Provider Pack

V1

Breaking down barriers to LGBTIQ+ inclusive cancer care

Live Through This

About this booklet

Live Through This is the UK's only LGBTIQ+ cancer charity. This means our unique expertise has been sought nationally across different cancer settings. So we can maximise our reach and deliver on our promise to improve cancer services for all LGBTIQ+ patients, we have created this booklet, which combines some of our core training and information, so that everyone can begin to improve the LGBTIQ+ inclusivity of their local services.

This booklet should be considered as a whole, but we support individual pages being displayed internally to improve staff awareness. For example, it may benefit your team(s) to have our glossary to hand or to display our pronoun guide on your notice board. However, we encourage you to display the Visible Commitments poster in a place where it can be seen by staff and patients. Guidance on how to do this can be found on page 15.

This booklet is intended to improve awareness of LGBTIQ+ issues in cancer and its treatment, and how we as individuals and organisations can work together to address the barriers to equitable care.

If you have read anything in this booklet that you would like further training on or would like to commission a custom programme, resource or talk, please email us with your requirements at contact@livethroughthis.co.uk

We aim to update this booklet in line with any new information or developments within the field of LGBTIQ+ cancer health and care. For this reason, we recommend that you keep regularly updated with our resources to be sure you have the most current version. You are currently viewing Version 1. You can be notified of the publication of any updates to this document or additional resources by registering for our mailing list which can be found on our website www.livethroughthis.co.uk

This booklet and its contents are not intended for any form of reissue, reproduction or resale. Please reference this booklet or Live Through This when promoting its ideas. In APA format, this would look like: Live Through This. (2021). Provider Pack: Breaking down barriers to LGBTIQ+ inclusive cancer care, V1.

I hope that you find the contents of this booklet interesting, informative and useful. By appreciating the fundamentals of LGBTIQ+ affirmative healthcare, I firmly believe that we can improve the patient experience for all.

I look forward to us making this progress together.

Stewart O'Callaghan (they/them)
Founder & Executive Director

The basics

The initialism 'LGBT' refers to Lesbian, Gay, Bisexual and Transgender people.

Being lesbian, gay or bisexual is an example of a sexual orientation, whereas being transgender is a form of gender identity. You may see 'LGB' used when referring only to sexual orientations. 'LGBT' is used as a more collective term for all sexual orientations and gender identities, but there are variations of this initialism that make this more apparent. Sometimes you may see a plus to refer to 'others' (LGBT+), sometimes a 'Q' is added for queer (LGBTQ), at times you may see culturally specific versions with third gender representation such as Two Spirit (LGBT2S). At Live Through This we opt for LGBTIQ+ to include intersex people. All forms are valid.

Sexual Orientation (SO) is how a person feels sexually about different genders. Sexual activity does not always indicate sexual orientation. Because of this, we at times will see the terms women who sleep with women (WSW) and men who sleep with men (MSM) as inclusive labels of sexual activity.

Sex refers to the biological characteristics that define humans as female, male or intersex, the latter also being known as variations of sex characteristics (VSC).

Gender is the social construct that we use to label our characteristics, social norms, behaviours and social roles as masculine, feminine or third gender. Our gender identity (GI) is where we see ourselves in this social coding.

This interplay between our sex, which is commonly assigned to us at birth by a medical professional, and our gender identity is what gives us the labels cisgender and transgender (trans). A person who is cisgender will have a sex that aligns with their gender, whereas a person who is trans will have a sex assigned at birth that does not align with their gender. Non-binary people may also identify as trans if they experience this lack of alignment, but it is important to note that they do not identify their gender within the binary constructs of 'male' and 'female'.

This lack of alignment, referred to as gender incongruence, can lead to feelings of discomfort or distress that may be experienced physically, mentally and socially. We call these feelings gender dysphoria.

Based on their identity, LGBTIQ+ patients have:

- Been refused care or treatment
- Feared poorer levels of care or treatment
- Been unable to access or attend screening in the same way as others
- Reported lower satisfaction scores in numerous health surveys

It is important that providers of healthcare or support are able to help their LGBTIQ+ patients navigate the barriers they face when accessing care. We hope that this booklet will provide an introduction to the area of LGBTIQ+ affirmative care and assist you in creating positive change for the improvement of patient experience.

A brief glossary

LGBTIQ+ community language is as rich and nuanced as its community members. Here is a brief list of common terms currently in use. This list is by no means exhaustive and we encourage all people to engage with their local community in order to appreciate local and cultural variations.

Ace
An umbrella term to include variations in an absence of sexual or romantic interest, including the experiences of asexual, aromantic, demisexual, demiromantics and grey-As.

Agender
A lived experience that does not relate to gender.

Ally
A person who supports and advocates for LGBTIQ+ people.

Assigned Female at Birth (AFAB)
Any person whose sex assignment at birth resulted in a declaration of "female".

Assigned Male at Birth (AMAB)
Any person whose sex assignment at birth resulted in a declaration of "male".

Biphobia
Prejudice, discrimination, fear or dislike towards someone that is bisexual based on their identity.

Bisexual
An individual who is attracted to more than one gender. One should not assume this is always an equally weighted attraction to different genders.

Cisgender
A person whose gender identity aligns with the sex they were assigned at birth.

Deadname
A trans person's previous or birth name. It is considered offensive to use this name. 'Deadname' can be used as a noun and a verb.

Demisexual
A person who only experiences sexual attraction once they have an emotional bond with a person.

Enby
Colloquialism for non-binary.

