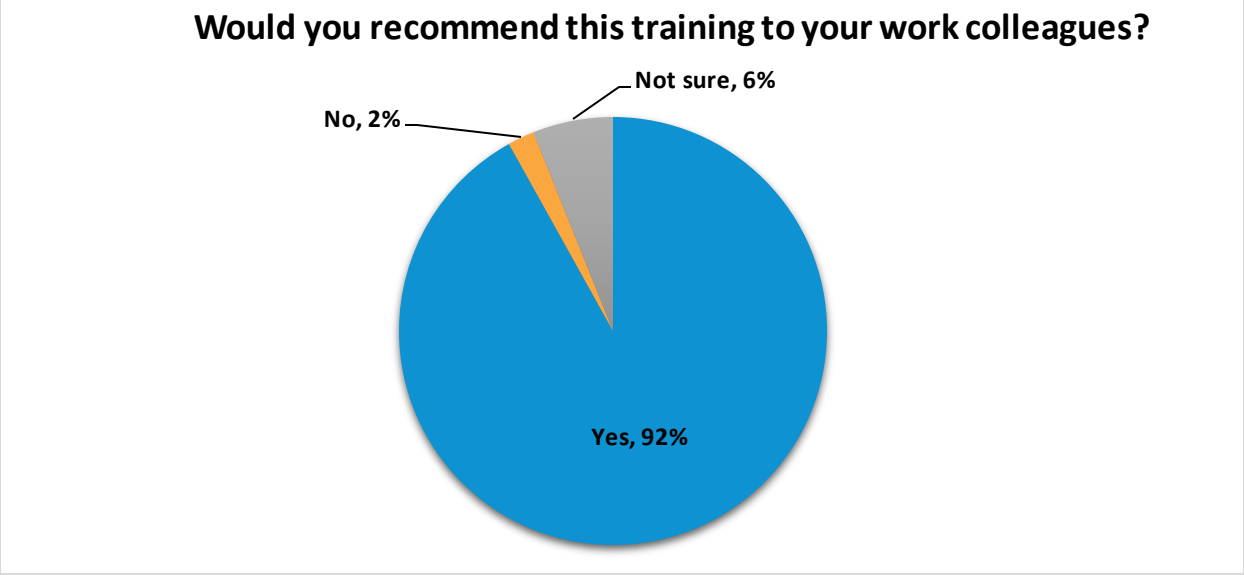
The additional comments of the trainees included appreciation of the idea of two trainers who represented different perspectives: LGBTI person and medical professional. The participants felt encouraged by the enthusiasm of the trainers, their support and willingness to accept conflicting opinions.

Figure 3.16. Evaluation of the trainers by participants



The post-test questionnaire asked to each participant if they would recommend this training to their work colleagues (Figure 3.17; q40). A very significant majority of participants across all the countries answered positively (92%).

Figure 3.17. Recommendation of training to work colleagues by participants



Follow up results

Sixty one trainees filled a follow up form (response rate with respect to the all participant who attended the training: 55%).

Since the completion of the training more than half of the participants (57.4%) were able to apply the knowledge in their job at least occasionally (Table 3.10). Almost a third (27.9%)

witnessed stigmatising or discriminatory behaviour against LGBTI people at their work place, and the majority of them were able to intervene. Neutral language was used often or very often by more than two thirds of the respondents (68.8%), but only 44.3% of them asked about the sexual orientation, gender identity and/or sex characteristics, even occasionally.

Most of the participants (81.9%) discussed the content of the training with their work colleagues.

Table 3.10. Reported behaviours and attitudes 2 month after training

Question	Scale	Distribution of answers (N, %)
Since completing the training, how often have you been able to apply what you learnt in your job?	very frequently	2 (3.3%)
	frequently	8 (13.1%)
	occasionally	25 (41.0%)
	rarely	16 (26.2%)
	very rarely	3 (4.9%)
	never	7 (11.5%)
	Total	61 (100%)
Since completing the training, have you witnessed any stigmatizing or discriminatory behaviour against an LGBTI person at your work place?	yes	17 (27.9%)
	no	35 (57.4%)
	not sure	9 (14.8%)
	Total	61 (100%)
/question only for participants, who answered 'yes'/ **While witnessing a stigmatizing or discriminatory behaviour against an LGBTI person at your work place were you able to intervene?**	always	5 (29.4%)
	more often than not	5 (29.4%)
	on half of such occasions	6 (35.3%)
	less often than not	1 (5.9%)
	never	0 (0.0%)
	Total	17 (100%)
Since completing the training, how often have you used a neutral language (e.g.: "partner" instead of "husband / wife", "parent" instead of "mother / father" etc.) when asking about the family relations ?	very often	26 (42.6%)
	often	16 (26.2%)
	somewhat often	8 (13.1%)
	not very often	6 (9.8%)
	no often at all	5 (8.2%)
	Total	61 (100%)
Since completing the training, how often have you asked about the sexual orientation / gender identity / sex characteristics of your new patients?	very frequently	4 (6.6%)
	frequently	8 (13.1%)
	occasionally	15 (24.6%)
	rarely	7 (11.5%)
	very rarely	7 (11.5%)
	never	20 (32.8%)
	Total	61 (100%)
Do you agree with the following statement: "It's difficult to talk about sexual orientation / gender identity with my patient/client."	strongly disagree	10 (16.4%)
	disagree	21 (34.4%)
	neither agree nor disagree	18 (29.5%)
	agree	8 (13.1%)
	strongly agree	4 (6.6%)
	Total	61 (100%)

Since completing the training, how often have you discussed the content of the training with your colleagues at work?	very frequently	6 (9.8%)
	frequently	16 (26.2%)
	occasionally	28 (45.9%)
	rarely	6 (9.8%)
	very rarely	1 (1.6%)
	never	4 (6.6%)
	Total	61 (100%)

Summary of the SWOT matrix results

The following tables summarises the main strengths, weakness, opportunities and threats reported by the trainers in their comments. Please note that the empty box (without "check" mark) does not mean that the trainers disagree with this issue. This only means that trainers did not emphasise this issue in the open-ended SWOT form. The results are organised according to the themes that emerged, indicating whether or not they emerged in each of the pilot sites.