FTM / MTF
Referring to Female-to-Male / Male-to-Female transition.

Gay / Homosexual
A general label for same sex attraction. Most commonly used with men who are exclusively or preferentially attracted to other men in an emotional, sexual and/or physical manner.

Gender
A social construct informed by the norms, roles and behaviours that we attribute to being masculine, feminine or third gender.

Gender confirmation / affirmation
Replacing the term 'Gender Reassignment'.

Gender dysphoria
The discomfort felt between one's gender and their sex assigned at birth. This may be mental, physical or social.

Gender fluid
A form of gender and expression that is not fixed.

Gender identity
An individual's personal sense of having a particular gender.

Heterosexism / Heteronormative assumptions
A system of attitudes or beliefs that assumes or favours opposite sex relationships and attraction.

Heterosexual
A person who is romantically or sexually attracted to someone of a different gender.

Homophobia
Prejudice, discrimination, fear or dislike towards someone that is homosexual based on their identity.

Intersectionality
Theory introduced by Prof. Kimberlé Crenshaw to describe how multiple facets of a person's identity can combine to make unique forms of oppression and discrimination.

Intersex
A general term used for a variety of instances in which a person is born with reproductive or sexual characteristics that do not fit the typical definitions of female or male. They may express their gender as male, female or non-binary. Clinically known as Variations in Sex Characteristics (VSC).

Lesbian
A woman who is exclusively or preferentially attracted to other women in an emotional, sexual and/or physical manner.

LGBT
Initialisation of Lesbian, Gay, Bisexual and Transgender. Used to refer to the broader sexual and gender minority community.

LGBTQIA+
A variant of LGBT that includes Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and others.

LGBT-phobia
Prejudice, discrimination, fear or dislike towards someone that is LGBT based on their identity.

Men who have sex with men (MSM)
A term for any man who has sex with men to include homosexual, bisexual, pansexual and those who do not identify as a sexual minority.

Non-binary
A term for people who do not identify with the discrete categories of male and female. This term includes a variety of gender expressions.

Outing someone
Identifying someone as LGBTIQ+ without their consent. This is considered extremely harmful as there may be social factors or issues of safety involved in a person's choice to be discreet.

Pansexual
A person whose attraction to others is not constrained by sex or gender.

Pronoun
A word that takes the place of a noun in a sentence. The most common third-person pronouns we encounter are he, she and they. Correct pronoun use corresponding to a person's gender is important.

Queer
An umbrella term for LGBTIQ+ people. Also refers to a mode of critical theory and political discourse. It is a reclamation of a slur.

Sex
The underlying biological profile of a person. It influences a range of bodily responses that are important in tackling infection or disease.

Sexual minority
Individuals who do not identify as heterosexual. Gender minority may also be used for individuals who do not identify as cisgender.

Sexual orientation
A person's sexual feelings towards certain genders. Activity does not equate orientation as some people will have same-gender sexual activity for various reasons and not classify themselves as LGB+.

Sexuality
A term referring to someone's sexual attractions, behaviours, kinks and desires. Sexuality is a term broader than sexual orientation to encompass a sense of what a person enjoys and with whom.

SOGI
Shorthand for sexual orientation and gender identity.

Stealth
Community term describing the ability to live as your gender without disclosing your transition.

Third Gender
A distinct form of gender from that of male or female. Often culturally informed with a rich history such as the Hijra, Māhū, Fa'afafine, Two-Spirit and Muxe.

Top surgery
Common term for bilateral mastectomy and male chest reconstruction.

Trans(gender) man
A man who was assigned female at birth.

Trans(gender) woman
A woman who was assigned male at birth.

Transfeminine
A person who was assigned male at birth but whose gender identity is more female than male.

Transgender
An umbrella term for a person whose gender identity differs from the sex they were assigned at birth.

Transmasculine
A person who was assigned female at birth but whose gender identity is more male than female.

Transphobia
Prejudice, discrimination, fear or dislike towards someone that is transgender based on their identity.

Women who have sex with women (WSW)
A term for any woman who has sex with women to include homosexual, bisexual, pansexual and those who do not identify as a sexual minority.

An introduction to LGBTIQ+ experiences of cancer support

It is estimated that 5-7% of the UK population identify as lesbian, gay or bisexual[1] (LGB) and cancer has higher rates of incidence and risk in these communities. The government does not currently collect any robust data for transgender (trans) people. We know that lesbians are less prevention oriented in their health care behaviour and avoid routine screening tests such as Pap smears and mammograms,[2] gay men can show up to a twofold increase in diagnosis of cancer with HIV being a risk factor[3,4] and have a higher risk of anal cancer[5,6,7] and trans people report poorer health[8] and a higher incidence of late stage diagnoses due to healthcare access issues or avoidance.[4,6,9]

An intersectional approach is key in appreciating the lifestyle factors and socioeconomic disparities associated with increased risk of cancer in LGBT+ (lesbian, gay, bisexual, trans and others) people.[9,10,11] Therefore, there needs to be a complimentary focus in care to address these stressors and their subsequent risk behaviours in this population.[9,12,13] Smoking is an area that has received some attention[12] however research into the LGBT+ experience of cancer is largely underexplored.[10] Other socioeconomic factors for LGBT+ people include barriers to education, gainful employment and access to healthcare.[3,4,9,14] Research is so sparse that in order to comment, inferences must be taken from around the globe and thus we must be mindful of cultural variations of accessing healthcare for LGBT+ patients, such as barriers to acquiring health insurance for private healthcare.[8,10]

It is important for a patient's wellbeing for them to be their authentic selves,[15,16] however, due to the difficulty in coming out and the fear of other people's responses.[3,10,17] This is especially the case for bisexual patients.[15] Patients may go 'back into the closet' in order to avoid anticipated complications in their clinical interactions.[7,15,17,18] Sensitivity is required to appreciate the compound stress and the social stigma from being both LGBT+ and a cancer patient.[17] One must note that whilst a healthcare provider may not be overtly prejudiced, microaggressions, heterosexist assumptions and behavioural cues can often give rise to this discordance.[3,4,7,10,17,19,20,21,22,23] Providers tend to report confidence regarding LGBT+ affirmative care[24] despite gaps in their knowledge.[24,25] Of these respondents, around only a quarter spoke to their patients about gender or sexual orientation, contesting that their care was sufficient without including this consideration.[4,24] Recording gender identity or sexual orientation is often avoided out of fear of offence, despite only 10% of patients responding that they would feel this way.[26] Likewise, attempts at inclusion must take into account the aforementioned social stigmas and barriers faced by this population that leads to psychosocial stress posing further risk to their health[9] in addition to the intersectional nature of race.[3,4,11] Without these considerations, patient adherence begins to wane as they lose confidence in their care and their agency in the decisions being made.[3,17,23,27] While our political and social climate moves towards acceptance, we must note that it was not until the Equality Act of 2010 that it was made illegal for organisations to discriminate against characteristics such as sexual orientation. Therefore, due to the typically higher age range of cancer patients, this is a lived memory for some in addition to the AIDS epidemic and the illegality of homosexuality.[21]

Both LGB and trans patients report poorer quality of life and mood markers when compared to their cisgender and heterosexual peers.[4,9,29] This self reported outcome is in part due to negative healthcare interactions but also the lack of additional support available. LGB patients are significantly less satisfied with the written information provided around diagnosis and subsequent care.[27] In order to improve the uptake of information it is important to represent LGBT+ people in supporting media and divert from the current over-representation of heterosexual imagery.[17,30] This is key for trans patients and the assumptions made in provided information about the body at screening, during treatment and in remission.[10,17,31,32] An example of this is the overt gendering of breast and gynaecological cancers as women's

cancers, which becomes a barrier for trans patients seeking care and may be an attributing factor to later stage diagnoses.[10,32] Also to consider is the outcome of potential mastectomy and the different nuances to be appreciated with non-binary or trans patients when discussing their chests.[23,31,32] Likewise the conversation surrounding wigs is often gendered to overt femininity or relating to an assumed male partner, which leaves some patients avoiding the service all together.[7]

LGBT+ patients are more likely to report that no family or friends are involved in their care.[17,22,27] Family and friends are key to both emotional and social support respectively,[3,28] but one patient interviewed suggested that "An LGBTI person who has to live with their heterosexual family is more socially isolated than a heterosexual person in the same situation."[22] Therefore it is important to find ways to support the psychosocial needs of LGBT+ patients as a lack of adequate support leads to fatalistic attitudes and social isolation.[3,17,21,27,28,29] Patients emphasised the importance of support groups,[9,17,21] especially those with a targeted focus reflecting their identity.[22,25] Patients report being more satisfied with support when it comes from someone who is aware of their orientation.[26,28] This reflects the importance of queer agency[31] in the patient's experience of support and care as they often demonstrate a better understanding of the impact of how their LGBT+ identity intersects with other factors in their lives, such as illness.[17,32] The use of peer support through LGBT+ specific support groups is a key source of information for trans patients[32] as opposed to the heavily gendered presentation of other support groups that may be discussing specific cancers.[32] To give another example, the discussion of anal cancer in gay men can be better facilitated by social initiatives where sex and intimacy are discussed with greater ease than in the standard healthcare setting.[7,17] Community is a key factor for LGBT+ people and building a supportive framework to compliment this through cancer therapy is a goal that benefits professionals, patients and future research.[9,17]

The hesitation of individuals to discuss gender and sexual orientation is often rooted in a lack of information or confidence with these sensitive topics. Whilst accessing and supporting this patient demographic is vital it is also important not to 'out' an individual who has chosen not to disclose their sexual orientation or gender history. Instead, a more appropriate goal is to make the service suitable to every individual on the gender identity and sexual orientation spectrums so that patients may find a knowledgeable, accessible and supportive environment in which they might feel that they can share themselves fully. Ultimately, engaging with patients about how their health intersects with their life is crucial in supporting their psychosocial needs, treatment adherence and also demonstrating sensitivity and compassion to a population who may otherwise fall into social isolation and additional detriment if not properly supported.

Document Published: May 2019

— References —

1. The Department of Business, Enterprise and Regulatory Reform [Internet]. Final Regulatory Impact Assessment: Civil Partnership Act 2004. *https:// webarchive.nationalarchives.gov.uk/20090609004826/http://www.berr. gov.uk/files/ file23829.pdf* (accessed on 7.03.2019)

2. Fish J. & Anthony D. (2005). UK national Lesbians and Health Care Survey. *Women Health, 41(3),* 27-45. doi: 10.1300/J013v41n03_02. PMID: 15970574.

3. Boehmer, U. (2018). LGBT Populations' Barriers to Cancer Care. *Seminars in Oncology Nursing, 34(1),* 21-29.

4. Ceres, M., Quinn, G.P., Loscalzo, M. & Rise, D. (2018). Cancer Screening Considerations and Cancer Screening Uptake for Lesbian, Gay, Bisexual and Transgender Persons. *Seminars in Oncology Nursing, 34(1),* 37-51.