STRENGTHS:	BE	BG	IT	LT	PL	UK
Content of training						
The content was appropriate with a good overview of subjects, terms and inequalities in healthcare settings specific to L, G, B, T, and I people. The different modules – from terminology to trans and intersex health topics – provided a wide-ranging and easy-to-understand overview of the main LBGTI issues in healthcare setting, which resulted specific and relevant for different healthcare professionals. The training contained international scientific background and context. Slides included a lot of scientific evidence to demonstrate the health inequalities and a lot of examples based on the focus groups report, which helped to raise awareness and see the LGBTI people's actual experience and their point of view.	✓		✓			✓
Teaching method						
The methods were a good combination of practical activities and slides presentation. The learning strategy was evaluated as good. The Module which was considered the most successful – because of the highest levels of interest and engagement of the participants – were Module 1 (Introduction, Awareness Raising, Concepts & Terms) and Module 3 (Communication & practice). Trainers observed as for the trainees the opportunity to take part in the roll-play was crucial.	✓	✓	✓	✓	✓	✓
Benefits for participants						
Trainers reported that the training was seen as very useful by the majority of the training participants. The correct use of terminology and understanding/experience of how to		✓	✓	✓	✓	✓

	BE	BG	IT	LT	PL	UK
communicate in an inclusive way was evaluated as a specific benefit for participants. This training content could improve their competencies in every-day professional situations (e.g. knowing how to consult LGBTI patients in everyday life, where to refer then if they (as health care practitioners) cannot help).						
Trainers' Manual The Manual was seen as a very useful tool for preparing and executing the training	✓	✓	✓	✓	✓	
Tandem of two trainers The involvement of two trainers for the training facilitation, a health/medical professional and a representative of the LGBTI community with expertise in providing training, worked well.				✓	✓	✓
Trainers The trainers preparation for the training using the manual but also their professional/personal skills and previous experiences in leading training were evaluated as a strength of the piloted training.		✓	✓	✓	✓	✓
Local organizations' support In Poland, the training was organised by the National Institute of Public Health-NIH, which has authority among medical professionals. This aspect has been recognised by the trainers as influencing the importance of the subject among the trainees. In Lithuania, the training course was organised by the national LGBT rights organization in cooperation with the medical students' union. This provided additional credibility for the pilot training and encouraged participation.				✓	✓	

WEAKNESSES:	BE	BG	IT	LT	PL	UK
More is less The training volume of contents was seen as too high. Too many slides, too much theory to cover in the timeframe allowed for the training. Some parts of the lectures could be shortened.	✓	✓	✓	✓	✓	✓
Lecture The trainers noted that Module 2 (Health & Health Inequalities) and Module 4 (Trans & Intersex Health) should be more interactive and practical, with space for more informal discussions, and more icebreakers for participants to make the learning process more efficient, to generate greater interest and engagement among the trainees. They considered that the focus on research findings was too strong which made the modules very theoretical and resulted in difficulties to keep the participants focused.	✓		✓	✓	✓	✓
Provided time The provided time was too short, especially to go more in detail and to allow more informal discussions, more icebreakers and interactive exercises.	✓			✓	✓	✓

	BE	BG	IT	LT	PL	UK
Need of adaptation to the local context Some of the topics in the training were not very relevant to the local context. It did not correspond to the interest and knowledge of the participants.	✓	✓		✓	✓	
Translation problems The trainers noted that the terminology regarding trans identities is difficult to translate.		✓				
Trainer-to-be Trainers need to have previous experiences and knowledge on the topic, as the manual is not covering all the information needed to properly manage group discussions. In case of the activities the trainers "must have" general social skills and previous experience as a trainer.	✓		✓		✓	✓
Recruitment strategy The recruitment strategy was complicated and a bit confusing, especially concerning the system of reminders (IT). Sending the consent forms and all the documents before the training seemed to be confusing for trainees.			✓			

OPPORTUNITIES:	BE	BG	IT	LT	PL	UK
Participants The trainers observed that the feedback on the pilot training from the trainees was very positive. Some participants declared that they wanted to transfer the knowledge from the training to other colleagues/staff in their healthcare workplace. Trainers noted that participants of the training can be treated as "ambassadors" of LGBTI health issues. Therefore in the future the training participants could be potentially used as multipliers in disseminating information and recommending the training for their colleagues and broader professional circles. They could be also recommended for LGBTI community as friendly practitioners.		✓	✓	✓	✓	✓
Future use of the training The trainers recognised the opportunity of use of the materials for future trainings. The training could be implemented in universities and schools for the medical/health care students or health related conferences.	✓	✓	✓	✓	✓	✓
The institutions support The trainers do not believe that there could be any significant institutional obstacles in replicating this training for health care professionals in the future. In Belgium the NGO organisation KliQ can use the lessons learnt for giving trainings, maybe in collaboration with different hospitals or schools. The training could be implemented in universities and schools for healthcare workers. The training	✓	✓	✓	✓	✓	✓

could be implemented by the network of LGBTI-teachers in university colleges teaching in the field off wellbeing and care.

In Bulgaria the training course would be more recognised if training were initiated and advocated by the Medical University of Sofia and its Faculty of Public Health

In Italy, university and medical course leaders could support the implementation of future trainings as part of the university course/curricula.

In Lithuania the pilot training was attended by a general practitioner, who is also involved in the national association for general practitioners. Upon the corresponding recommendation, the trainers have established a direct contact with the leadership of the national association and currently are discussing the possibilities of disseminating the training among the broader circles of the general practitioners. The trainers in Lithuania have also established a close working relationship with the medical students' association and association for young health care professionals, i.e. institutions which could be potentially used in the future with the view of dissemination information about this particular training.

In Poland, medical universities can help in implementing the training. The pilot training in Poland was held under the honorary patronage of the Rector of Medical University of Warsaw and the honorary patronage of the Commissioner for Human Rights. The best way to implement the training would be to liaise with national consultants in Obstetrics and Gynaecology, Paediatrics and other specialities as well as Centre of Postgraduate Medical Education and ask for help. The training could become part of National Institute of Public Health–NIH curriculum.

In the UK Department of Health, Nursing and Midwifery Council, General Medical Council, Health and Care professions Council could support reducing health inequalities of LGBTI people through their standards, policies and regulations.

Accreditation of the training course

It would be very useful to obtain official accreditation and validation of the training through the relevant pubic body, so that the training participants would be able to obtain specific certification of the knowledge acquired within the framework of the training and could subsequently declare it under the scheme of the requirements for professional development	✓	✓	✓	✓	

THREATS:	BE	BG	IT	LT	PL	UK
"LGBTI friendly" participants						
Participants attending the training course were in most cases "LGBTI friendly" – this could probably create a bias and mean that the feedback and inputs of "less inclusive" colleagues are not taken into account in this evaluation.	✓		✓	✓	✓	
Participants-to-be						
The training requires active participation and contribution by both trainers and participants. If trainees do not wish to participate in	✓	✓	✓	✓	✓	✓

activities, especially in role-playing, the training will have no benefits and will be just a piece of information. If the training were voluntary (extra-curricular) the participants would have to pay for attending and it may be difficult to organize the training. On the contrary – if it were compulsory – not all participants would be willing to actively participate in the course. If a training were conducted for a not "LGBT friendly" group of medical professionals, who, for example, were directed to the training by their professional bodies, the general resistance to the topic and trivialization of specific needs of LGBTI populations in the health care setting could be encountered. These tendencies would negatively impact the climate of the training, and much more time would be required to challenge negative stereotypes and justify the need for LGBTI-specific skills and knowledge among the health care professionals.				
The institution barriers Not all institutions are open to LGBTI people, general and institutional stigma can be present. For this reason, trainees might have difficulties in implementing acquired skills during the training. Some participants declared that they wanted to transfer the knowledge from the training to the staff in their workplace. At the same time, they had a lot of fears about it (didn't know how to explain the necessity of that issues).	✓	✓	✓	✓
The lack of resources Lack of human, organizational and financial resources for continuing this important job.			✓	

Summary of the site visits results

Every training organised during the piloting phase was observed by an external evaluator who was familiar with the project (part of the Health4LGBTI Consortium). Evaluation was conducted based on prepared grid (Appendix 4). The following suggestions and recommendations represent a summary of the analysis of site visits forms filled out by the external evaluators. Qualitative analysis was carried out according to this strategy: the most frequently appearing issues have been included in the final version of this report, as well as remarks from evaluators that were relevant for the final refinement of the training materials.