5. Goldstone, S., Palefsky, J.M., Giuliano, A.R., Moreira, E.D., Aranda, C., Jessen, H., Hillman, R.J., Ferris, D.G, Coutlee, F., Liaw, K.L., Marshall, J.B., Zhang, X., Vuocolo, S., Barr, E., Haupt, R.M., Guris, D & Garner, E.I. (2011) Prevalence of and risk factors for human papillomavirus (HPV) infection among HIV-seronegative men who have sex with men. *Journal of Infectious Diseases, 203(1),* 66-74.

6. Institute of Medicine. The health of Lesbian, Gay, Bisexual and Transgender People: Building a foundation for better understanding. Washington DC: National Academy of Sciences; 2011.

7. Fish, J. & Williamson, I. (2018). Exploring lesbian, gay and bisexual patients' accounts of their experiences of cancer care in the UK. *European Journal of Cancer Care, 27.*

8. Jennings, L., Barcelos, C., McWilliams, C., Malecki, K. (2019). Inequalities in lesbian, gay, bisexual and transgender (LGBT) health and health care access and utilization in Wisconsin. *Preventive Medicine Reports, 14,* 100864.

9. Matthews, A.K., Breen, E. & Kittiteerasack P. (2018). Social Determinants of LGBT Cancer Health Inequities. *Seminars in Oncology Nursing, 34(1),* 12-20.

10. Quinn, G.P., Schabath, M.B., Sanchez, J.A., Sutton, S.K. & Green, B.L. (2015). The importance of disclosure: Lesbian, Gay, Bisexual, Transgender/ Transsexual, Queer/ Questioning and Intersex Individuals and the Cancer Continuum. *Cancer, 121(*),* 1160-1163.

11. Damaskos, P., Amaya, B., Gordon, R.A. & Burrows Walters, C. (2018). Intersectionality and the LGBT Cancer Patient. *Seminars in Oncology Nursing, 34(1),* 30-36.

12. Kamen, C., Blosnich, J.R., Lytle, M., Janelsins, M.C., Peppone, L.J. & Mustian, K.M. (2015). Cigarette smoking disparities among sexual minority cancer survivors. *Preventive Medicine Reports, 2,* 283-286.

13. Baskerville, N.B., Dash, D., Shuh, A., Wong, K., Abramowicz, A., Yessis, J. & Kennedy, R.D. (2017). Tobacco use cessation interventions for lesbian, gay, bisexual, transgender and queer youth and young adults: A scoping review. *Preventive Medicine Reports, 6,* 53-62.

14. Ravishankar, Mathura (January 18, 2013). *"The Story About Robert Eads"*. *The Journal of Global Health.* Archived from the original on September 14, 2013*. Accessed May 26, 2019.*

15. Durso, L.E., Meyer, I.H. (2013). Patterns and Predictors of Disclosure of Sexual Orientation to Healthcare Providers Among Lesbians, Gay Men and Bisexuals. *Sex Res Social Policy, 10,* 35-42.

16. Axtell, S. (1999). Disability and chronic illness Identity: Interviews with Lesbians and Bisexual Women and their Partners. *Journal of Gay, Lesbian and Bisexual Identity, 4(1),* 53-72.

17. Kamen, C. (2018). Lesbian, Gay, Bisexual and Transgender (LGBT) Survivorship. *Seminars in Oncology Nursing, 34(1),* 52-59.

18. St Pierre, M. (2012). Under what conditions do Lesbians disclose their sexual orientation to primary healthcare providers? A review of the literature. *Journal of Lesbian Studies, 16(2),* 199-219.

19. Sabin, J.A., Riskind, R.G. & Nosek, B.A. (2015). Health Care Providers' Implicit and Explicit Attitudes toward Lesbian Women and Gay Men. *American Journal of Public Health, 105,* 1831-1841.

20. Irwin, L. (2007). Homophobia and heterosexism: Implications for nursing and nursing practice. *Australian Journal of Advanced Nursing, 25(1),* 70-76.

21. Hill, G. & Holborn, C. (2015). Sexual minority experiences of cancer care: a systematic review. *Journal of Cancer Policy, 6,* 11-22.

22. Jowett, A. & Peel, E. (2009). Chronic illness in non-heterosexual contexts: An online survey of experiences. *Feminism & Psychology, 19(4),* 454-474.

23. Carr, E. (2018). The Personal Experience of LGBT Patients with Cancer. *Seminars in Oncology Nursing, 34(1),* 72-79.

24. Shetty, G., Sanchez, J.A., Lancaster, J.M., Wilson, L.E., Quinn, G.P. & Schabath, M.B. (2016). Oncology Healthcare Providers' Knowledge, Attitudes and Practice Behaviors Regarding LGBT Health. *Patient Educ Counsel, 99,* 1676-1684.

25. Griggs, J., Maingi, S., Blinder, V., Denduluri, N., Khorana, A.A., Norton, L., Francisco, M., Wollins, D.S. & Rowland, J.H. (2017). American Society of Clinical Oncology Position Statement: Strategies fr reducing Cancer Health Disparities among Sexual and Gender Minority Populations. *Journal of Clinical Oncology, 35(19),* 2203-2208.

26. Maragh-Bass, A.C., Torain, M., Adler, R., Schnieder, E., Ranjit, A., Kodadek, L.M., Shields, R., German, D., Snyder, C., Peterson, S., Schuur, J., Lau, B. & Haider, A. (2017). Risks, Benefits and Importance of Collecting Sexual Orientation and Gender Identity Data in Healthcare Settings: A Multi-Method Analysis of Patient and Provider Perspectives. *LGBT Health, 4(2),* 141-152.