General results and recommendations

The first conclusion that arises from the analysis of the site forms is that regarding the timing of conducting the individual modules. The completion time of almost every module has gone beyond the allocated timeframe. This caused many omissions of activities that are an integral part of the modules.

In the following list **key recommendations** are reported.

Organizational aspects

- Training implementation should take place over two days. It works better for the level of attention of the participants.

- Adjusting amount of content by reducing the amount of data that is presented.
- Reducing the number of participants may improve the time aspect as practically all the activities were longer than expected.

Group dynamics

- On the second day of the training (provided it is implemented in two days) it is necessary to make a quick revision of previous modules.
- Change the composition of small groups of the exercises to enhance exchange of experience between participants e.g. role playing.

Implementation of modules

- The use of the "Genderbread person v2.0" (added during some pilot sessions to better explain the concepts) was very helpful to the group, as terminology was immediately understood and it represented a good "parameter/example" for the discussion.
- Local adaptation is essential and it is an added value of the training as it creates an opportunity to better understand and relate knowledge to experience of participants. Simple translation from English may not result in neutral or inclusive language. This underlines the need for adaptation of the training to the local context, in consultation with the local community.
- Topics that could be considered to be added: coping with discriminative behaviors in health care, specific needs of older LGBTI people, short description of disorders of sex development, current standards of care.

Module 1 - Introduction, Awareness Raising, Concepts and Terms

This module presents, inter alia, the Health4LGBTI project. In some countries it was noticed that the project presentation itself was too long and not very interesting for the training participants (PL, IT). In each pilot site, participants shared their own experience and were encouraged to ask questions. If these issues were not covered by the Manual and the training material the trainers supplemented it with their own expertise. The trainees were particularly interested in the issues that are strictly related to the national context (e.g. country's law regulations) or the distinction between gender identity, sexual orientation and gender characteristics. Some of the training materials in this module have been supplemented with additional information. One such example was "genderbread" (BE, UK). The implementation of this module allowed to conclude that issues related to trans and intersex are the most problematic ones to understand.

Module 2 – Health and health inequalities

Participants in this part were interested in the results of the project, inter alia, the report on the systematic review (BE). Another comment reported that information about inequalities in health should be reduced due to its large word count (BE, PL). They should, however, retain their informative character, as the participants very much appreciated the information coming from this report (UK). Positive examples should also be added to the case study activity so as not to focus only on negative practical aspects (BE). Intersectionality is a topic that has been appreciated by the participants. The video that was presented in this module worked very well. Even with difficult translation and a different cultural context, it has been well received by participants (IT). There was a remark regarding the adaptation of terminology in the field of HIV and AIDS to that used in the rest of the training materials. It was very important to adapt

the materials to the local context (e.g. using quotes from the focus groups report more appropriate to the local context). A similar remark was also made regarding information on the legal status (PL, LT, BG). The use of patients/users quotes turned out to be very important for some participants (LT) because they enrich the awareness of the real practice in the clinical settings.

Module 3 – Communication and practice

When training modules were performed in two days, before any activity, participants were asked about contents discussed in the first day (different terminologies, main health inequalities). This procedure should be included in the training manual (UK). One of the observations that emerged during the training highlights the lack of ease of speaking about sexuality and suggests that the trainer should pay particular attention to this topic (IT). Once again, it was important to adapt to the local context (e.g. care during pregnancy is differently performed in many countries) (IT). The role-playing activity was carried out in large groups due to the lack of time in two piloting sites, which, however, turned out to be a good alternative solution (IT, PL). Trainers knowledge of local context (e.g. organizations that can be a reference point for trainees) was seen as an important issue (PL). In several countries (UK, BG, LT) the discussion about creating a friendly medical practice has proven very fruitful – if enough time is allocated to this activity.

Module 4 – Trans and intersex health

The issue that appeared as very important in this module is the theoretical preparation of trainers for its implementation (BE, LT). A solid theoretical preparation of the trainers and the relevance of adapting the information to the local context has again been revealed (IT, BG, PL). As a general consideration, trainees lacked general knowledge especially on the intersex issues. For this reason, it would be good to understand the concept of disorders of sex development and in which very specific cases intersex people may require the medical interventions. It would be good to include more on the recommended standards of care while the slides on inequalities in health care services could be summarised in less slides and focus could be placed on trans and intersex peoples' specific needs and the standards of care (PL). In one of the countries, the presence of an activist for intersex people enriched the discussion (BG).

4. Final comments and conclusions

Conclusions

A wide range of health care professionals were recruited in the pilot sites across 6 different EU countries. Participants were mainly psychologists, physicians and nurses, but other professionals including support staff working in healthcare setting also attended the training. There was a fair representation of all age groups. However, more than half of the participants identified themselves as LGBTI and practically all attended the training due to personal interest and reported inclusive attitudes towards LGBTI people already before the training. Additionally, the composition of groups differed between the sites. The results from any given site should not be considered representative for the country, where this pilot site was located, as such

conclusions could be misleading due to the small number of participants and self-selection for the training.

The purpose was not to recruit a representative sample of health care workers but to recruit individuals with different backgrounds and prior experience and in different settings to assess how well the devised training modules perform and how they could be improved. Basic overall findings have been reported but a further analysis considering the differences across trainees' characteristics and pilot sites could be implemented to better understand the training impact.

1 The training contributed to increase in knowledge

The pre- and post- training tests revealed a significant increase in the participant's knowledge. This increase in the knowledge was consistent across demographic characteristics of the participants as well as in all EU piloting sites. This proves that the training manual and the training materials are generally suitable in allowing successful implementation in wide range of countries. Moreover, the increase of knowledge was the highest among the heterosexual people attending the training among whom the initial knowledge level was the lowest. However, it is interesting to note the existence of substantial gaps in the participants' knowledge prior to the training, even among those participants who identified as LGBTI people.

2. The training contributed to increased awareness and competence in care provision of LGBTI people

Attitude change is usually more difficult to achieve than increasing the level of knowledge. The training therefore focused on the specific aspects relevant to health care practice. We noted an important increase in awareness that access to health care of LGBTI people may be in fact worse than that of other patients. Even if the participants were very LGBTI-friendly from the beginning, their willingness to improve their practice to become more inclusive tended to be higher after the training. Importantly they also felt more competent to provide for this group and intended to implement the training content in their practice.

During the 2 months after the training the participants were in fact able to apply what they learnt in their practice. A third of participants, who responded to the follow-up survey witnessed some discrimination events against LGBTI people in health care and most of them were able to intervene. A great majority spoke about the training to their colleagues and over two thirds used neutral language in their practice, a ten percent-point increase as compared to pre-test.

3 The training module was well received

The participants were satisfied with the training and the trainers. They appreciated the structure, the teaching methods and the length of the training, although there were some problems with the timing. More than half of the participants found all modules very relevant, especially the introductory Module 1 including terms and concepts and Module 3 on communication. Both modules were described as very relevant by approximately two thirds of the participants. Reflecting back on the situation from before the training, the participants themselves felt they substantially increased both their knowledge and skills.

All trainers across the European pilot sites evaluated the training methods as a specific strength of this training. The majority of them reported also two additional main strengths: they attributed great value to the training manual and appreciated the great benefits resulting

from the training implementation for the participants. Indeed, the trainers across all piloting sites received positive feedback and evaluation from the participants.

4 Importance of the trainers, their knowledge and experience

The trainers participating in the pilot had already experience in the LGBTI and/or health inequalities fields and had previous experiences as trainers. They recognised that previous trainer's experience and knowledge on this topic is essential to be able to lead in a proper way this training course. Some of them highlighted the tandem of two trainers with different profiles as a specific strength of this training. This aspect has been seen as positive also by the participants. These results should be carefully considered in the trainers' future selection procedure.

5 Importance of adaptation to local context and to the audience

The need to adapt the training materials to the local context was underlined by the trainers and the site-visitors. During the piloting, some trainers already added examples and contents according to their local context mainly in response to specific questions from the participants. The ability of the trainers to "relate the training to the job role" of the participants was given lower scores by almost a quarter of the participants, which further supports the necessity to adapt the training to the audience. When speaking about adaptation, the importance to have an accurate translation was also highlighted by the trainers. The need for a local adaptation is a topic already highlighted in the manual (and further stressed in the revised version of the training materials, as described below) and is an essential issue that has to be considered when training will be implemented in the future.

Furthermore, an additional critical aspect is connected to the attitude of future trainees. In the pilot the majority of the participants evaluated themselves inclusive already from the baseline. The future possible presence of less inclusive or even LGBTI hostile participants (should the training be implemented in a mandatory way), could require adaptation of the training. The presence of negative stereotypes could require more time to create change and improve awareness, knowledge and skills. For this reason, as suggested in the manual, the training should be adapted also to the characteristics of the trainees, including their attitude. In the manual some suggestions have been reported to facilitate the communication and create a good group climate, also when negative opinions or attitudes emerge.

6 Health4LGBTI network

The trainers recognised the great value of this piloting activity as starting up networking activities among the pilot trainees and their colleagues. Given the attitudes expressed by the participants the trainers saw the possibility that the trainees can involve other healthcare colleagues in the need to improve their awareness and competences on LGBTI issues in healthcare setting. This already occurred to a certain extent as the trainees reported in the follow-up questionnaire to have discussed the training with their colleagues at work. Moreover, 63 of the trainees volunteered to be further involved in an international "Heath4LGBTI network" exchanging knowledge and experience as well as informing each other of new arising opportunities.

7 Wider roll-out much needed but barriers do exist

The need to implement the training on a wider scale was acknowledged by the participants, of whom over 90% would recommend the training to their colleagues and of whom many commented on the lack of such a topic in the training curricula of the medical professionals.

The trainers recognised the opportunity to re-use the training materials for future trainings and the relevance to implement it in the healthcare professional formal education (medical schools and Universities). It is interesting to note that some of the trainers already identified opportunities for contacting local organizations and training institutions. Finally, the majority of trainers, and also some participants highlighted the utility to obtain official accreditation under the scheme of the requirements for professional development and validation of the training through the relevant pubic body.

Nevertheless, the trainers reported also possible institutional barriers. These barriers may operate on two levels. Firstly the stigma and fear could limit the dissemination of new knowledge and skills across colleagues and the utilisation of the newly acquired skills. Secondly, this may lead to a lack of human, organizational and financial resources for the training course.

8 The pilot identified issues to be addressed

A relevant suggestion emerging both from the trainers and the site visitors, and also from participants comments, concerned the length of the training course. On this topic, all the trainers across the piloting sites asked to reduce the contents in order to be able to implement the training and to have more space for group discussion and participants' engagement. Their requests regarded in particular the lecture sections of Module 2 and 4. This issue has been reported also by the site visitors and has been taken into account in the revision of the final training materials. Another indication for change concerned the need for local adaptation.

Given that the trainees may experience difficulties in applying their new competences in a stigmatizing environment, this issue should be addressed during the training and when appropriate could be discussed among the trainees (for example during Module 3 when participants discuss inclusive practice).

Limitations

As no ready instrument was available to use for pre-, post-training and follow-up evaluation the questionnaires were developed by the project team. They are based on existing validated items, but due to limited time available for evaluation during the training session the number of questions had to be reduced and some of them were modified to better represent the concepts to be measured. However, the new tool was not formally evaluated. The pre-, post- and follow-up questionnaires were developed in English. For some questions the translation was challenging and the precise concept behind the question difficult to capture. However, the questionnaire was translated by the trainers with a good understanding of the field and they had an opportunity to discuss with the project team and report the translation issues and also whether they noticed questions that did not work well in their setting. The only question identified by this process was Q24, which was excluded from analysis. Nevertheless, the data, especially when relating to the comparisons between countries should be treated with caution.

The training was facilitated by the inclusive attitudes of the participants and their high motivation to improve their knowledge and skills. This can possibly impact on their satisfaction with the training and learning capability. The same level of improvement may not be possible with a less motivated group. Moreover, the follow-up results must be treated with caution as

the response rate was 55% and possibly the more engaged or the already inclusive participants were more likely to respond.

Main improvements made to the training

The integrated results and comments by participants, by trainers and site visitors were crucial to consider improvements in the training module. At this stage we focused on issues identified by larger groups of the evaluators (participants, trainers and/or site visitors) as some differences in opinions in such situations are inevitable.

The refinement process took place in two phases:

1) a first revision by the members of the Health4LGBTI Consortium
2) a second revision by external participants of the Health4LGBTI final Conference.

As concerns phase 1, the Health4LGBTI team of researchers discussed the results and the majority of the issues during a face to face meeting in December 2018. The contribution of the site visitors (all members of the Consortium) in the different pilot sites, who have directly observed the challenges in each piloting site, was essential to prioritize the most relevant changes and issues to be addressed.

The following is a summary of the main improvements made to the training after this meeting.