27. Hulbert-Williams, N.J., Plumpton, C.O., Flowers, P., McHugh, R., Neal, R.D. & Semleyn, J. (2017). The cancer care experiences of gay, lesbian and bisexual patients: A secondary analysis of data from the UK Cancer Patient Experience Survey. *European Journal of Cancer Care, 26,* e12670.

28. Grossman, A.H, D'Augelli, A.R. & Hershberger, S.L. (2000). Social support networks of lesbian, gay and bisexual adults 60 years of age and older. *Journals of Gerotology, 55(3),* 171-179.

29. Boehmer, U., Glickman, M. & Winter, M. (2012). Anxiety and depression in breast cancer survivors of different sexual orientations. *Journal of Consulting and Clinical Psychology, 80(3),* 382-395.

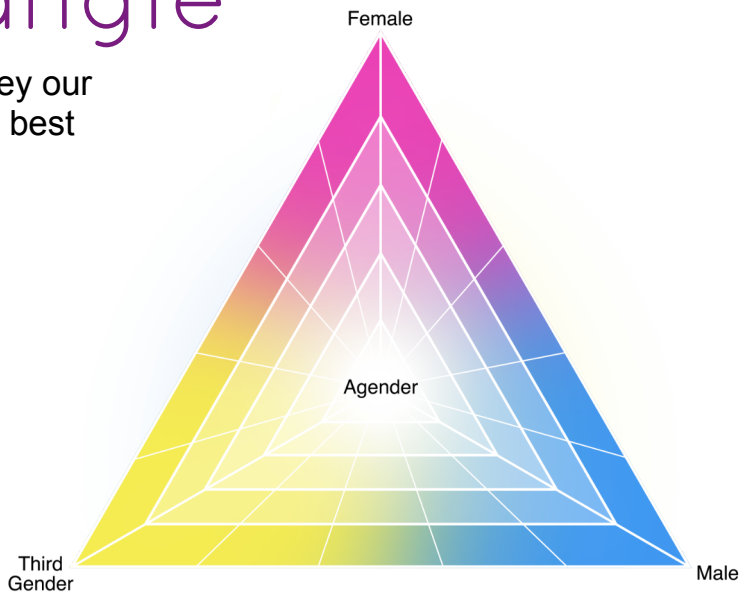
30. Blank, T.O. (2005). Gay men and prostate cancer: Invisible diversity. *Journal of Clinical Oncology, 23,* 2593-2596.

31. Horncastle, J. (2018). Practicing care: queer vulnerability in the hospital. *Social Identities, 24(3),* 383-394.

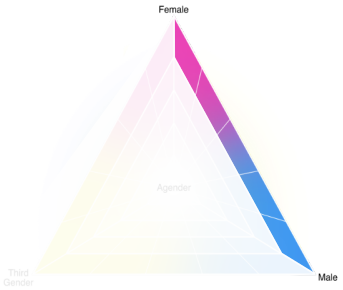
32. Taylor, E.T., Bryson, M.K. (2016). Cancer's margins: Trans* and gender nonconforming people's access to knowledge, experiences of cancer health and decision making. *LGBT Health, 3(1),* 79-89.

The Gender Triangle

Gender is often described as a spectrum to convey our variations in personal experience, but what is the best way to represent this idea visually?



The Gender Triangle, also referred to as the Triangular Model of Gender, depicts this spectrum between three commonly encountered and socially defined genders: ‘female’, ‘male’ and ‘third gender’. Introduced by Live Through This’ founder Stewart O’Callaghan in 2020, this model allows us to think in new ways about gender identity and how we might describe ourselves to others if labels feel limiting.



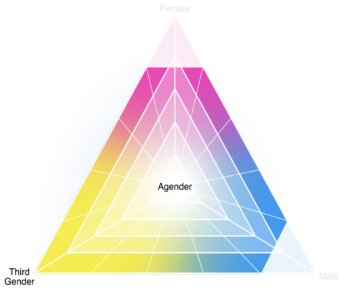
Away from the binary

The Triangular Model moves us away from the idea that gender is binary. Current popular models of gender identity in circulation often rely on a single line that places ‘male’ and ‘female’ at polar opposite points. This one-dimensional approach makes the assumption that male and female are absolute values of gender and that any other gender we encounter must exist somewhere between them on this line. This view is too simplistic and fails to represent the breadth and nuance of the transgender and non-binary experience.

Third gender

By using a third value when modelling gender we are able to not only represent people who identify as a third gender, but we also are able to broaden our understanding of the gender spectrum. There are many third genders in the world such as the Fa’afafine of Samoa, the Hijra of India, the Muxe of Latin America, the Two Spirit of North America and the Burrnesha of Balkan tradition to name a few. These are distinct forms of socially upheld gender identity with varied histories and cultural importance attached.

Non-binary



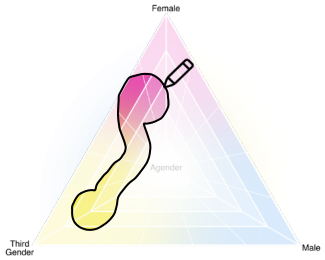
By using the Gender Triangle we are able to more accurately represent the variation in non-binary and gender-variant experience. Assuming that all non-binary people are somewhere on a fixed line between ‘male’ and ‘female’ has the potential to incorrectly infer some level of androgynous gender expression. By using The Gender Triangle, we can appreciate that people identifying as non-binary might include people with no feeling of gender (agender), a partial feeling of gender (demigender), people who are third gender and any other identity that may exist beyond being either exclusively male or female. By using this visual model, we present an opportunity to describe one’s own gender identity without the need for labels which may support those who do not wish to use or identify with them.

Agender

The Gender Triangle allows for a meaningful inclusion of agender people, those who do not experience gender or identify with any of its labels. Other models tend to over-simplify or exclude the agender experience from their models which can negatively affect our implicit bias towards agender people. It is also important to note that being agender is not always absolute and there can be multiple levels of intensity for gender identity. In the Triangular Model, a scale of agender experience is demonstrated by placing ‘agender’ centrally in the broader gender spectrum. The further from the centre the person identifies, the stronger the experience of their gender is in that direction, whether that be towards ‘male’, ‘female’, ‘third gender’ or elsewhere in the spectrum.

Gender fluid

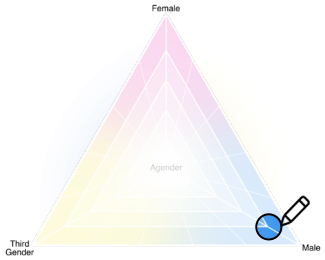
For some people, their gender identity may be fixed and inflexible. In the Triangular Model, this may be shown as a small circle or point on the spectrum where the person identifies their gender. For others, their gender may be more fluid. To visualise this, a person might draw a larger circle, or any shape for that matter, across the area of the spectrum that they feel their gender moves between.



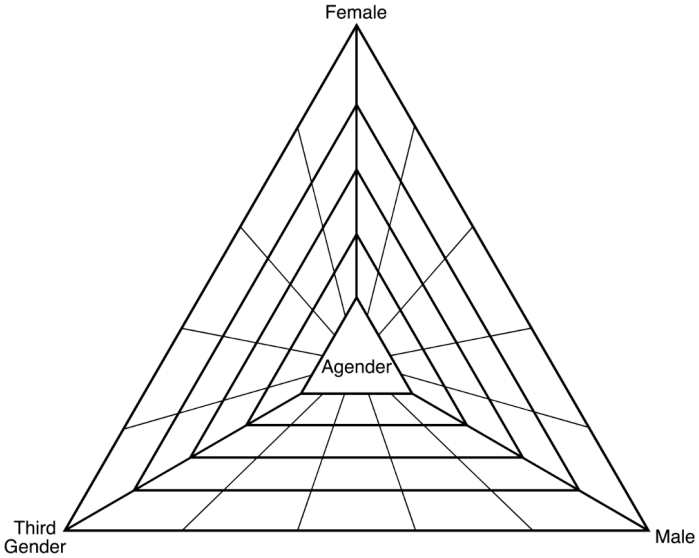
Fluid

A note on colours

The colours used in the Gender Triangle are merely arbitrary placeholders to represent the differences between genders and how they may overlap. Of course, this model is informed by western coding of gendered colours, but we appreciate that particular colour-coding of cancers and resources can alienate some. We therefore encourage people to not only draw their own personal shape on the Gender Triangle but also to assign themselves the colours that feel are most correct to them.



Fixed



The Gender Triangle and you

Gender is a social construct and a spectrum of personal experience. We hope that this model helps to convey this idea and foster a greater understanding of the trans and non-binary experience. This model can also help us to appreciate these nuances in cisgender people too, which may in turn support a greater understanding of others.

We encourage you to think about how the The Gender Triangle might represent your own gender identity and what shape and colour you might use to express yourself. Here we have a blank diagram, so why not try it out for yourself?

Pronouns

Correct pronoun use is important for everybody but especially for trans, non-binary and gender diverse people. Although pronouns are nothing new, some people may be unfamiliar with discussing how they are used. This poster provides information and examples to help everyone comfortably talk about pronouns in their own daily conversations. By normalising the discussion around pronouns we can help to create an inclusive environment for everyone.

The most commonly encountered pronouns are:

Subjective	*Objective*	*Possessive*	*Reflexive*	*Example*
She	Her	Her(s)	Herself	She is a good boss. Her team appreciates her.
He	Him	His	Himself	He is a good listener. People like him.
They	Them	Their(s)	Themself	We appreciate their skills. They are valuable.
Ze	Hir/Zir	Hir(s)/Zir(s)	Hirself/Zirself	Ze works for zirself. Ze loves zir career.

Pronunciation guide: Ze; Zee / Zir; Zeer / Hir; Hear

It is always better to ask rather than assume

You should not assume a person's pronouns based on their appearance. Instead, when meeting someone new, take the opportunity to respectfully check which pronouns they use. Remember, some people may use multiple pronouns.

Be gender inclusive when addressing groups

Consider using gender inclusive openers such as "Welcome everyone" as opposed to "Ladies and Gentlemen". This care can also be applied to other things such as letters, mailing lists, posters, information and other public or group statements.

Try introducing yourself with your own pronouns

Leading with your own pronouns shows the patient that you are aware of their importance and that you are a person they can be confident in for receiving respectful care. A potential introduction might be: "Hello, I'm Dr Jones and my pronouns are he and him. May I ask yours?"

You can also include your pronouns in your email signature, name badge, social media or screen name in video calls

IF YOU MAKE A MISTAKE

Mistakes can happen, but it is our recovery that matters. Remember, a person's pronouns may change in the time that you have known them so it is important to remain open to this and continue to be respectful. If you do misgender somebody by using the wrong pronouns, we suggest that you:

Acknowledge your error and apologise.
Ask which pronouns they use so you can get it right.
Correct yourself and demonstrate your changed behaviour.
Commit to using their pronouns consistently. Do not rely on others to keep correcting you.