Table 4.1 Summary of changes to the Health4LGBTI Training material based on the results of the evaluation of the piloting

General changes	- Number of slides and the content in each slide has been reduced - More animation has been added to the slides - More activities have been added (see details below) - The timing for activities and overall duration of the modules and the course has been revised - More detailed possible implementation scenarios have been included - Recommended numbers of participants have been reduced from 20 to 15
Module 1	- Reduced background information about the Health4LGBTI project - Added genderbread person picture v2.0 - Moved ground rules to the beginning of the session - Included a slide on the ILGA map of Lesbian and Gay rights in the world to provide understanding of recent rights and freedom gained by some but also the continued marginalization in some parts of the world. - Activity 4: "Correct use of terminology": Added instructions in the manual to ensure that this exercise is anonymous (that is, participants are not necessarily linked with their answers) - Activity 5: "Let's practice your knowledge: made it an individual exercise. Deleted the column "Sex Behaviour" from the work sheets

Module 2	- Added the activity "Quiz on health inequalities" - Activity 4: Adapted two cases to make them positive -> recipes for success - Added a suggestion and a reference to use the ILGA video on older LGBTI (slides and manual)
Module 3	- Added to the manual that the 1st part of the video shown to participants in module 2 can be shown again as a recap for participants. The second part of the video is then shown as originally described. - Added symbols (sad face/happy face) instead of text in the box with examples of positive and negative use of language - Added the activity 3 table in the slides
Module 4	- Added EC Intersex video - Included more bibliographic references in the slides - Used the most recent definition of intersex

After this first refinement phase the Health4LGBTI training course was presented and discussed during a final Conference in Brussels in February 2018. Participants from different European Countries discussed the modules during the conference and were invited to send comments to further improve the training modules (see the Health4LGBTI Conference evaluation report). The final version of the training modules also considers the results of this second refinement phase.

In particular the slides and the manual were improved with regard to items that could be imprecise or interpreted in an incorrect way. Several activities were modified in order to better address relevant issues and concepts, including definitions; some terms were changed (e.g. we explained that when presenting case-studies, the trainers should refer to "situations" rather than "cases"); more examples were provided (e.g. new additional case-studies on trans and intersex in the manual), corrected English/formatting mistakes, redundant sentences or paragraphs.

Appendix 1 Pre-training Evaluation questionnaire

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

PRE-test

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

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

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

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

DEMOGRAPHICS

1. **My age is:**
   1. ☐ 18-30
   2. ☐ 31-50
   3. ☐ 51-64
   4. ☐ 65 and over

2. **My sex is:**
   1. ☐ female
   2. ☐ male
   3. ☐ other, please specify:

3. **My gender identity is:**
   1. ☐ female
   2. ☐ male
   3. ☐ other, please specify:

4. **My sexual orientation is:**
   1. ☐ asexual
   2. ☐ bisexual
   3. ☐ heterosexual
   4. ☐ homosexual
   5. ☐ other, please specify:

5. **My profession is:**
   1. ☐ physician
   2. ☐ nurse
   3. ☐ midwife
   4. ☐ psychologist
   5. ☐ social worker
   6. ☐ physical therapist
   7. ☐ other, please specify:

6. **What is your specialty in medicine, if any:**

7. **What were your main reasons for taking part in the training?** *You may choose more than one*
   1. ☐ My job or responsibilities have changed.
   2. ☐ To improve my skills or knowledge.
   3. ☐ I was asked to take part by my manager.
   4. ☐ It may be of some use in a future.
   5. ☐ I was interested in this topic.
   6. ☐ It was the right thing to do.
   7. ☐ Other, please specify:

ATTITUDE - SKILLS - KNOWLEDGE

8. **How likely are you to intervene if you witness a stigmatizing or discriminatory behavior against an LGBTI person at your work place?**
   1. ☐ very likely
   2. ☐ most likely
   3. ☐ somewhat likely
   4. ☐ not very likely
   5. ☐ I do not know

9. **How likely are you to ask about the sexual orientation, gender identity, and/or sex characteristics of a new patient/client?**
   1. ☐ very likely
   2. ☐ most likely
   3. ☐ somewhat likely
   4. ☐ not very likely
   5. ☐ I do not know

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

1. ☐ very often
2. ☐ often
3. ☐ somewhat often
4. ☐ not very often
5. ☐ not often at all

Do you agree with the statements below (Q11-Q14):

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

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

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

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

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

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

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

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

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

inclusive negative

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you agree with the statements below (Q16-Q18):

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

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

17. **"It's difficult to talk about sexual orientation, gender identity and/or sex characteristics with my patient/client."**

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

18. **"I think that LGBTI perspective should be an integral part of the medical staff education curriculum."**

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

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

With	**Yes**	**No**	**I do not know**
lesbian patients/clients	☐	☐	☐
gay patients/clients	☐	☐	☐
bisexual patients/clients	☐	☐	☐
trans patients/clients	☐	☐	☐
intersex patients/clients	☐	☐	☐

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

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

21. **Using a neutral language (e.g.: "partner" instead of "husband/wife", "parent" instead of "mother/father" etc.):**
1. ☐ can be confusing, as it may not be very clear to whom the health professional is referring
2. ☐ is not necessary for the majority of people, so it is the patient/client that should make things clear when the health professional uses the wrong term or assume a standard situation
3. ☐ is one of the things that a health professional can do in order to set an inclusive environment

22. **When speaking with patients/clients, health professionals should:**
1. ☐ refer to them and their situation with the terms that are generally used in the scientific and medical field, as this is what their professional role requires
2. ☐ be aware both of the medical terms and the terms preferred by the LGBTI community, but they should ask the patients themselves how they want to be addressed
3. ☐ refer to them with the terms that they know are generally accepted by LGBTI community as soon as it gets clear they belong to this group

23. **The terms "gay" and "MSM (men-who-have-sex-with-men)" are:**
1. ☐ different, because "MSM" refers to a sexual behavior that does not necessarily imply that the person identifies as gay or bisexual
2. ☐ synonyms, but "gay" is more well-known also outside the LGBTI community while "MSM" is less known
3. ☐ synonyms, but the term "gay" can also be used for women, whereas MSM specifically refers to a behavior between men

24. **Check the correct statement:**
1. ☐ He is homosexual
2. ☐ He is a gay
3. ☐ He is a gay man

25. **Intersectionality. When speaking about LGBTI people, this concept highlights social disadvantages and factors other than being LGBTI that people can face:**
1. ☐ true
2. ☐ false
3. ☐ I do not know

26. **The terms "sexual orientation", "gender identity" and "sex characteristics" are:**
1. ☐ synonyms, as they all refer to a person's specific set of characteristics
2. ☐ different, and they are not necessarily related nor do necessarily affect/imply certain specific development of the other ones
3. ☐ different, but they are related and each one necessarily implies compliant results in the development of the other ones

27. **Corrective surgeries and other medical, hormonal and psychological treatments for intersex people are:**
1. ☐ always necessary, as having both male and female sex characteristics leads to medical problems, but they have to be put in place in infancy in order to be followed by a normal life
1. ☐ always necessary, as having both male and female sex characteristics leads to medical problems, but they should be put in place in adulthood so that patients can choose the sex they feel more comfortable
2. ☐ not always necessary, as in many cases an intersex body is a perfectly healthy body

28. **The fact that someone has an intersex body:**
1. ☐ will not certainly become apparent, it is possible that some intersex people never find out at all
2. ☐ will certainly become apparent at prenatal stage or at birth at last, as soon as it becomes clearly visible to medical staff
3. ☐ will certainly become apparent, but this could be at different times in life: at birth, during childhood, in puberty or even in adulthood

29. **"Maria is a trans woman":**
1. ☐ Maria identifies as a man: her gender identity is female.
2. ☐ Maria identifies as a woman: her gender identity is female. However, at birth her assigned sex was male
3. ☐ Maria has both male and female sex characteristics, but she has chosen to identify as a woman

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

Appendix 2 Post-training Evaluation questionnaire

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

POST-test

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

Please complete the following questions to reflect your opinions as accurately as possible and answer factual questions to the best of your knowledge. There are no "right" or "wrong" answers. Your responses will be anonymous and will never be linked to you personally. Once you have completed this questionnaire, please put it in the envelope provided and return it to the trainer.
Instructions: Please put a '**x**' in the box ☐ next to the answer of your choice or write in the grey space provided as the case may be.
The acrnym **LGBTI** means **Lesbian, Gay, Bisexual, Trans** and **Intersex**.