Please remember that the small effort to learn and respect pronouns makes a large impact on the inclusion of trans, non-binary and gender diverse people.

Towards disclosure

Stonewall reports that 1 in 5 LGBT patients are not out to any healthcare staff and 1 in 7 have avoided healthcare for fear of discrimination. Encouraging and supporting safe disclosure can lead to better health, engagement, satisfaction and access to cancer screening.

Factors affecting disclosure:

Facilitators

- Challenging heteronormative assumptions
- Inclusive language
- Open body language
- Healthcare provider is perceived as accepting of LGBTIQ+
- LGBTIQ+ Healthcare provider
- Accepting visual cues

Barriers

- Heteronormative assumptions
- Fear of breach of confidentiality
- Fear of poorer care / discrimination
- Healthcare provider is perceived as non-accepting of LGBTIQ+
- Lack of knowledge on LGBTIQ+ issues from healthcare provider
- Unwelcoming location or setting

Three opportunities to welcome disclosure:

1) Introductions: Welcome your patient with your name and your pronouns. This will set the tone for the conversation to be LGBTIQ+ inclusive and affirming.

2) Small talk: Ask if they have a(ny) partner(s). Avoid making assumptions based on the details shared. Let the patient explain their identity in their own words.

3) History taking: Ask respectfully about sexual orientation and gender identity. Position questions in the interest of patient health. Be clear about the reason for asking to avoid being seen as inappropriately curious.

Coming Out: Voluntary self-disclosure of one's LGBTIQ+ identity
Outing Someone: Revealing a person's identity without permission

Disclosure can be encouraged but should never be forced or coerced. Outing someone is a harmful act and in the case of a trans person's gender history, **it is against the law.**

Ask patients who have disclosed their identity if they want this recorded. Explain to them where it will be stored, who will see it and how it may be used.

Help to create a visibly inclusive environment by placing LGBTIQ+ leaflets or posters in waiting rooms, a rainbow sticker in the window, wearing a rainbow badge or lanyard.

Patients are not always aware of their health risks. Expecting them to lead disclosure based on their knowledge of community or identity based risk is a flawed model of practice. It is the healthcare provider's responsibility to consider their patient's identity and how it may relate to their care.

The goal is to make an environment where LGBTIQ+ patients feel safe enough to disclose and support them when they choose to do so.

Intersectionality

Introduced by Prof. Kimberlé Crenshaw, intersectionality is a framework that helps us understand how different aspects of one's identity may combine to create distinct, compound forms of discrimination.

Intersectionality helps us to appreciate when a person is being impacted by multiple inequalities and create appropriate responses or support.

Some examples of intersecting factors resulting in inequality might include:

A **Black woman**

An **older trans man**

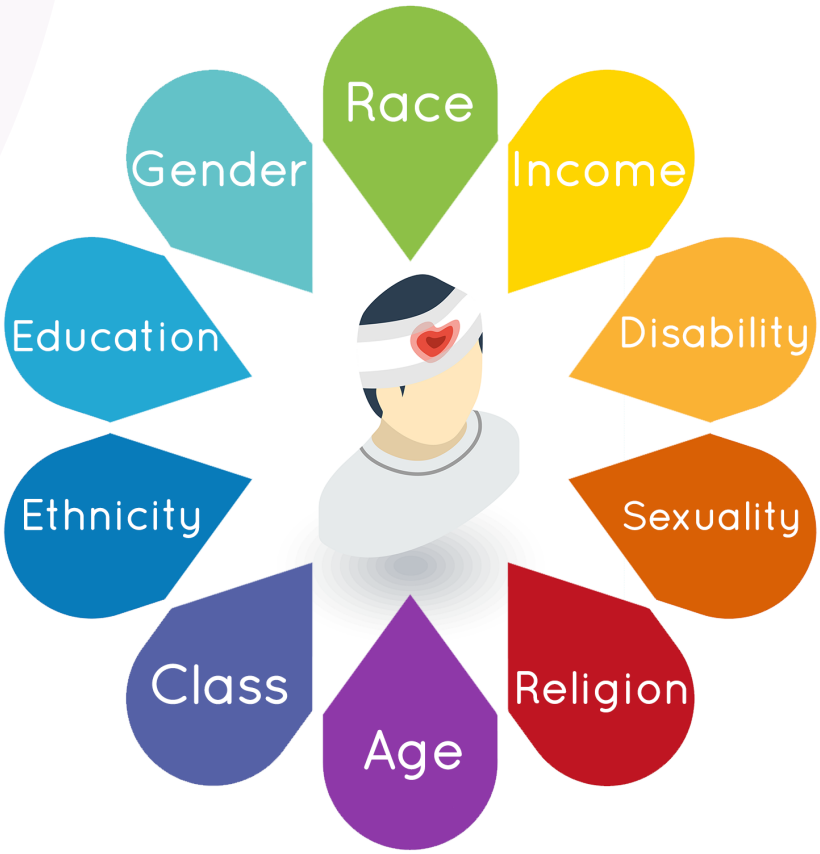
A **bisexual Asian Muslim woman**

A multitude of factors make up each and every person.

A person may be affected by other factors than those listed here.

Taking a one-dimensional approach to discrimination limits the ability to appreciate the nuance and complexity of a person's experience.