DEMOGRAPHICS

1. **My age is:**
   1. ☐ 18-30
   2. ☐ 31-50
   3. ☐ 51-64
   4. ☐ 65 and over

2. **My sex is:**
   1. ☐ female
   2. ☐ male
   3. ☐ other, please specify:

3. **My gender identity is:**
   1. ☐ female
   2. ☐ male
   3. ☐ other, please specify:

4. **My sexual orientation is:**
   1. ☐ asexual
   2. ☐ bisexual
   3. ☐ heterosexual
   4. ☐ homosexual
   5. ☐ other, please specify:

5. **My profession is:**
   1. ☐ physician
   2. ☐ nurse
   3. ☐ midwife
   4. ☐ psychologist
   5. ☐ social worker
   6. ☐ physical therapist
   7. ☐ other, please specify:

6. **What is your specialty in medicine, if any:**

7. **What were your main reasons for taking part in the training?** *You may choose more than one*
   1. ☐ My job or responsibilities have changed.
   2. ☐ To improve my skills or knowledge.
   3. ☐ I was asked to take part by my manager.
   4. ☐ It may be of some use in a future.
   5. ☐ I was interested in this topic.
   6. ☐ It was the right thing to do.
   7. ☐ Other, please specify:

ATTITUDE - SKILLS - KNOWLEDGE

8. **How likely are you to intervene if you witness a stigmatizing or discriminatory behavior against an LGBTI person at your work place?**
   1. ☐ very likely
   2. ☐ most likely
   3. ☐ somewhat likely
   4. ☐ not very likely
   5. ☐ I do not know

9. **How likely are you to ask about the sexual orientation, gender identity, and/or sex characteristics of a new patient/client?**
   1. ☐ very likely
   2. ☐ most likely
   3. ☐ somewhat likely
   4. ☐ not very likely
   5. ☐ I do not know

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

1. ☐ very often
2. ☐ often
3. ☐ somewhat often
4. ☐ not very often
5. ☐ not often at all

Do you agree with the statements below (Q11-Q14):

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

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

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

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

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

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

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

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

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

inclusive negative

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you agree with the statements below (Q16-Q18):

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

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

17. **"It's difficult to talk about sexual orientation, gender identity and/or sex characteristics with my patient/client."**

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

18. **"I think that LGBTI perspective should be an integral part of the medical staff education curriculum."**

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

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

With	**Yes**	**No**	**I do not know**
lesbian patients/clients	☐	☐	☐
gay patients/clients	☐	☐	☐
bisexual patients/clients	☐	☐	☐
trans patients/clients	☐	☐	☐
intersex patients/clients	☐	☐	☐

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

1. ☐ strongly agree
2. ☐ agree
3. ☐ neither agree nor disagree
4. ☐ disagree
5. ☐ strongly disagree

21. **Using a neutral language (e.g.: "partner" instead of "husband/wife", "parent" instead of "mother/father" etc.):**
1. ☐ can be confusing, as it may not be very clear to whom the health professional is referring
2. ☐ is not necessary for the majority of people, so it is the patient/client that should make things clear when the health professional uses the wrong term or assume a standard situation
3. ☐ is one of the things that a health professional can do in order to set an inclusive environment

22. **When speaking with patients/clients, health professionals should:**
1. ☐ refer to them and their situation with the terms that are generally used in the scientific and medical field, as this is what their professional role requires
2. ☐ be aware both of the medical terms and the terms preferred by the LGBTI community, but they should ask the patients themselves how they want to be addressed
3. ☐ refer to them with the terms that they know are generally accepted by LGBTI community as soon as it gets clear they belong to this group

23. **The terms "gay" and "MSM (men-who-have-sex-with-men)" are:**
1. ☐ different, because "MSM" refers to a sexual behavior that does not necessarily imply that the person identifies as gay or bisexual
2. ☐ synonyms, but "gay" is more well-known also outside the LGBTI community while "MSM" is less known
3. ☐ synonyms, but the term "gay" can also be used for women, whereas MSM specifically refers to a behavior between men

24. **Check the correct statement:**
1. ☐ He is homosexual
2. ☐ He is a gay
3. ☐ He is a gay man

25. **Intersectionality. When speaking about LGBTI people, this concept highlights social disadvantages and factors other than being LGBTI that people can face:**
1. ☐true
2. ☐false
3. ☐I do not know

26. **The terms "sexual orientation", "gender identity" and "sex characteristics" are:**
1. ☐synonyms, as they all refer to a person's specific set of characteristics
2. ☐different, and they are not necessarily related nor do necessarily affect/imply certain specific development of the other ones
3. ☐different, but they are related and each one necessarily implies compliant results in the development of the other ones

27. **Corrective surgeries and other medical, hormonal and psychological treatments for intersex people are:**
1. ☐ always necessary, as having both male and female sex characteristics leads to medical problems, but they have to be put in place in infancy in order to be followed by a normal life
2. ☐ always necessary, as having both male and female sex characteristics leads to medical problems, but they should be put in place in adulthood so that patients can choose the sex they feel more comfortable
3. ☐ not always necessary, as in many cases an intersex body is a perfectly healthy body

28. **The fact that someone has an intersex body:**
1. ☐ will not certainly become apparent, it is possible that some intersex people never find out at all
2. ☐ will certainly become apparent at prenatal stage or at birth at last, as soon as it becomes clearly visible to medical staff
3. ☐will certainly become apparent, but this could be at different times in life: at birth, during childhood, in puberty or even in adulthood

29. **"Maria is a trans woman":**
1. ☐ Maria identifies as a man: her gender identity is female.
2. ☐ Maria identifies as a woman: her gender identity is female. However, at birth her assigned sex was male
3. ☐Maria has both male and female sex characteristics, but she has chosen to identify as a woman

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

	Before	After	
1.	☐	☐	very good
2.	☐	☐	good
3.	☐	☐	acceptable
4.	☐	☐	poor
5.	☐	☐	very poor
6.	☐	☐	no knowledge

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

	Before	After	
1.	☐	☐	very good
2.	☐	☐	good
3.	☐	☐	acceptable
4.	☐	☐	poor
5.	☐	☐	very poor
6.	☐	☐	no skills

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

1. ☐ very confident
2. ☐ confident
3. ☐ somewhat confident
4. ☐ not very confident
5. ☐ not confident at all

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

1. ☐ very often
2. ☐ often
3. ☐ somewhat often
4. ☐ not very often
5. ☐ not often at all