Intersectionality is an important tool to help us appreciate the social and structural barriers affecting LGBTIQ+ people when they are accessing healthcare such as cancer screenings.



These attributes and their intersections exist within a context of society, structure and power which can give rise to the barriers and inequalities experienced by the individual.

When addressing inequalities:

- Appreciate all parts of a person's identity and their potential impact
- Be aware of compound barriers to accessing equitable care
- Consider the context that the inequality is operating in and how it is relevant
- Try to address both the individual factors *and* how they intersect

Visible Commitments

Our Visible Commitments poster is an opportunity for you to demonstrate your understanding of LGBTIQ+ issues and your commitment to patient centred, affirming care.

To use this poster effectively, we recommend that you create a pledge for each colour or the rainbow. These pledges should be actions or attitudes that promote inclusion that LGBTIQ+ patients can hold you to.

We recommend that:

- The poster is printed in colour
- The poster is completed in black ink only (manually or digitally)
- Sufficient LGBTIQ+ training is provided before making pledges
- The poster is completed and signed as a team with input from all levels of staff
- Pledges are simple, affirming and achievable
- You display the poster in a place where both patients and staff can see it
- You laminate and monitor the poster to avoid it being vandalised
- You place a point of contact below the pledges in the space provided
- You review your pledges periodically should they need to be updated, expanded, redefined or if any additional training is needed to meet them

We suggest that you follow any pledges dutifully. If an LGBTIQ+ person notices any inconsistency between your actions and your pledges, this should be dealt with with utmost humility and efforts be made towards a solution-focused resolution. If this resolution is not immediately achievable, the person who raised the issue should be updated on, or be given the opportunity to be involved in, the progress towards its resolution.

If non-LGBTIQ+ patients question the poster, we would suggest that you remind them that the pledges are there to create a more inclusive environment for all.

Pledges might include:

- We treat everybody with respect
- We have a gender neutral toilet which can be found *(location)*
- We ask for and respect names and pronouns
- We continue to train staff regularly on LGBTIQ+ inclusion
- We provide private consultations rooms for those in need

If you are struggling to create your pledges, consider asking for patient input either directly, via questionnaire or a focus group. Co-production and patient and public involvement are fantastic ways to create authentic resources as well as build better connections with the communities in need.

We strongly believe in supporting the LGBTIQ+ people who access our services. We do this by:

Signed by: _____

If you have any feedback for our team, please direct it to:

Virtual consultations

These top tips were developed to compliment the Virtual Consultation guidance produced by the South East London Cancer Alliance. Please consider these points **before** virtual appointments with trans patients.

T — Treat me with respect

Every good conversations begins with respect. It is important that I feel that I am accessing a service that values me and my health without judgment. Asking me if there's anything you could do that might make me more comfortable can be a great start.

R — Read my notes

Before calling me, make sure that you have read my notes thoroughly. There may be information on my file that could prepare you for our conversation regarding my gender or what support I might need when attending appointments.

A — Ask me for my name and pronouns

When you ask it shows me that our conversation is going to be affirming of who I am. It also gives me an opportunity to use the name that is safe for the environment I am in when you call. There may be times where I cannot use certain details for personal safety or discretion.

N — Never assume my identity

When we are on the phone we lack the visual information that helps us to appreciate who we are speaking to. That is why it is important not to make any assumptions about me or my health based on characteristics like my voice.

S — Speak fluently and confidently

Any hesitation when discussing my identity, my care or my options may be interpreted as discomfort or judgment. It is important that you are able to speak in a way that shows me that I am being treated fairly and with respect.

Accessing screening

Breast Screening

For trans men and non-binary people who have breast tissue:

- Regular self-examination is recommended
- Those who have not had top surgery/mastectomy should continue with regular screening
- If they are registered as female they will be automatically invited for breast screening
- If they are registered as male their GP should refer them to the breast screening service for mammography

People who have undergone top surgery should continue independent monitoring of any remaining breast tissue. They can use a standard cisgender male pattern for checking. Please remember that they may wish to refer to their breast tissue as their "chest".

Trans women registered as female with their GP will be routinely invited for screening from ages 50 to 71. Long-term hormone therapy may increase the risk of developing breast cancer when compared to cisgender men. However, this risk is no greater than the risk experienced by cisgender women.

Cervical Screening

Trans men and non-binary people registered as female with their GP will receive invitations for cervical screening between the ages of 25 and 64.

Trans men and non-binary people registered as male with their GP will not be automatically invited to screening and will need to request an appointment.

When conducting a cervical smear for a trans patient, the screening laboratory should be contacted directly advising them of a sample being sent from a trans person with a cervix. This can also be included on relevant forms as "Patient with a cervix."

To make the cervical smear more tolerable for transgender people with a cervix you can:

- Check the name and pronouns the patient wants to use for the appointment
- Arrange their appointment at the beginning or end of a clinic
- Discuss the procedure and their options to improve comfort such as using a smaller speculum, allowing the patient to insert it or taking one home to practice
- Inform them of the higher rates of unsuitable samples and the possibility of a repeat test. This may be related to testosterone or discomfort in the procedure
- Explain that they will need to retrieve their results from the referring doctor/service and how to do this

Trans women registered as female with their GP may receive invitations for cervical screening but will not be eligible. This should be explained to patients.

- When the patient re-registers their gender with their GP, the screening team should contact the practice for a no cervix confirmation
- If they do not, practices should submit a cease request via Open Exeter to CSAS before the cut off shown on the Prior Notification List (PNL) to avoid inappropriate invitations