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

	1	2	3	4	5
Module 1. Introduction, Awareness Raising, Concepts and Terms	☐	☐	☐	☐	☐
Module 2. Health and Health Inequalities	☐	☐	☐	☐	☐
Module 3. Communication and practice	☐	☐	☐	☐	☐
Module 4. Trans and Intersex Health	☐	☐	☐	☐	☐

EVALUATION THE TRAINING

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

1. ☐ very good
2. ☐ good
3. ☐ acceptable
4. ☐ poor
5. ☐ very poor

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

1. ☐ very good
2. ☐ good
3. ☐ acceptable
4. ☐ poor
5. ☐ very poor

37. **How useful did you find the following methods in helping you to learn?**

(from **1** = *not useful* to **5** = *very useful*)

	1	2	3	4	5
Group Discussion	☐	☐	☐	☐	☐
Brain storming	☐	☐	☐	☐	☐
Case studies	☐	☐	☐	☐	☐
Role playing	☐	☐	☐	☐	☐
Lecture	☐	☐	☐	☐	☐
Videos	☐	☐	☐	☐	☐

38. **Please rate your trainers in the following areas**

(from **1** = *very poor* to **5** = *very good*)

	1	2	3	4	5
knowledge in the subject/activity	☐	☐	☐	☐	☐
creating interest in the subject/activity	☐	☐	☐	☐	☐
relating the training to your job role	☐	☐	☐	☐	☐
understanding your needs	☐	☐	☐	☐	☐
responding to quesions	☐	☐	☐	☐	☐

39. **Please rate the following aspects of the training facilities and its administration**

(from **1** = *very poor* to **5** = *very good*)

	1	2	3	4	5
administration and recruitment	☐	☐	☐	☐	☐
room/venue	☐	☐	☐	☐	☐
convenience of location	☐	☐	☐	☐	☐
technical support during training	☐	☐	☐	☐	☐
catering	☐	☐	☐	☐	☐

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

1. ☐ Yes
2. ☐ No
3. ☐ Not sure

40a. **Please, explain briefly why:**

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

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

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

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

b) comments about the relevance of the training:

c) comments on the content of the training:

d) comments about training methods:

e) comments about the trainers:

f) comments about the event facilities or administration:

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

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

Appendix 3 Follow-up questionnaire

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

FOLLOW-UP

Please put here the 3 initial letters of the oldest parent's/guardian's first name

and the day and month of the oldest parent's/guardian's birthday: |__|__|__|-|__|__|__|__|

We would like to take this moment and thank you once again for attending **training within Health4LGBTI project**. It has been **two months since** we had a chance to foster our skills of working with LGBTI patients and clients.

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

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

Thank you!

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

1. ☐ very frequently
2. ☐ frequently
3. ☐ occasionally
4. ☐ rarely
5. ☐ very rarely
6. ☐ never

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

1. ☐ Yes */ go to filter questions 2a /*
2. ☐ No
3. ☐ Not sure

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

1. ☐ always
2. ☐ more often than not
3. ☐ on half of such occasions
4. ☐ less often than not
5. ☐ never

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

1. ☐ very often
2. ☐ often
3. ☐ somewhat often
4. ☐ not very often
5. ☐ not often at all

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

1. ☐ very frequently
2. ☐ frequently
3. ☐ occasionally
4. ☐ rarely
5. ☐ very rarely
6. ☐ never

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

1. ☐ strongly disagree
2. ☐ disagree
3. ☐ neither agree nor disagree
4. ☐ agree
5. ☐ strongly agree

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

1. ☐ very frequently
2. ☐ frequently
3. ☐ occasionally
4. ☐ rarely
5. ☐ very rarely
6. ☐ never

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

Appendix 4 Grid for the site visit

SITE VISIT FORM

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

Date **City**

The name of Inspector

Part I. Note-taking during piloting

A. GUIDELINES FOR NOTE-TAKING

General

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

Participants specific

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

Trainers

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

B. EVALUATION OF MODULES

Topic	**MODULE 1 - Introduction, Awareness Raising, Concepts and Terms**
Aims	✓ To introduce Trainers and Participants; ✓ To introduce the Health4 LGBTI Project and the Training course; ✓ To establish group cohesion and a positive learning environment; ✓ To raise awareness and improve knowledge on terms and concepts related to LGBTI topics.
After this module, the participants will:	✓ Be able to understand the overall aims, background and contents of the project and of the training; ✓ Have a greater awareness and knowledge about terms and concepts in the field of gender identity, sexual orientation and sex characteristics; ✓ Feel more comfortable in discussing LGBTI issues and be able to correctly use the relevant terminology.
Planned duration: 2 hours Start time: End time:	
Main issues presented	• Presentation of the Health4LGBTI project ☐Yes ☐No • Presentation of the work carried out to date and how it forms the basis of the training ☐Yes ☐No • Presentation of the objectives of the training ☐Yes ☐No • Presentation of ground rules – explanation of privacy statement etc., respect, participation (participants were asked if they wanted to add ay ground rules) ☐Yes ☐No • Terminology (sexual orientation, sexual characteristics, gender identity) ☐Yes ☐No
Activity:	
Introduce Yourself Start time: End time:	Comments:
Video: Experience of	Comments:

Healthcare settings: LGBTI people tell their stories

Start time:

End time:

Ground rules – large group discussion

Comments:

Start time:

End time:

Values Shuffles

Comments:

Start time:

End time:

Correct Use of Terminology

Comments:

Start time:

End time:

Lecture - Terms and concepts

Comments:

Start time:

End time:

Let's Practice your Knowledge	Comments: Start time: End time:
Feedback from participants AND/OR notes from an Observer	Comments:

Topic	**MODULE 2: Health and Health Inequalities**
Aims	✓ To raise awareness and improve knowledge on the root causes of health inequalities experienced by LGBTI people; ✓ To raise awareness and improve knowledge on the health needs of LGBTI people and the health inequalities they experience; ✓ To improve knowledge on potential barriers and challenges faced by healthcare professionals when providing care for LGBTI people ✓ To raise awareness and improve knowledge on the concept of intersectionality and how it relates to health inequalities experienced by LGBTI people

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

Planned duration: 2 hours and 20 min

Start time:

End time:

Main issues presented	• Health Inequalities and root causes (heteronormativity, heterosexism, discrimination, stigma, minority stress) ☐ Yes ☐ No • Health Inequalities – what are they? ☐ Yes ☐ No • HIV ☐ Yes ☐ No • STI ☐ Yes ☐ No

Activity:

Position and Privilege Comments:

Start time:

End time:

Lecture – Health inequalities Comments:

Start time:

End time:

Let's talk about LGBTI healthcare

Comments:

Start time:

End time:

Quiz

Comments:

Start time:

End time:

Case studies

Comments:

Start time:

End time:

Lecture – Intersectionality

Comments:

Start time:

End time:

Feedback from participants AND/OR notes from an Observer	Comments:

Topic	**MODULE 3: Communication and practice**
Aims	✓ To raise awareness on the importance of inclusive communication with LGBTI patients/clients; ✓ To improve communication skills with LGBTI patients/clients; ✓ To improve knowledge on how to better organise and manage healthcare settings with regard to privacy, trust and comfort of LGBTI patients/clients.
After this module, the participants will:	✓ Have a better understanding of the relevance of using inclusive language taking account the spectrum of sexual orientation, gender identities and sex characteristics. ✓ Be able to take case histories of LGBTI patients/clients with an attitude of inclusivity and without judgment; ✓ Be better informed on how to make their practice/healthcare setting more welcoming for LGBTI patients/clients, respecting privacy and ensuring trust and comfort.
Planned duration: 2 hours and 15 min Start time: End time:	
Main issues presented	• Language as a potential barrier ☐ Yes ☐ No • Video as example of inclusive language and related discussion ☐ Yes ☐ No • Assumptions during the interview (and tips for asking properly) ☐ Yes ☐ No • Role playing in a general practitioner setting ☐ Yes ☐ No
Activity:	
Lecture - Language and Communication: Introduction Start time: End time:	Comments:

Video “Cuál es la diferencia?"	Comments:

Start time:

End time:

Lecture – Inclusive Communication	Comments:

Start time:

End time:

Role play – inclusive communication	Comments:

Start time:

End time:

Creating an inclusive practice	Comments:

Start time:

End time:

Lecture – Reducing barriers in your practice	Comments:

Start time:

End time:

Promising solutions to make your practice more inclusive	Comments:

Start time:

End time:

Discussion – Recommendations	Comments:

Start time:

End time:

Feedback from participants AND/OR notes from an Observer	Comments:

Topic	**MODULE 4: TRANS and INTERSEX HEALTH**
Aims	✓ To deconstruct myths, stereotypes and prejudices related to trans and intersex people; ✓ To provide a better understanding of barriers faced by trans and intersex people accessing general and specific care; ✓ To improve awareness about the specific needs of trans and intersex people in healthcare setting.
After this module, the participants will:	✓ Have a greater awareness and improved knowledge of concepts in the field of gender identity and sex characteristics; ✓ Be more familiar with the health needs of trans and intersex people; ✓ Be aware of the standard of care and human rights of trans and intersex people.
Planned duration: 2 hours Start time: End time:	
Main issues presented	• To deconstruct myths related to TI people ☐ Yes ☐ No • Topics related to trans health ☐ Yes ☐ No • Topics related to intersex health ☐ Yes ☐ No
Activity:	
To deconstruct myths Start time: End time:	Comments:
Lecture – Trans Health and health inequalities Start time: End time:	Comments:
Lecture – Gatekeeping and SoCs	Comments:

Start time:

End time:

Lecture – Legal situation

Comments:

Start time:

End time:

Lecture – Intersex Health

Comments:

Start time:

End time:

Lecture – Intersex Health: access to general healthcare

Comments:

Start time:

End time:

Role-play

Comments:

Start time:

End time:

Feedback from participants AND/OR notes from an Observer	Comments:

Part II. Overall Evaluation

1. Organization and logistics

Please rate the following (from 1 – *poor* to 5 – *very good*)

	1	2	3	4	5
Adequacy of the premises	☐	☐	☐	☐	☐
Punctuality	☐	☐	☐	☐	☐
Logistics information provided to participants	☐	☐	☐	☐	☐
Technical support during training	☐	☐	☐	☐	☐
Catering	☐	☐	☐	☐	☐

Comments:

2. Implementation of the activities

Please rate the participation of trainees in the modules (from 1 – *not active at all* to 5 – *very active*)

	1	2	3	4	5
Module 1. Introduction, Awareness Raising, Concepts and Terms	☐	☐	☐	☐	☐
Module 2. Health and Health Inequalities	☐	☐	☐	☐	☐
Module 3. Communication and practice	☐	☐	☐	☐	☐
Module 4. Trans and Intersex Health	☐	☐	☐	☐	☐

Comments:

Please rate the efforts of the trainer to involve all the participants (from 1 – *no efforts made* to 5 – *all participant actively involved*). If no problem with participation was encountered, please mark N/A

	1	2	3	4	5	N/A
Module 1. Introduction, Awareness Raising, Concepts and Terms	☐	☐	☐	☐	☐	☐
Module 2. Health and Health Inequalities	☐	☐	☐	☐	☐	☐
Module 3. Communication and practice	☐	☐	☐	☐	☐	☐
Module 4. Trans and Intersex Health	☐	☐	☐	☐	☐	☐

Comments:

Please rate the efforts made to manage problematic group interactions, including intimidating or aggressive behaviours (1- no efforts made to 5 – all problems efficiently resolved). If no problem with participation was encountered please mark N/A

	1	2	3	4	5	N/A
Module 1. Introduction, Awareness Raising, Concepts and Terms	☐	☐	☐	☐	☐	☐
Module 2. Health and Health Inequalities	☐	☐	☐	☐	☐	☐
Module 3. Communication and practice	☐	☐	☐	☐	☐	☐
Module 4. Trans and Intersex Health	☐	☐	☐	☐	☐	☐

Comments:

3. Adherence to requirements

Please rate the following (from 1 – *poor* to 5 – *full adherence*)

	1	**2**	**3**	**4**	**5**
Requirements for promotion	☐	☐	☐	☐	☐
Trainers' competencies	☐	☐	☐	☐	☐
Diversity of participants	☐	☐	☐	☐	☐

Comments:

Part III. Key recommendations

A. Organisational aspects

Comments:

B. Group dynamics

Comments:

C. Implementation of modules

Comments:

Appendix 5. SWOT matrix for the Trainers

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

Trainer's feedback form (SWOT matrix)

This form is meant to collect the trainers' critical opinions based on the knowledge of the local context and the experience of the conducted pilot training on the following issue:

<<In your country, if an organization, which is independent but willing to collaborate with relevant stakeholders, would plan for wider dissemination of this Training course, what would be the factors which could have an impact on such initiative>>

The SWOT matrix is a tool for identifying and understanding the internal and controllable (strengths and weaknesses) and uncontrollable external forces (opportunities and threats) affecting possible future training courses.

STRENGTHS **the areas, in which the training course is doing well** Which aspects of the training content and implementation method were effective? Which aspects of the training manual and recruitment strategy are useful? What are the benefits of the training for the participants? What competencies of the trainer help? What capacities of the organisation would be useful for wider implementation?	**WEAKNESSES** **specific areas we need to improve** Which methods, implementation strategies did not work? Which content turned out to be the least useful and what was lacking? What should be added to the training manual? Which were the draw-backs of the recruitment strategy? What could the trainees improve? What trainers' capacities may be lacking in the organisation?	Internal analysis
OPPORTUNITIES **outside factors or situations that exist or may occur and that may contribute to the training success** What benefits could the trainees gain by completing the training? What trends can support applying the lessons learnt in medical practice? What structures are available where such training could be implemented? Who (institutions, opinion leaders) could support future training implementation?	**THREATS** **outside factors or situations that exist or may occur and that may affect the training in a negative way** What characteristics of participants may hinder successful training? What are the institutional barriers to applying the skills acquired during training at work? What are the barriers to future use of training (e.g. in the formal education system)? Are there other competing needs that would prevent training and/or application of the lessons learnt?	External analysis
Positive factors	Negative factors	

Please enter text here:

STRENGTHS:

WEAKNESSES:

OPPORTUNITIES:

THREATS: