Thesis submitted in partial fulfilment of the Lancaster Doctorate in Clinical Psychology

"Honestly, transwomen just look out for ourselves" Experiences of HIV Care in Sexual Health Clinics

By

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Thesis Section	Main Text	Appendices (including tables, figures, and references)	Total
Thesis Abstract	236	-	236
Literature Review	7836	11845	19681
Research Paper	8000	6799	14799
Critical Appraisal	3906	5152	9058
Ethics	6000	5436	11436
Total	25978	29232	55210

Thesis Abstract

This thesis presents two papers exploring the experiences of transwomen within healthcare systems: a meta-synthesis of the literature on the perceptions of physical healthcare providers of transwomen; an interpretive phenomenological analysis of the experience of 5 transwomen accessing sexual health services in the UK for HIV healthcare.

In the first section, the meta-synthesis is presented, which reviewed 17 papers exploring on the perceptions of physical healthcare providers of transwomen. Four main themes were identified: (1) Healthcare providers' perceptions exist in the context of a cisnormative system, (2) The acceptability of transphobic and marginalising attitudes among healthcare providers, (3) Expected ways for Transwomen to exist, and (4) Education and Communication. The review also discussed clinical implications and the widespread nature of transphobia in healthcare settings.

The empirical section of this thesis presents the experiences of 5 transwomen accessing sexual health services in the UK for HIV healthcare. Four main themes emerged during analysis: (1) Interpersonal Experiences of accessing healthcare for HIV, (2) The Practicalities of Accessing Healthcare for HIV, (3) “Honestly, transwomen like kind of just look out for ourselves.”: The importance of connection to the community, and (4) Political and systemic influences on HIV healthcare.

The final section offers a critical appraisal of the similarities and differences between the papers and the strengths and limitations of this thesis. The researcher’s motivations and place within the research are also discussed alongside suggestions for future research.

Declaration

This thesis was completed in partial fulfilment of the Doctorate in Clinical Psychology at Lancaster University, submitted in May 2024. The following presented work is my own and does not contain the work of any other authors except when due reference is made. This thesis has not been submitted for any other academic award.

Name: Crystal Webster

Date: 23/05/2024

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To my parents, thank you for all your support throughout the last three years; I wouldn't be here without you. To the little girl who said she wanted to be a psychologist all those years ago to change the world for other adopted children. Look at you now!

And to Andrew, thank you for your love, grace, and support. The last three years have had many ups and downs, and you have been beside me throughout them all (often with tissues and a jar of Biscoff Spread). Finally, to Nala, my adorable little ginger cat, thank you for being as inconvenient as possible, often lying on the papers I need and stealing all of my pens. I couldn't have done this without you both.

Contents Page

Section One: Physical Healthcare Providers Perceptions and Attitudes towards Transwomen: A meta-ethnography of qualitative research

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Abstract

Introduction: The current literature suggests that transwomen face stigmatization and discrimination when presenting outside of the gender binary and, as a result, are more likely to experience health inequalities than cisgender peers. While perceptions of transwomen have been extensively researched in mental health settings, little consideration has been given to physical health settings. Thus it is essential to review the available literature that has focused on physical healthcare providers' perceptions and biases of transwomen accessing healthcare in order to understand better barriers and facilitators to gender-affirming care.

Aims: This review aims to explore systemic and personal influences on physical healthcare provider's perceptions, attitudes, and beliefs towards transwomen, as well as their impacts on barriers and facilitators to healthcare for transwomen

Method: A meta-ethnography was conducted on 17 papers that focused on a range of physical healthcare providers' experiences caring for transwomen.

Results: The subsequent synthesis indicated four main themes: Theme One) Healthcare providers' perceptions exist in the context of a cisnormative system, Theme Two) The acceptability of transphobic and marginalizing attitudes among healthcare providers; Theme Three) Expected ways for Transwomen to exist, and Theme Four) Education and Communication.

Conclusion: The results suggest that transphobic views are widespread among physical healthcare providers and within physical health systems. While some providers hold positive perceptions of transwomen and can provide affirming and trans-inclusive care, this is often hindered by providers in other parts of the healthcare system. Current educational programmes are not sufficient to educate healthcare providers on the need of transwomen. However, engagement in trans-inclusive education and knowledge building can mediate and

shift previously harmful attitudes. Therefore, transphobia in physical health settings must be systematically addressed to improve healthcare provision and outcomes for transwomen.

Keywords: Transwomen; Physical Health; Perceptions; Providers

Introduction

The terms transgender or trans refers to individuals whose gender identity differs from the biological sex they were assigned at birth (Reisner et al., 2016; Scime, 2019). There are an estimated 25 million transgender individuals globally (Thomas et al., 2017), of which 262,000 live in the United Kingdom (UK), accounting for 0.5% of the general population. Of these, 48,000 identify as transwomen (Office for National Statistics, 2023). However, despite only comprising a small proportion of the UK and global population, trans and gender-diverse individuals are more likely than their cis-gendered peers to experience significant health disparities (Kcomt, 2019; Zeeman et al., 2018).

Transwomen face disadvantages and stigmatization when presenting outside of binary gender norms (Verbeek, 2020; Wright et al., 2021) and are more likely than their cis-gender peers to experience physical and sexual violence, rejection, substance misuse, and discrimination related to their gender expression (Hsiang, 2022). These disadvantages and stigmatization may be further compounded by intersecting forms of marginalization such as racism, socioeconomic factors, and classism. Intersectionality proposes that multiple forms of inequality/minority identities are compounded to create unique obstacles that cannot be understood from one theoretical perspective (Crenshaw, 1998; Williams et al., 2020). These obstacles can impact access to safe housing, increased exposure to verbal or physical violence, substance misuse, and involvement in high-risk sexual activities (Day et al., 2017; Glick et al., 2020). All of these factors, combined with the intersectionality of gender identity with these factors contribute to increased life stresses and are associated with poor physical and mental health outcomes (Glick et al., 2020).

Drawing on minority and gender stress theories can increase our understanding of health disparities between transgender and cis-gendered individuals (Lefevor et al., 2019; Testa et

al., 2015; Wilkerson et al., 2017). Minority stress theory proposes that health disparities are caused by distal (external factors enacted through social structures) and proximal stressors (internal individual experiences, e.g. internalizing stigma such as transphobia) that minority groups, including transwomen disproportionally experience (Delozier et al., 2020). While both factors have significant implications for the health and well-being of transwomen, for this review, more consideration will be given to distal factors, as these are more likely to be experienced systemically in healthcare settings. Within healthcare systems, distal factors may take the form of being denied access to gender-affirming care, transphobic attitudes from staff, and/or systems that are not set up to meet their health needs. Examples of these factors may include things such as a lack of trans-specific services (Mikulak et al., 2021), a lack of education for practitioners (McPhail et al., 2016), and medical records that do not reflect their gender identity.

Gender affirmation is a key factor associated with positive health and well-being outcomes for transwomen (Reisner et al., 2016). Gender affirmation refers to the process by which one's gender identity and expression are internally and externally recognized and supported (Sha et al., 2021). Gender-affirming care refers to any interaction with a healthcare provider that reaffirms a patient's authentic self, which includes but is not limited to medical intervention such as gender-affirming surgery and respecting an individual’s social and/ or legal identity, for example, preferred or legally changed names. Misgendering is a unique minority stressor for transgender individuals that undermines this process of gender affirmation (Dolan et al., 2020). The language used in healthcare settings can be used to abuse and marginalise transwomen (Bouman et al., 2017), contributing to transwomen feeling unable to disclose their gender identity. The culmination of both proximal and distal stressors is likely to result in the development of damaging relationships with physical and mental health services (Davis et al., 2021).

Transwomen are systematically discriminated against when accessing healthcare services, although the nature of this discrimination varies with healthcare system, setting, and culture (Abreu et al., 2020; Shires & Jaffee, 2015; Socías et al., 2014). For example, in the USA, insurance companies may refuse to pay for care when pronouns do not match biological sex (Bakko & Kattari, 2020). However, this is not a shared experience in countries like the UK or Australia, where care is partially or fully publicly funded.

Mental health providers' interactions with transwomen have been studied extensively (Ali et al., 2016; Canvin, 2020; Canvin et al., 2023; Kanamori & Cornelius-White, 2017). Although most literature has suggested that mental health professionals hold positive views of trans individuals, views are heterogeneous, with significant differences between healthcare providers of different genders and religious beliefs (Brown et al., 2018; Nisley, 2010). There is literature demonstrating that female mental healthcare providers hold more positive views of trans individuals compared to male mental healthcare providers (Hill & Willoughby, 2005; Riggs & Bartholomaeus, 2015) and some religious beliefs are associated with negative beliefs against transgender patients. While this research is helpful, gender identity is not a mental disorder, and this focus may risk reinforcing a relationship between the two. Transwomen still experience disparities in physical health settings; therefore, it is important to understand how physical healthcare providers' beliefs, attitudes, and perceptions impact the healthcare they receive.

Research into transwomen’s experiences in physical health settings is relatively limited and has predominantly been conducted in sexual healthcare settings (Baral et al., 2013), which has been distributed across different countries and healthcare systems. This potentially limits understanding of transwomen’s experiences, as they will differ depending on the setup of the healthcare system they are in. For example, the way transwomen engage with the National Health Service (NHS) in the UK will differ from how transwomen may

engage in private healthcare systems like those in the USA. Much of the research has been quantitative, but it can be difficult to ascertain the validity of statistical measures of interpersonal experience (Brown et al., 2018). Despite these limitations, it has been reliably demonstrated that transphobia and cisgenderism are frequent in physical healthcare settings (Johnson & Nemeth, 2014; Rosenberg et al., 2021) and that both experiences with transphobic providers and the lack of providers who understand the specific needs of transwomen are likely to disincentivize transwomen from engaging with primary and secondary services (Jaffee et al., 2016).

Transwomen often delay accessing healthcare to avoid potential discrimination from healthcare providers (Jaffee et al., 2016; Rosenberg et al., 2021) and are more likely to engage with healthcare providers who respect their gender identity and provide safe, confidential care (Ssekamatte et al., 2022). The term cisgenderism addresses the systemic, cultural, and societal-driven prejudices that exist to delegitimize the experiences of people who do not identify as their gender as assigned at birth (Ansara, 2016; Lennon & Mistler, 2014; Wright et al., 2021). This is often a form of systemic discrimination that is used to undermine the gender-affirming experiences of transgender people and is thought to be widespread in some healthcare environments (Kcomt, 2019). While in recent years there has been an increase in the number of trans-specific health services providing access to gender-affirming and sexual healthcare, these services often experience long waitlists, thus limiting access (Zimmerman et al., 2020). Therefore, transwomen are forced to access mainstream services for gender-non-specific health needs, with transwomen reporting instances of covert and overt discrimination in these settings (Garcia & Crosby, 2020).

Aims

The review aims to synthesize qualitative literature using a meta-ethnographic (Noblit & Hare, 1988) approach to answer the following question: What are the beliefs, attitudes, and perceptions of physical healthcare professionals when providing care for transwomen? For the purposes of this review, physical healthcare professional is defined as any medical/ helping professional who provides physical healthcare only (e.g. doctor, nurse, healthcare assistant, physiotherapist). The literature will be interpreted and understood through the lens of the minority stress framework (Wilkerson et al., 2017). This review aims to explore systemic and personal influences on these perceptions, attitudes, and beliefs. As well as their impacts on barriers and facilitators to healthcare for transwomen.

Method

Design

The present systematic review employs a meta-synthesis approach to establish physical healthcare providers' attitudes toward transwomen. Noblit and Hare (1988)' guidance for conducting a meta-ethnography was followed. Furthermore, guidance related to meta-ethnography in health research and guidance for reporting were consulted (France et al., 2019; Sattar et al., 2021). The review was registered in PROSPERO with the ID CRD42023444359.

Search strategy

The systematic search was conducted on 1st September 2023 on the following databases: Medline, PsycINFO, CINAHL, and LGBTQ+ Source. The database PubMed was excluded due to the difficulties in performing a systematic search within the database, upon the advice of the faculty librarian. These databases were chosen in an attempt to find all relevant data. A latest publication date limitation of the 31st of August 2023 was applied. However, no

limitations were placed on the language of publication. However, only papers in English were eligible for inclusion since none of the research teams spoke a second language fluently. Full Inclusion and Exclusion criteria are presented in Table 1.

[Insert Table 1]

The main researcher developed initial search terms with support from the faculty librarian and then developed them in a multi-step process. The APA thesaurus was used to identify further terms for " attitudes " and " biases " and a broad range of terms associated with physical health providers. For ethical reasons, the final strategy did not include terms that were considered derogatory or transphobic. For this review, discrimination and stigmatization are defined below:

Discrimination is the structure through which society and systems perpetuate both covert and overt prejudicial treatment of those who do not conform to traditional gender norms (Lombardi et al., 2002). Most commonly, this is perpetuated through the denial of access to social structures (e.g. safe housing, gender-affirming care, and legal gender recognition (Delozier et al., 2020; Hendricks & Testa, 2012; Mikulak et al., 2021).

Stigmatization is the complex interpersonal social process of labelling and rejecting others due to perceived human differences (White Hughto et al., 2015). The minority stress model suggests that gender-based stigmatization is enacted via proximal stressors that result in internalized transphobia and increased fear of future discrimination due to their gender-minority status (Delozier et al., 2020).

Once search terms had been developed, scoping searches were conducted using each of the three areas of interest, attitudes, physical health providers, and transwomen. The process for identification of studies can be found in Figure 1. These were combined into a single

search to search titles and abstracts within each database. The final search strategy is presented in Appendix 1-A.

[Insert Figure 1]

Studies that met the inclusion criteria after abstract and title screening were screened again via full-text review, yielding seventeen studies identified as appropriate for analysis. The studies focused on the attitudes and perceptions of a range of physical healthcare professionals towards transwomen. A summary of the seventeen included papers can be found in Table 2.

[Insert Table 2]

Data Quality appraisal

The Critical Appraisal Skills Programme (CASP) checklist (CASP, 2018) was used to appraise the quality of the 17 included studies. The CASP uses a 10-item checklist endorsed within the context of healthcare research and the methodology of meta-ethnography (Long et al., 2020; Sattar et al., 2021). To map quality across the data set, numerical scoring was applied to the ten items of the CASP Checklist (Yes-3, Cannot tell- 2, No- 1), allowing a total score out of 30 to be calculated from the CASP checklist. CASP scores for analysed studies can be found in Table 3. Duggleby et al. (2010) developed this approach to quality appraisal for their systematic review, which has since been supported by other studies (Toye et al., 2014). Scoring splits papers quality into categories of "high" (papers scoring 24-30), "Moderate" (papers scoring 16-23), and "low" papers scoring ≤ 15). Due to the availability of health research exploring care for transwomen, the decision was made in advance not to exclude papers that produced scores deemed as "low". This was done because the research team felt these papers still contributed knowledge to a narrow literature base. Instead, scores

were used to inform synthesis with more weight given to papers of higher quality (Boeije et al., 2011).

[Insert Table 3]

Critical appraisal of the 17 papers highlighted both strengths and weaknesses. Consideration of ethical issues was either absent or unclear in 12 papers included in the synthesis. This is of note as the area of research for most papers included sensitive subjects (gender identity, HIV) with human participants that should have required ethical panel approvals. However, this has not been made clear in the papers. Moscheta et al. (2016) was one of the lowest-scoring papers, but they do address the significant ethical questions around its use of transphobic terminology. Not all papers within the synthesis addressed the nature of the comments made by the participants in their studies, even those with high ethics scores. A strength of the paper's synthesized is that most of the methodologies used were consistent with the aims of the papers. It was unclear if the aims of the papers and methodologies matched in Moscheta et al. (2016), Bolderston et al. (2018), Sutter et al. (2021) and (Banerjee et al., 2020); however, due to scores being above the low cut-off the decision was made to keep them in the synthesis and instead to consider the weight placed on these papers throughout the synthesis.

Analysis

Once identified the 17 papers were read in full, and a document was created containing information for each study, including study aims, interview format, and the key concepts developed. The use of meta-ethnography (Noblit & Hare, 1988) remained the appropriate approach for this review due to the quality of the qualitative data relating to transwomen specifically in each paper. All the papers identified used similar interview-based qualitative methods, apart from three papers that used open-ended survey questions to gather

their data. Therefore the weight given to the latter papers was considered when writing up the results. All papers used similar qualitative analysis methods, the most common being thematic analysis.

Comparisons were made to establish how the identified papers were related. This was done by establishing if the relationship between papers was either refutational (differing in their accounts) or reciprocal (their accounts are similar) (Noblit & Hare, 1988) and how this related to the aims of this review. Once completed, a Microsoft Word document captured the reviewer's initial thoughts and concepts identified within each paper. Britten et al. (2002) and Sattar et al. (2021) approaches to meta-ethnography were used to identify first-order (participants' direct quotes) and second-order (original authors' interpretations of first-order constructs) constructs within each paper.

Once first- and second-order constructs had been identified, the researcher collated the first- and second-order constructs for each paper in a Word document. An excerpt of this document can be found in Appendix 1-B. Sattar et al. (2021) recommendations for the process of translating the studies together were followed. This was done by reading and identifying common underlying metaphors across the data set, and the reviewer was able to establish relationships between the studies. Third-order constructs were identified from this process. Third-order constructs are considered to be the research team's interpretation of the second-order constructs (Cahill et al., 2018). The third-order constructs from each paper were collated in a Microsoft Excel spreadsheet (Appendix 1-C). Third-order constructs contained most of the second-order constructs. However, some did not fit within the focus of the review and were discounted (i.e. did not answer the question regarding perceptions and attitudes towards transwomen directly).

Most second-order constructs in each paper were considered to be directly comparable to one another as reciprocal translations (Luong et al., 2023; Noblit & Hare, 1988). However, some concepts in Munro et al. (2017) could be understood as refutational translations between the rest of the data sets. This was due to participants in Munro et al. (2017) expressing more positive and understanding attitudes towards transwomen, potentially due to the exposure they experienced to transwomen working in HIV services. In contrast, most participants in other studies presented with attitudes, perceptions, and biases that either consciously or unconsciously perpetuated harmful or transphobic interactions.

Results

Four third-order constructs (henceforth referred to as themes) were produced. These were as follows: Theme One: Healthcare Provider's Perceptions Exist in the Context of a Cisnormative System, Theme Two: The Acceptability of Transphobic and Marginalizing Attitudes among Healthcare Providers, Theme Three: Expected Ways for Transwomen to Exist, and Theme Four: Education and Communication.

Healthcare providers' perceptions exist in the context of a cisnormative system

Healthcare Providers' perceptions of transwomen exist within the context of a cisnormative system. Overall, ten papers contributed to this theme that explores the importance of the healthcare system in the context of provider perceptions and bias.

Healthcare providers hold attitudes that perpetuate the gender binary by disregarding the need for person-centered healthcare for transwomen. In (Madera et al., 2019), it is described by a cardiologist as "I don't think it [transgender health] is something particular, right? For good health, for everyone, right?" (Page 10). While the cardiologist positioned themselves as supportive of transwomen, this quote suggests a lack of awareness of the need

for flexibility in how they deliver genuinely person-centered care. This perpetuates a cisnormative environment as it does not acknowledge the deeply personal experience of transwomen and the multitude of different ways in which they choose to transition. This lack of flexibility is also seen in Beagan et al. (2015) “it doesn’t impact the way I practice, because I wouldn’t do anything different.’’ (Page 16). Both doctors dismiss the trans experience as impacting their patients. By confusing the concepts of equality and equity, physical healthcare providers contribute to the cisnormative system, as they undermine evidenced inequities in health outcomes for transwomen that cannot be addressed by treating everyone the same.

Several papers discussed how cisnormative health care systems allowed and gave space for transphobic and discriminatory attitudes towards transwomen. While some attitudes were overtly transphobic, as in Sileo et al. (2022) “a transgender woman came with an ID marked “female”, their name was changed to a female name, and we – oh no you’re providing false identification bye’’ (Page 12), which resulted in the complete denial of care. Some are more nuanced, for example, in Madera et al. (2019), a participant comments, “She can’t go to a gynecologist who supposedly only sees women’’ (Page 10), in this case, while systemic stigmatization of transwomen is openly acknowledged, there is no concern to rectify this.

Systemic/ administrative policy was noted to be important in permitting healthcare providers’ attitudes toward transwomen. Participants in Arora et al. (2022) noted that policy allowed them to choose where to admit transwomen “we used to admit them in male ward’’ (page 10). Despite acknowledging that transwomen experienced “embarrassment’’ (page 10) from this arrangement, the nurse did not feel that this was wrong as it was policy. Both Sutter et al. (2021) and Banerjee et al. (2020) also discussed the impact of ward assignment policy on provider attitudes. However, the absence of inclusive policy can also lead clinicians to

develop their own systems that show their personal biases. In the absence of such a policy, a non-prescribing healthcare professional in Sileo et al. (2022) devised a system for identifying gender identity by asking patients about the gender of their sexual partners: “as soon as they tell me “both” my next question is, “Which pronoun would you like me to use to address you?” (Page 9). This is inherently problematic as it conflates gender identity with bi-sexuality, which are two completely separate concepts that are not interrelated. When thinking about how this can be helped, Moscheta et al. (2016) noted that top-down training on inclusivity can positively impact providers' attitudes.

Participants in Banerjee et al. (2020) noted how operating in a cisnormative system obstructed them from providing compassionate care towards transwomen: “ We went out of our way to address her by her female name. It was awful that her medical ID could not match who she was as a person’’ (Page 923). Despite clearly holding supportive attitudes towards transwomen, nurses are forced to engage in a system that perpetuates harm. This is noted by a healthcare provider in a prison in Clark et al. (2017) "She wasn't able to start hormones because she had not been on them on the outside.’’ (Page 83). In this example, regardless of the provider's attitudes, the system prevented access to gender-affirming care. This may understandably encourage transwomen to perceive all providers as being aligned with the system. This can cause mistrust, leading to negative experiences for both the patient and the provider. However, doctors in Bolderston et al. (2018) pointed out that even if transwomen achieve gender affirmation by changing their gender on their care record, the system still forces them to ask stigmatizing questions: “if medical record states ‘female’, [I] have to ask LMP (last menstrual period)’’ (Page 431).

This theme demonstrates that healthcare systems function within a cisnormative structure that perpetuates cisnormative attitudes. These attitudes can be internalized by physical healthcare providers and directly impact the care they provide to transwomen.

Without access to inclusive policy, healthcare providers are left to make up their own templates for interactions with transwomen, sometimes resulting in harmful personal attitudes and bias being invited into the clinical environment.

The Acceptability of Transphobic and Marginalizing Attitudes among Healthcare Providers

This theme highlights the prevalence of overt and covert transphobia and marginalization expressed by healthcare providers in their interactions with transwomen in the healthcare system. 11 papers contributed to this theme, implying that these attitudes are widespread in healthcare settings.

All papers displayed stigmatizing and damaging views of transwomen in some way. However, 11 papers displayed particularly transphobic and marginalizing attitudes. Some healthcare providers equated being a transwoman with mental illness; in Clark et al. (2017), a participant referred to transwomen as having " histrionic personality disorder" (Page 85), while Sileo et al. (2022) equated transwomen as being "delusional" (Page 11). In Carabez et al. (2016) this was displayed through a harmful fascination with trans-identity "We all took turns putting her on the bedpan because we all wanted to see [the patient's genitalia]" (Page 6).

Misgendering was present in five papers included in this theme. In many papers, the misgendering was overt and intended to discriminate against transwomen. In Madera et al. (2019) a doctor refers to transwomen as having to "accept himself" (Page 9), and in Carabez et al. (2016) a nurse uses the phrase "*he* wanted breasts" (Page 7). On both occasions, the function of the misgendering attitude is to minimize the gender expression of the patient. In Clark et al. (2017), the context of the misgendering was less clear; while the provider seems

to hold positive attitudes toward transwomen, they misgender her, referring to “his hormones’’ (Page 83). Clark et al. (2017) note the disconnect between the surface-level acceptance of transwomen juxtaposed with the act of misgendering.

Intersectional bias and discrimination were present across many papers within this theme. Di Lorito (2023) noted that older age transwomen faced marginalization based on both their age and gender expression that resulted in “behind the curtain sniggering and derision’’ (Page 5). There were intersectional biases displayed when transwomen were involved with sex work, with an HIV healthcare provider in Lacombe-Duncan et al. (2021) noting that other healthcare professionals engage in “profiling’’ (Page 37) in the form of stereotyping when they hear of transwomen engaged in sex work.

It was noted that problematic views of transwomen were seen as acceptable as long as the provider felt they were hidden. In Beagan et al. (2015) a GP refers to gender transition as “half hearted mutilation’’ (Page 17) but does not view this as problematic as they feel they are “non-judgmental’’ (Page 17). Justification for transphobic views was also seen in Madera et al. (2019), where an internal medicine doctor justified diversion from the World Professional Association for Transgender Health (WPATH) guidelines because “hormones have side effects’’ (Page 9). Expressing his personal views on the prescription of hormones rather than clinical or guidance-based indications. In Arora et al. (2022), transphobic views were justified through hospital policy: “They appear mardana (masculine) so we keep them in male ward’’ (Page 10).

In some papers, challenges of transphobic attitudes by trans-inclusive healthcare providers were met with resistance. A nurse in Carabez et al. (2016) describes their colleague insisting “ No. He has a penis. He’s a man’’ (Page 7) when they challenged their misgendering of the patient. Their colleague’s insistence on their transphobic attitudes was

frustrating to the trans-inclusive nurse, who did not feel they should have been able to treat the patient. Trans-inclusive staff find it challenging to provide care to transwomen in settings where the transactional nature of some parts of the healthcare system requires buy-in from non-clinical staff. HIV healthcare providers in Munro et al. (2017) felt conflicted by this: "Unfortunately, they [housing workers] were aggressively misgendering people and, well like all kinds of transphobic stuff. They were actually getting people housing so people were like, ''Don't make them leave even though they're jerks!'' 'cause they were really good at getting people housing. But they were so disrespectful, um, so when I have to refer people [to them] for housing, and to other actual organizations, I often give them a disclaimer'' (Page 717). However, there are some instances where providers who held strong positive attitudes were able to overtly challenge problematic views: "We refer to them as they self-identify'' (Clark et al., 2017, Page 84). Munro et al. (2017) suggested that there was a need for trans-inclusive healthcare providers to maintain a balance of keeping transphobic providers onside in order to elicit necessary care for their transfemale patients alongside challenging views and supporting patients' complaints when possible. However, not all staff felt comfortable challenging transphobic views of transwomen, a participant in Sileo et al. (2022), when overhearing overt transphobic comments, expresses "I can't believe he's saying this'' (Page 11), but yet takes no action to correct or challenge this view. When providers do not stand against harmful attitudes towards transwomen, they can appear complicit in perpetuating a harmful system.

This theme highlights that transphobia and discriminatory attitudes are widespread and accepted in healthcare settings. While healthcare providers may view themselves as sympathetic to trans healthcare needs, they may still either consciously or unconsciously engage in harmful practices, which ultimately result in the same outcome of providing poor quality services and causing distress to transwomen accessing services. On the whole the

evidence suggests that many healthcare providers have internalized transphobic, discriminatory, and stigmatizing views, that are often left unchallenged by trans-inclusive colleagues.

Expected ways for Transwomen to exist

The theme of expected ways for transwomen to exist relates to the trans-normative (Johnson, 2016) expectations of healthcare providers across seven papers.

When transwomen presented themselves outside of the norms that healthcare providers deemed personally acceptable, most papers noted resistance on the part of the provider to provide care. According to Clark et al. (2017) healthcare providers viewed transwomen's attempts to have their needs met as "flag-waving'' (Page 84), or as to "strut their stuff''(Page 84). Suggesting that transwomen who strive for gender affirmation loudly are manipulative and calculating. The idea of providers wishing to impose their ideals on trans care can be seen when a doctor expresses their discomfort in Madera et al. (2019), regarding an 18-year-old wishing to transition from male to female: "the 28-year-old person is more conscious about decision-making, to me, reflecting a decision that is more thought-out.'' (Page 9). The intersection of age and the perceived life stage of the patient seems to impact the provider's willingness to provide gender-affirming care, despite evidence that delay in providing gender-affirming care can be harmful.

Perceptions of how transwomen should exist in the world lead to the display of stigmatizing and discriminatory views. Some of these views demonstrated the intersectional marginalization of transwomen, with the use of the term "survival sex'' (Sileo et al., 2022, p. 10) to justify providers reductionist views that transwomen must be promiscuous. This shows a distinct lack of understanding from healthcare providers of the context in which

some transwomen live. Participants in Carabez et al. (2016) portrayed attitudes and perceptions of transwomen's adherence to cis-gender beauty norms "five o'clock shadow in a skirt'' (Page 7), reflecting deeply judgmental attitudes around what constitutes as traditionally feminine and how transwomen are expected to fit into these ideals. In both of these papers, these views seek to oppress transwomen that do not fit the gender-binary constructs that society has created, with discriminatory attitudes towards those who noticeably present outside these norms both encouraged and accepted by healthcare professionals

Gender-affirming surgery was noted as being important to how healthcare professionals viewed transwomen and their desire to transition. Nurses in Carabez et al. (2016), displayed confusion regarding the mechanics of gender-affirming surgery "You have to take into account certain complicated issues, for instance, if is a transgender, um, male to female, and there hasn't been no prostatectomy (surgical removal of all or part of the prostate gland). You have to still worry about the issues whether or not the patient will still develop prostate cancer down the road'' (Page, 9), a prostatectomy is not part of gender reassignment surgery, and by making this link, the nurse may treat transwomen differently based in her perception of their surgical status. Judgment around gender-affirming surgery was noted in Heng et al. (2019) with nurses referring to transwomen who are not committed to their gender identity will eventually "self-select out'' (Page 440) of the process. These attitudes fail to recognize that there are multiple paths to gender affirmation that do not involve surgery. When thinking about other aspects of transition, Gerritse et al. (2018) question what is " a full social transition'' (Page 2324) and how healthcare providers can judge commitment to gender identity from social and medical transitions. This confusion could be because this study was undertaken only four years after sterilization was no longer a legal requirement for official gender recognition in the Netherlands.This is an extreme prerequisite for gender-affirming care and will have an impact on provider perceptions of what it means to be transgender.

This is another demonstration of providers' trans-normative and gender-binary normative views as they seem to suggest that transwomen's identities can only come from having accessed gender-affirming surgery or living their lives in ways deemed acceptable by society.

Conversely, participants in Lacombe-Duncan et al. (2021) recognized that service-level encouragement to participate in training positively impacted their interactions with transwomen. "we are strongly encouraged to participate in at least some kind of yearly training." (Page 42). These interactions created a shift in HIV nurses' perceptions and appreciation of the benefit of being more inclusive in their perceptions of transwomen. HIV services are often linked to sexual health services, where, generally, staff are perceived to be more gender inclusive.

This theme draws attention to how healthcare providers privileged the perception of transwomen who were transitioning "accordingly" with traditional gender binary norms, i.e. through surgery and hormones, while also seeking to reinforce the marginalization of transwomen presenting outside of the binary construct. It does, however, suggest that education can act as a mediating factor to these attitudes and perceptions.

Education and Communication

11 papers referred to the needs or impacts of education and communication on healthcare providers' attitudes or perceptions of transwomen.

Several papers noted the role reversal between healthcare providers and patients, as transwomen are seen as educators of transgender health by providers (Heng et al., 2019; Lacombe-Duncan, 2016; Paradiso & Lally, 2018; Sutter et al., 2021). In some cases, healthcare providers saw this desire to learn from transwomen as a positive thing. Oncologists in Sutter et al. (2021), saw this learning as expanding their understanding of the "context" (Page 4) of transwomen. For some, this came from feeling like a "novice" (Heng et

al., 2019, Page 440). In Lacombe-Duncan et al. (2021) one participant's experience of transwomen being resistant to teaching her about trans health as it "shook my whole world view" (Page 38). This led to a turning point in her previous perception of transwomen as educators rather than patients. This role reversal contributes to the ongoing narrative of cisnormativity and brings into question the adequacy of training on transgender health for healthcare professionals.

In the absence of guidance from professional bodies or systems, healthcare providers developed individual ways of interacting with transwomen. This confusion was more apparent in departments where the profession is governed by the gender binary, like genetic counselling. One participant in Ruderman et al. (2021), discussed their uncertainty about how to describe the relationship of a transwoman as while she was the "paternal contributor to the fetus" (Page 1109) it felt "disrespectful" (Page 1109) to reduce her relationship to this. This confusion on guidance for inclusive practice being absent from policy was seen in Clark et al. (2017), "No one really knows, what's the right thing to do?" (Page 82). In both papers healthcare providers made up individual solutions when trying to include transwomen in their practice, some were helpful and some allowed for harmful personal biases to enter into the clinical interaction, for example, adjusting clinical leaflets and allowing space for their identity in genograms (Ruderman et al., 2021).

Communication was seen as a barrier and facilitator to good perceptions and interactions with transwomen from the perspective of healthcare providers. In Madera et al. (2019), a doctor describes his avoidance of communication with transwomen as being associated with being professional. This avoidance of communication is attributed in Sileo et al. (2022) as not knowing how to "appropriately ask" (Page 7). Participants in Lacombe-Duncan et al. (2021) were able to acknowledge that while transwomen viewed some methods of communication as "not cool" (Page 36), this could be overcome by effectively

communicating with transwomen about why they need the information. Participants in Paradiso and Lally (2018) also agreed with the importance of "lay those lines out" (Page 53) to aid understanding and avoid judgmental interactions. However, healthcare providers need to be able to reflect on the impact of their communication, which requires some level of communication skills and a desire to learn. Bolderston et al. (2018) note that encouraging communication without education is "pointless, throwing staff in at the deep end" (Bolderston et al., 2018, p. 431), as this can increase the likelihood of negative and stigmatizing interactions with healthcare providers.

Lack of education and knowledge encourages stigmatizing or stereotyping attitudes towards trans healthcare. Munro et al. (2017) discussed participants frustration at the lack of knowledge about transwomen outside of HIV services that allowed for the spread of a "myth" (Munro et al., 2017, p. 714) regarding gender-affirming surgery and HIV status. Lack of knowledge and education can contribute to the display of transphobic and ignorant attitudes (Paradiso & Lally, 2018; Sileo et al., 2022). Interestingly in Moscheta et al. (2016), a doctor demonstrated the ability to learn and change their perspectives about transwomen when provided with guidance "Doctor: Would it be helpful to ask the user which ward she would prefer? Transwoman: Yes, definitely." (page 375).

This theme highlights the importance of communication and education in the interaction between healthcare providers and transwomen. In particular, it draws attention to the extent of the need for more specific guidance from both governing bodies and from within healthcare systems. Education around new and existing guidance would enable systems and providers to identify educational needs. While providing space for providers to build confidence in complying with professional guidance

Discussion

As far as the researcher is aware, this review is the first to consider the attitudes, perspectives, and biases of physical healthcare providers directly toward transwomen, which may contribute to physical healthcare disparities. Four themes were constructed through this meta-synthesis representing the attitudes, perspectives and biases exhibited by physical health care providers towards transwomen. Past systematic reviews have emphasized the prevalence of healthcare disparities across both mental and physical health settings from the perspective of gender minorities and mental health professionals (Brown et al., 2018; Kcomt, 2019; Zeeman et al., 2018). Four themes were inferred through this meta-synthesis representing the attitudes, perspectives and biases exhibited by physical health care providers towards transwomen.

The first theme highlighted that physical healthcare providers internalize the cisnormative and gender-binary constructs within which they practice. Attitudes that perpetuate the gender binary are accepted and encouraged at the cost of flexible person-centered care for transwomen. These attitudes and biases often go against clinical and professional guidelines (Coleman et al., 2022). The gender and minority stress model places clinicians in a position of power over transwomen. Therefore, the acceptance of these attitudes within systems perpetuates distal factors and promotes the oppression of transwomen. Mental health difficulties as a result of this oppression, when interacting with structures that are not designed to meet their needs, may indicate why transwomen have high needs for mental health services.

Gender and minority stress was perpetuated via the widespread acceptance of transphobia that was found in this review. The use of language by physical healthcare providers is employed to marginalize transwomen, most commonly in this review, through

the use of misgendering. Misgendering is considered to undermine the process of gender affirmation (Dolan et al., 2020) and this undermining use is employed by participants in several papers (Carabez et al., 2016; Madera et al., 2019). However, while transphobia is considered in more detail through this theme, it is important to note that transphobia is a consistent thread across all four themes presented in this review. The cost of transphobia is high, with research showing healthcare seeking hesitation from gender minorities due to the risk of re-traumatization and stigmatization (Seelman et al., 2017), contributing to overall poorer physical health outcomes for transwomen.

Multiple intersections of minority stress increase transwomen's vulnerability to oppression within the construct of physical healthcare providers' attitudes and perceptions (Abreu et al., 2020; Lacombe-Duncan, 2016). This review highlights how older transwomen, those who engage in sex work, are living with HIV, or do not conform to cis-normative beauty standards, are uniquely marginalized and stigmatized by physical healthcare providers. Transwomen sit at the intersection of two widely marginalized identities within the physical healthcare settings, that of being trans and woman. This review presents evidence of the marginalization and oppression of transwomen's identities in physical healthcare settings, with a shift away from providers as experts of care, with the burden shifted to transwomen to evidence the need for care.

There was a clear contrast in attitudes between HIV services and other settings. In HIV services, providers held more positive views and seemed to be more understanding of the trans experience, including the social context within which transwomen are forced to exist. However, this understanding of the trans experience outside medical settings and its effects on engagement with services was not found in the other papers in this synthesis. Research has found that provider competence in providing care to transgender individuals can act as a facilitator of care (Bockting et al., 2019). Therefore as HIV services

may be more likely to come into contact with transwomen, providers are more likely to have increased competence and continuing education development than other services on gender identity.

There is a general lack of confidence in treating gender minorities among medical professionals (Vasudevan et al., 2022). Studies in this review exhibited a lack of confidence in interacting with transwomen or openness to learning and education regarding healthcare for transwomen. These expressions were usually well-meaning and viewed as a positive quality by physical healthcare providers. However, healthcare providers often overlook the resulting role reversal between patients and providers. This role reversal of transwomen as educators of physical healthcare providers increases the health burden placed on transwomen in a system where this would not be required of cisgender patients. Despite this, it was encouraging to see active learning and perception shift within healthcare professionals through participation in these studies (Moscheta et al., 2016). Research into trans-educational programmes for medical professionals shows encouraging results (Braun et al., 2017; García-Acosta et al., 2019), showing that a robust and positive commitment to inclusive practice can overcome structural barriers. Consideration must also be given alongside these programmes for anti-transphobia teaching.

It cannot be ignored that gender identity is a highly divisive political and, in some contexts, religious issue. Most healthcare systems exist within the political constructs of a ruling regime. It is, therefore, possible that healthcare providers display attitudes in this review that they perceive as aligning with the current political movement in their country at the time of publication. Most of the synthesised papers were conducted within Canada and the USA, which research suggests had high levels of unmet health needs within the trans and gender minority population (Giblon & Bauer, 2017). Gerritse et al.'s (2018) paper was written only four years after sterilization was no longer a legal requirement for gender

recognition in the Netherlands, which may have impacted providers' perceptions of transwomen. Little is known about the UK context of physical healthcare providers' perceptions of transwomen outside of mental, sexual health and gender identity services and how this interacts with transwomen's engagement with healthcare systems in the UK. Further research is required in this area.

This review has identified that, overall, physical healthcare providers hold attitudes and biases that are either intentionally or unintentionally harmful towards transwomen. Transphobia is widely accepted, and the construct of the gender binary is privileged over the wellbeing of transwomen in physical health settings. However, this review highlighted that good education and trans-inclusive policy implemented at a systemic level can mediate these attitudes.

Strengths and Limitations of the Review

The present review is limited by its presentation of some papers which included healthcare providers' perceptions, attitudes, and biases towards other gender minority groups, meaning that attitudes towards transwomen only account for a small part of their data. As such, the main researcher decided if this data was significant enough for inclusion. Independent screening of these papers by a second reviewer would have increased the reliability and validity of this review. The above review is also limited by the search strategy that excluded the database PubMed due to the difficulties in performing a systematic search within the database, upon the advice of the faculty librarian. However, a comprehensive range of databases were searched, and papers from PubMed would likely have been included in these databases. Reference searches of the included papers would have further strengthened this review. It is important to note that participants in the synthesized papers were self-selected for participation. Therefore, this review may not accurately capture the full

range of attitudes held by physical healthcare providers toward transwomen. However, a strength of the review is that this is the first review within the literature to draw together qualitative research focused on the perceptions of physical health care providers towards transwomen. Most previous qualitative reviews have focused on the attitudes of mental health care providers, whereas reviews of physical health care providers have synthesized quantitative studies. Therefore, this review offers a more in-depth picture of the attitudes and biases that transwomen interact with when they interface with physical health systems. Researcher positionality should also be considered, as all of the research team identified as cisgender, and therefore, we do not presume to fully understand the trans experience. A strength of the review is that a second rater was used to ensure quality appraisal of the papers. Reflection on this was an ongoing process throughout the review.

Cultural considerations

Training, employment of healthcare providers, and healthcare systems differ worldwide. This review considered papers from eight different healthcare systems from various cultures. Consideration should also be given to how transwomen are viewed across these cultures. The acceptability of gender identity differs both internally and within global populations. Culturally there are variations in language use; while there has been some reclaiming of language by transwomen, we decided to use the current dominant official non-exclusionary language used by healthcare services. Although in our search strategy, the word transvestite was excluded from the search strategy due to its transphobic connotations in the UK, Moscheta et al. (2016) paper was included despite their use of the word due to the cultural context they provided around the use of the word transvestite in Brazil.

Clinical Implications/Future Research

Further qualitative research in this field may wish to focus on the experiences of a wider variety of healthcare professionals' perceptions and experiences of treating transwomen, as the majority of papers in this review focused on doctors and nurses. Some themes highlighted the need for further research into the prevalence of transphobic attitudes among helping professionals. Research into the effects of education interventions on student doctors' perceptions of gender minorities does exist (Cooper et al., 2022), and this, in some parts, is showing positive trends. Clinical psychology has a place in providing gender-inclusive supervision in physical health settings that allows safe spaces for professionals to learn and challenges transphobic views. Psychological perspectives on training and healthcare policy would be beneficial.

Conclusion

In conclusion, the present review synthesized qualitative research exploring the perceptions, attitudes, and experiences of physical health providers treating transwomen. Overall, this review highlights that transphobic views are widespread among physical healthcare providers and within physical health systems. While some providers hold positive perceptions of transwomen and can provide affirming and trans-inclusive healthcare, this is often hindered by providers in other parts of the healthcare system. This must be systematically addressed to improve healthcare provision and outcomes. Finally, engagement in trans-inclusive education and knowledge building can mediate and shift previously harmful attitudes.

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Tables

Table 1. Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
The article is written in the English Language	Articles are written in any language other than English.
The article has been peer-reviewed	Abstracts, conference proceedings, book chapters and unpublished dissertations.
Articles that have used qualitative methodology. This review included mixed-methodology papers where the qualitative results have been clearly reported.	Articles that use a quantitative method only
The paper focused on physical healthcare providers' perceptions, attitudes and biases.	Articles that focus on mental health providers' perceptions, attitudes and biases.
These biases were towards Transwomen (papers that look at LGBT or gender minorities, in general, will be included if there is enough data on transwomen specifically for identification of first, second and third-order constructs.	Articles where the main focus has been that of transwomen’s experiences with physical healthcare providers.

Table 2. Summary of Studies included for Analysis

Author	Country	Study Aim	Sample	Data Collection Method/ Analysis Used	Main Findings
Arora et al., 2022	India	To understand discrimination against LGBTQ+ patients in hospitals and how systemic procedures contribute toward this.	15 LGBTQ+ Patients 23 cis-gendered, heterosexual hospital staff members from various disciplines.	1:1 Semi-structured interviews. Thematic Analysis	Two Main themes with subthemes Theme 1: Systemic level discrimination - The backdrop (legal, political, social and economic) - Healthcare System Challenges Theme 2: Organisational level discrimination - Organisational policies/ procedures - Organisational practices - Discrimination within health facilities - Binary structures - Gender minorities in hospital wards - Discrimination by Healthcare providers Improper caregiving
Banerjee et al., 2020	USA	To qualitatively examine healthcare providers' experiences of patients' disclosure of sexual and gender identity.	Healthcare providers (e.g. Doctors, nurses, HCAs, etc.) working in Oncology	Survey containing 4 open-ended qualitative questions. Thematic Analysis	Four main themes: Theme 1: How HCPs encourage patients to disclose their LGBT status? Theme 2: Communication challenges with LGBT patients Theme 3: Structural/administrative challenges with LGBT patients Theme 4: Suggestions to assist oncology professionals to care for/manage LGBT patients

Author	Country	Study Aim	Sample	Data Collection Method/ Analysis Used	Main Findings
Beagan et al., 2015	Canada	To establish the experiences and understandings of GPs when treating LGBTQ+ women.	24 General Practitioners (GP) doctors	1-1 Semi-structured interviews Inductive Thematic Analysis.	Three Main themes: Theme 1: physicians perceived that sexual/gender identity makes little or no difference; treating every patient as an individual while avoiding labels optimises care for everyone. Theme 2: Some physicians perceived sexual/gender identity matters primarily for the provision of holistic care, and in order to address the effects of discrimination. Theme 3: Some physicians perceived that sexual/gender identity both matters and does not matter, as they strove to balance the implications of social group membership with recognition of individual differences.
Bolderston et al., 2018	Canada, New Zealand, Australia, UK	To establish staff member's educational preparation to care for LGBT Patients.	A range of healthcare professionals	Tweets collected from a 1-hour tweet chat thread between a certain timeframe Thematic Analysis	Three Main Themes with subthemes Theme 1: Consistent lack of training - Self-directed learning - Aren't we all the same Theme 2: Signes of change - Policy and practice - Aren't we all the same Theme 3: Let's do more - Advocating for change - Aren't we all the same

Author	Country	Study Aim	Sample	Data Collection Method/ Analysis Used	Main Findings
Carabez et al., 2016	USA	To explore currently practicing nurses' knowledge and experiences of transgender health.	268 Nurses	Data was collected from 1 question in a 16-question structured interview. Grounded Theory	Three main themes Theme 1: discomfort, Theme 2: transition Theme 3: harsh consequences of being transgender
Clark et al., 2017	USA	To examine correctional health care providers' knowledge and experiences of providing care to transgender inmates.	20 Correctional (prison) healthcare staff (working mainly at a male prison)	1:1 Semi-Structured interviews Modified grounded theory and thematic analysis	Conceptual model of barriers to the provision of care Structural (Lack of training, restrictive policies, unsupportive prison culture) Interpersonal (Differences between providers and custody staff bias) Individual (Lack of cultural and clinical competence with transgender individuals
Gerritse et al., 2018	Netherlands	To map the moral and ethical challenges faced by healthcare professionals at a multi-disciplinary gender identity centre.	Healthcare providers at a gender identity clinic	Reports and participant observations of team meetings and assessments at a gender identity clinic over 7 months. Thematic Analysis on a Focused Ethnography	Six themes emerged from the data Theme 1: Assessing eligibility Theme 2: Content of treatment Theme 3: Sequential order of the treatment steps Theme 4: Role of the clinical guidelines Theme 5: Differing notions regarding gender identity Theme 6: Decision-making process
Heng et al., 2019	Australia	Explore client and provider perspectives on transgender healthcare interactions.	Transgender clients n= 15 Clinicians n= 8 (6 x nurses, 1x psychologist, 1 x GP)	1:1 semi-structured interviews. General Inductive approach	Four main themes Theme 1: Community attitudes and support in NQ Theme 2: Trans healthcare is "not just a matter of hormones.'' Theme 3: Clinicians who "went above and beyond to help'' Theme 4: Learning together

Author	Country	Study Aim	Sample	Data Collection Method/ Analysis Used	Main Findings
Lacombe-Duncan et al., 2020	Canada	Exploring transwomen's and service providers perceptions of barriers and facilitators to healthcare related to prevention and treatment of HIV.	Transwomen (n=26) Range of healthcare service providers (n= 10)	Focus groups with transwomen 1:1 semi-structured interviews with service providers. Thematic Analysis	Explored Barriers and Facilitators to care Barriers: - Anticipated and enacted stigma and discrimination in the provision of direct care - lack of provider knowledge of HIV care needs for trans women - Absence of trans-specific services/organisations - Cisnormativity in sexual healthcare Facilitators included: - provision of trans-positive trauma-informed care - Autonomy and choice for trans women in selecting sexual health services - Models for trans-affirming systems change
Madera et al., 2019	Puerto Rico	Document physicians' knowledge, competency, and knowledge towards transwomen in Puerto Rico.	30 physicians practicing in Puerto Rico	1:1 semi-structured interviews Qualitative Analysis	Results demonstrated a lack of recognition of the needs of transwomen, alongside the impact of stigma on clinicians' decision-making and attitudes.

Author	Country	Study Aim	Sample	Data Collection Method/ Analysis Used	Main Findings
Moscheta et al., 2016	Brazil	To understand the construction of meaning about resources to improve healthcare provision through conversations between LGBT service users and health professionals	Facilitated group discussion 4: Transwomen 1: GP 2: Nurses	Facilitated group discussion Discursive Analysis	Five main themes Theme 1: improve communication between users and health professionals Theme 2: question what constitutes an expert on lesbian, gay, bisexual and transgender care Theme 3: reconfigure rigid notions about sexual identity Theme 4: deconstruct the association between sexually transmitted diseases and lesbian, gay, bisexual and transgender service users Theme 5: adopt a less judgemental attitude towards lesbian, gay, bisexual and transgender people during hospital admissions.

Author	Country	Study Aim	Sample	Data Collection Method/ Analysis Used	Main Findings
Munro et al., 2017	Canada	To contribute to knowledge about barriers to effective HIV-related care for trans women living with HIV in Ontario, Canada.	Transwomen (n = 14) Healthcare providers (n – 10)	1:1 semi-structured interviews Modified Grounded Theory	Theme 1: Interactions with Healthcare Providers or Staff - Discrimination in Health care Encounters - Denial of services - Lack of training impacts HIV clinicians and trans people - Agencies not perceived as welcoming to trans people Theme 2: Health Navigation Issues - Lack of trans-specific services - Disorientated health care delivery models - Siloing reinforces limited service options - System navigation is complicated by discrimination - Geographic barriers to HIV testing and care.
Paradiso & Lally 2018	USA	To understand nurse practitioner's knowledge, attitudes, and beliefs when treating transgender patients and their influence on their educational needs.	11 Nurse practitioner	1:1 semi-structured interviews Conventional content analysis	Four Main themes with subthemes Theme 1: Personal and Professional Knowledge Gaps Theme 2: Fear and Uncertainty, Theme 3: Caring with intention and pride Theme 4: Creating an accepting environment

Author	Country	Study Aims	Sample	Data Collection Method/ Analysis Used	Main Findings
Ruderman et al., 2021	USA	To explore genetic counsellors' experiences with transgender patients in the prenatal setting.	Genetic Counselors (n= 9)	1:1 Semi-structured interviews Content Analysis	Six themes emerged: Theme 1: Trans individuals were referred for common genetic counseling indications Theme: 2 genetic counselors were driven to think of more inclusive language Theme 3: genetic counselors considered ways to make written materials more inclusive Theme 4: trans individuals expressed discomfort in the prenatal/ preconception setting Theme 5: genetic counselors observed challenges with the care team, Theme 6: genetic counselors felt underprepared.
Sileo et al., 2022	USA	To explore the occurrence of LGBTQ+ stigma in healthcare	Healthcare providers (n=18)	Focus groups Thematic Analysis	Three main themes mapped onto the health stigma and discrimination framework. Drivers of stigma: Knowledge deficits and fear and discomfort Facilitators: Medical and educational training, cisnormative system procedures, destigmatising policy and procedures, workplace culture and norms Stigma Manifestations: Stereotypes, prejudice, discriminatory attitudes, stigmatising behaviours.

Author	Country	Study Aims	Sample	Data Collection Method/ Analysis Used	Main Findings
Sutter et al., 2021	USA	To explore oncologists' experiences and perspectives in providing patient-centred care for sexual and gender minority individuals with cancer.	Oncologists (n = 85)	Open-ended responses to a national survey Content Analysis	Four main themes Theme 1: Experiences with LGBTQ patients with Cancer - Positive Experiences - Negative Experiences - Ambivalent experiences - Lack of experience Theme 2: Reservation in treating LGBTQ patients - Patient-provider communication barriers - Knowledge/information-related barriers Theme 3: Suggestions for improving cancer care - Information related changes - Provision of affirming care Theme 4: Microaggressions
Di Lorito & Pearce, 2023	UK	To explore healthcare professionals' experiences of supporting patients from the LGBTQ+ community	N = 8 healthcare professionals N = 1 Occupational therapist N = 1 Physiotherapist N= 6 doctors	Semi-structured Interviews Thematic Analysis	Four main themes. Theme 1: experiences of supporting patients that are LGBTQ+ Theme 2: Facilitators and barriers Theme 3: Confidence in practice Theme 4: Ideas for future practice

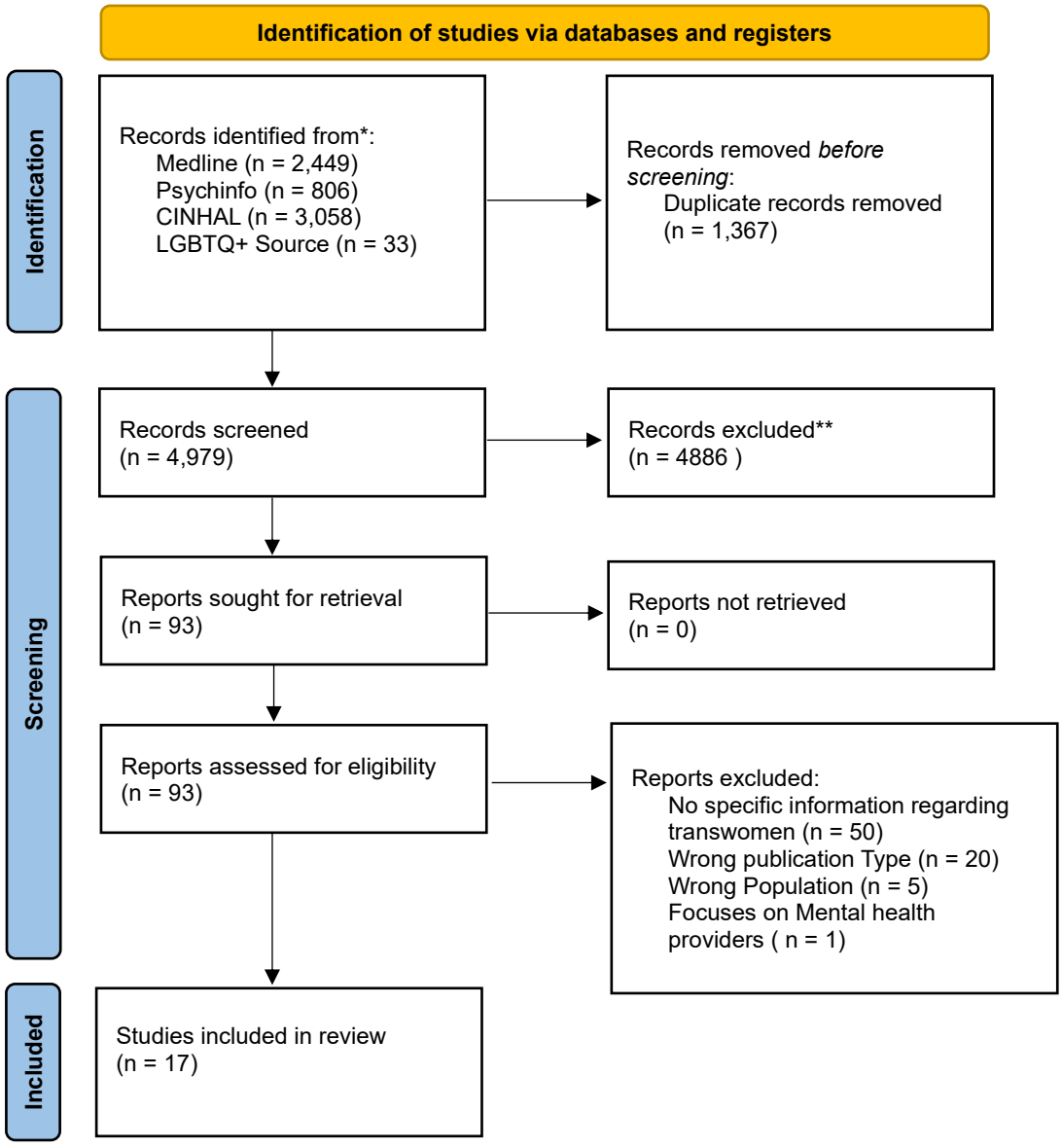
Table 3. CASP Quality Appraisal Scores

Beagan et al., 2015	3	3	3	3	3	1	1	3	3	3	26
Moscheta et al., 2016	3	3	2	3	3	3	1	2	1	2	23
Carabez et al., 2016	3	3	3	3	3	3	3	3	3	3	30
Clark et al., 2017	3	3	3	3	3	1	1	2	3	3	25
Munro et al., 2017	3	3	3	3	3	3	2	3	3	3	29
Gerriste et al., 2018	3	3	3	3	3	3	3	3	3	3	30
Paradiso & Lally, 2018	3	3	3	3	3	3	3	3	3	3	30
Bolderston et al., 2018	3	3	2	2	2	2	3	2	3	3	25
Heng et al., 2019	3	3	3	3	3	3	1	3	3	3	28
Madera et al., 2019	3	3	3	3	3	2	1	3	3	3	27
Lacombe & Duncan et al., 2020	3	3	3	3	3	1	1	3	3	3	26
Ruderman et al., 2021	3	3	3	3	3	1	1	3	3	3	26
Sutter et al., 2021	3	3	2	3	3	1	1	3	3	2	24
Arora et al., 2022	3	3	3	2	3	3	3	3	3	3	29

Figures

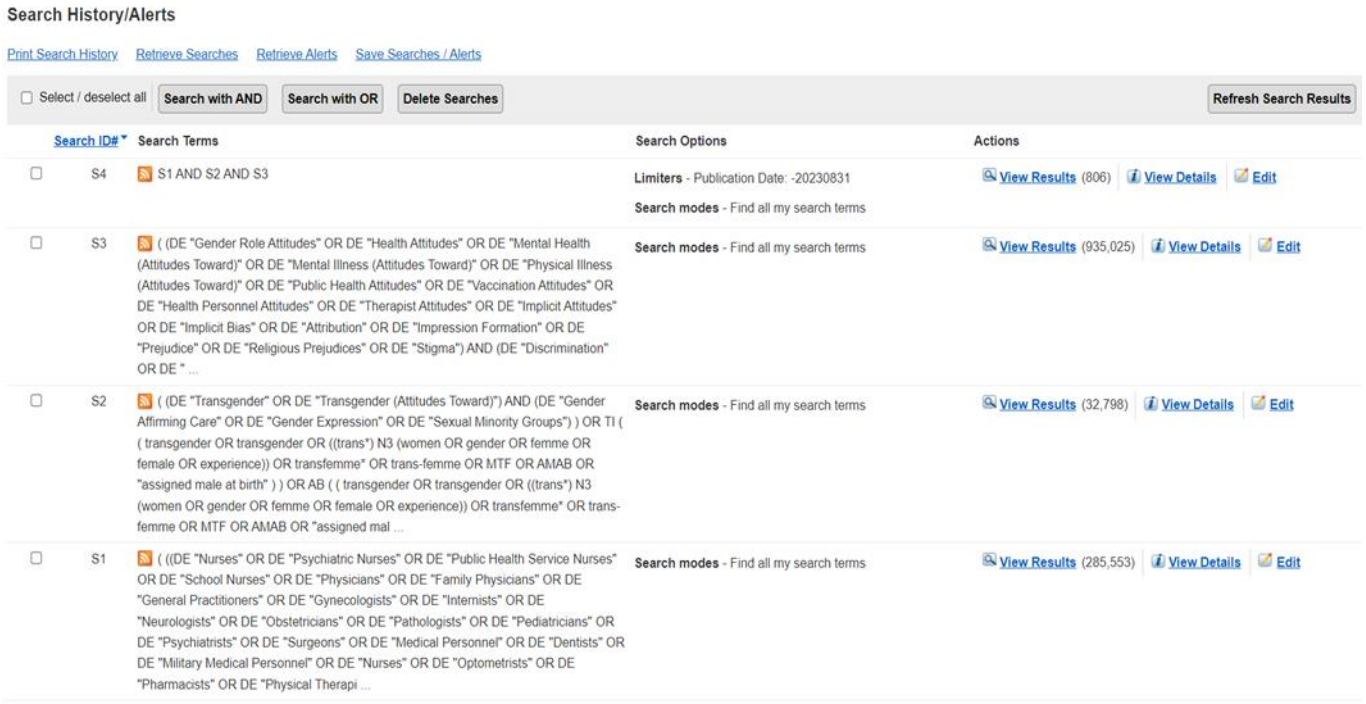
Figure 1: PRISMA Flow Diagram

Figure 1. PRISMA Flow Diagram



Appendix

Appendix 1-A: Search Strategy for PsycINFO Database



Search History/Alerts

Print Search History | Retrieve Searches | Retrieve Alerts | Save Searches / Alerts

Select / deselect all | Search with AND | Search with OR | Delete Searches | Refresh Search Results

Search ID#	Search Terms	Search Options	Actions
S4	S1 AND S2 AND S3	**Limiters** - Publication Date: -20230831 **Search modes** - Find all my search terms	View Results (806) | View Details | Edit
S3	((DE "Gender Role Attitudes" OR DE "Health Attitudes" OR DE "Mental Health (Attitudes Toward)" OR DE "Mental Illness (Attitudes Toward)" OR DE "Physical Illness (Attitudes Toward)" OR DE "Public Health Attitudes" OR DE "Vaccination Attitudes" OR DE "Health Personnel Attitudes" OR DE "Therapist Attitudes" OR DE "Implicit Attitudes" OR DE "Implicit Bias" OR DE "Attribution" OR DE "Impression Formation" OR DE "Prejudice" OR DE "Religious Prejudices" OR DE "Stigma") AND (DE "Discrimination" OR DE " ...	**Search modes** - Find all my search terms	View Results (935,025) | View Details | Edit
S2	((DE "Transgender" OR DE "Transgender (Attitudes Toward)") AND (DE "Gender Affirming Care" OR DE "Gender Expression" OR DE "Sexual Minority Groups")) OR TI ((transgender OR transgender OR ((trans*) N3 (women OR gender OR femme OR female OR experience)) OR transfemme* OR trans-femme OR MTF OR AMAB OR "assigned male at birth")) OR AB ((transgender OR transgender OR ((trans*) N3 (women OR gender OR femme OR female OR experience)) OR transfemme* OR trans-femme OR MTF OR AMAB OR "assigned mal ...	**Search modes** - Find all my search terms	View Results (32,798) | View Details | Edit
S1	(((DE "Nurses" OR DE "Psychiatric Nurses" OR DE "Public Health Service Nurses" OR DE "School Nurses" OR DE "Physicians" OR DE "Family Physicians" OR DE "General Practitioners" OR DE "Gynecologists" OR DE "Internists" OR DE "Neurologists" OR DE "Obstetricians" OR DE "Pathologists" OR DE "Pediatricians" OR DE "Psychiatrists" OR DE "Surgeons" OR DE "Medical Personnel" OR DE "Dentists" OR DE "Military Medical Personnel" OR DE "Nurses" OR DE "Optometrists" OR DE "Pharmacists" OR DE "Physical Therapi ...	**Search modes** - Find all my search terms	View Results (285,553) | View Details | Edit

Appendix 1-B: Data Analysis Table Excerpt (Clark et al., 2017)

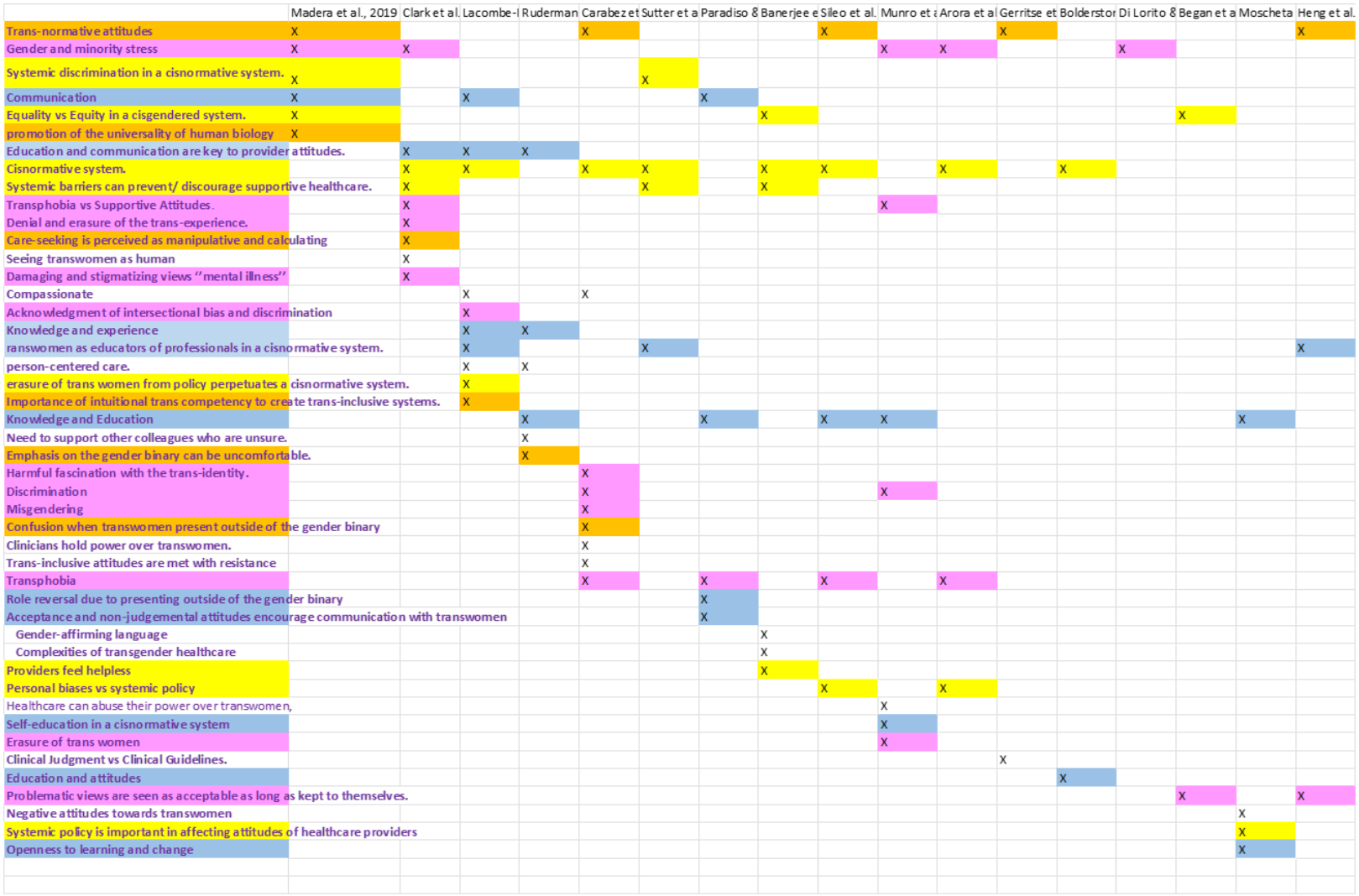
Third order Constructs/ key concepts	Third Order constructs	First Order Constructs	Second Order Constructs
Education and communication are key to provider attitudes. Cisnormative system.	**Lack of education creates confusion about how to operate in a cisnormative system** Lack of training, personal reflection, and policy direction causes confusion or healthcare providers, leading to harmful interactions with transwomen that perpetuate stigma and discrimination.	*" Frequently, like half of the healthcare staff might refer to the person as "she" and the other staff might refer to them as "he." Or if the person has changed their name, some of the healthcare staff might use the name of their choice, while other staff will use the name given on their birth certificate. No one really knows, what's the right thing to do? ... So I think that causes a lot of trauma for the clients. So maybe some training about what specifically would be most appropriate in that situation might be helpful." (health care provider)*	Lack of training on how to appropriately interact with Transwomen creates confusion for staff, leading to harmful interactions with transgender patients.
Gender and minority stress, misgendering, contrasting with providers' perception of their attitude towards trans women.	**Misgendering**, While healthcare providers view themselves as sympathetic to trans healthcare needs they still either consciously or unconsciously engage in harmful practice.	*" They can't continue [street hormones]. That actually happened with a client of mine. [The client] was getting his hormones out in California. Not really sure from where, but it seemed like a drop-in place for prostitutes, so they didn't really keep any records, and we couldn't verify anything, and so they weren't continued. It was devastating because that client*	The provider is clearly talking about a transwoman but misgenders " he" not she. The provider is sympathetic to the plight of the patient regarding loss of access to hormones and appears well-meaning. Still misgenders suggest underlying bias or lack of education.

Systemic barriers can prevent/ discourage supportive healthcare.	**Systemic barriers can prevent/ discourage supportive healthcare** are not set up to support, supportive attitudes of healthcare providers towards transwomen.	*began to grow facial hair again and they just were devastated. It impacts their depression and suicidality because they just feel so out of place." (Health care provider)* *" I encountered a transgender woman in the male facility … This inmate had decided to transition while incarcerated and had partially begun the process as far as changing her gender expression, and using different pronouns and name. She was still in the male facility due to her anatomy. She wasn't able to start hormones because she had not been on them on the outside." (Health care provider)*	Systemic barriers in the prison healthcare system limit the potential for prison health care providers to support their patients.
Transphobia vs Supportive Attitudes.	Transphobic colleagues lead to trans-supportive clinicians becoming complicit in the system.	*" With respect to the transgender piece, I remember one of the lieutenants was talking about somebody, and I referred to the person as 'she' and he goes, 'She?' and I said, 'Yeah we refer to them as they self-identify.' And he goes, 'Of course you would. We call them 'It'." (Healthcare provider)*	Lack of respect from other colleagues who are not sympathetic to the trans experience when staff try to affirm the patient gender.
Denial and erasure of the trans-experience. Transphobia. "flag-waving"	**Some healthcare providers express denial of the trans experience**. Some healthcare providers hold negative views of transwomen, blaming them for the reactions received when they attempt to get their healthcare needs met.		Perceived the patient's trans identity as attention seeking and causing problems. Showing off in

Care-seeking is perceived as manipulative and calculating.	Transwomen's desire for gender-affirming health care is seen as **manipulative and calculating.**	*" We have the people who are going through the transgender thing and we work with them to get them to not be, like, the "flag-waving, I'm going to change the world" types. That brings problems for them … Particularly for the transgender [females], they really want to be in people's faces about it and it causes problems. I'm kind of okay with it but stop saying it to my face all time, not everything is about that" (Health care provider)*	a sex-segregated system. Lack of cultural competencies in healthcare providers.
Seeing transwomen and human	**In contrast, some healthcare providers are trying to provide gender-affirming care in their interactions with transwomen.**	*" We're not supposed to [use female pronouns/names]. We call them by their last names. Yeah, we can't call them "Miss" or anything like that. But they will try. Like, if a new nurse comes on they will try to be, um, treated differently than the rest. Because they want to stand out … when they're in the prison setting, they tend to strut their stuff a lot more and look for more attention more often." (Health care provider)*	Instead of seeing patients' requests for providers to use female pronouns as a desire for gender affirmation, they are instead viewed as being manipulative and calculating to gain attention. Suggests a lack of knowledge regarding the psychological benefits of gender affirmation.
Healthcare providers engage in perpetuations of minority/ gender stress. Damaging and	**Minority stress** healthcare providers hold stigmatizing and damaging views of transwomen	*" Sometimes I can pick up based on how the they present themselves. Depending on what they want, I will either say 'Miss or Mr.*	Minority expressed gender-affirming positions but only when in private.

stigmatizing views "mental illness"		*Williams….. Don't form a judgment or opinion. They are a person first and foremost." (HealthCare Provider)* *"[Being transgender] is certainly not an encouraged thing. Everyone I've seen in here who's transgender seems to have, like, histrionic personality disorder. Like they're screaming about it, 'I'm transgender!" (Health care provider)*	Being transgender is seen as a mental illness rather than an attempt to gain access to healthcare.

Appendix 1-C: Excerpt of theme production table



	Madera et al., 2019	Clark et al.	Lacombe-I	Ruderman	Carabez et	Sutter et a	Paradiso &	Banerjee e	Sileo et al.	Munro et a	Arora et al	Gerritse et	Bolderstor	Di Lorito &	Began et a	Moscheta	Heng et al.
Trans-normative attitudes	X				X				X			X					X
Gender and minority stress	X	X								X	X			X			
Systemic discrimination in a cisnormative system.	X					X											
Communication	X		X				X										
Equality vs Equity in a cisgendered system.	X							X							X		
promotion of the universality of human biology	X																
Education and communication are key to provider attitudes.		X	X	X													
Cisnormative system.		X	X		X	X		X	X		X		X				
Systemic barriers can prevent/ discourage supportive healthcare.		X				X		X									
Transphobia vs Supportive Attitudes.		X								X							
Denial and erasure of the trans-experience.		X															
Care-seeking is perceived as manipulative and calculating		X															
Seeing transwomen as human		X															
Damaging and stigmatizing views "mental illness"		X															
Compassionate			X		X												
Acknowledgment of intersectional bias and discrimination			X														
Knowledge and experience			X	X													
ranswomen as educators of professionals in a cisnormative system.			X			X											X
person-centered care.			X	X													
erasure of trans women from policy perpetuates a cisnormative system.			X														
Importance of intuitional trans competency to create trans-inclusive systems.			X														
Knowledge and Education				X			X		X	X						X	
Need to support other colleagues who are unsure.				X													
Emphasis on the gender binary can be uncomfortable.				X													
Harmful fascination with the trans-identity.					X												
Discrimination					X					X							
Misgendering					X												
Confusion when transwomen present outside of the gender binary					X												
Clinicians hold power over transwomen.					X												
Trans-inclusive attitudes are met with resistance					X												
Transphobia					X		X		X		X						
Role reversal due to presenting outside of the gender binary							X										
Acceptance and non-judgemental attitudes encourage communication with transwomen							X										
Gender-affirming language								X									
Complexities of transgender healthcare								X									
Providers feel helpless								X									
Personal biases vs systemic policy									X		X						
Healthcare can abuse their power over transwomen,										X							
Self-education in a cisnormative system										X							
Erasure of trans women										X							
Clinical Judgment vs Clinical Guidelines.												X					
Education and attitudes													X				
Problematic views are seen as acceptable as long as kept to themselves.															X		X
Negative attitudes towards transwomen																X	
Systemic policy is important in affecting attitudes of healthcare providers																X	
Openness to learning and change																X	

Appendix 1-D: Formatting Guidelines for the International Journal of Transgender Health

Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements.

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- Complying with Funding Agencies
- My Authored Works

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International Journal of Transgender Health is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

International Journal of Transgender Health accepts the following types of article:

- Articles

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*Citations received up to 9th June 2021 for articles published in 2018-2022. Data obtained on 23rd August 2023, from Digital Science's Dimensions platform, available at https://app.dimensions.ai **Usage in 2020-2022 for articles published in 2018-2022.

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Article Types

Articles

- Should be written with the following elements in the following order: abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list)
- Should contain a structured abstract of 250 words.
- Read making your article more discoverable, including information on choosing a title and search engine optimization.

- While the journal has no word limit for submissions, manuscripts published are typically no more than 8000 words, all inclusive.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use American spelling style consistently throughout your manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”.

Please note that long quotations should be indented without quotation marks.

Formatting and Templates

Papers may be submitted in Word format. Please do not submit your paper as a PDF. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact us here.

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Authors must disclose all relationships or interests that could influence or bias the work. Although an author may not feel there are conflicts, disclosure of relationships and interests affords a more transparent process, leading to an accurate and objective assessment of the work. Awareness of real or perceived conflicts of interests is a perspective to which the readers are entitled and is not meant to imply that a financial relationship with an organization that sponsored the research or compensation for consultancy work is inappropriate.

The corresponding author will include a summary statement on the title page that is separate from their manuscript, that reflects a disclosure of any potential conflicts of interest.
Examples of disclosures include the following:
Funding: This study was funded by X (grant number X).
Conflict of Interest: Author A has received research grants from Company A. Author B has received a speaker honorarium from Company X and owns stock in Company Y. Author C is a member of committee Z.

If no conflict exists, the authors should state:
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Research involving human participants and/or animals

1) Statement of human rights

When reporting studies that involve human participants, authors should include a statement that the studies have been approved by the appropriate institutional and/or national research ethics committee and have been performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

If doubt exists whether the research was conducted in accordance with the 1964 Helsinki Declaration or comparable standards, the authors must explain the reasons for their approach, and demonstrate that the independent ethics committee or institutional review board explicitly approved the doubtful aspects of the study.

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"For this type of study formal consent is not required."

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If applicable (where such a committee exists): "All procedures performed in studies involving animals were in accordance with the ethical standards of the institution or practice at which the studies were conducted."

If articles do not contain studies with human participants or animals by any of the authors, please select one of the following statements:

"This article does not contain any studies with human participants performed by any of the authors."

"This article does not contain any studies with animals performed by any of the authors."

"This article does not contain any studies with human participants or animals performed by any of the authors."

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All individuals have individual rights that are not to be infringed. Individual participants in studies have, for example, the right to decide what happens to the (identifiable) personal data gathered, to what they have said during a study or an interview, as well as to any photograph that was taken. Hence it is important that all participants gave their informed consent in writing prior to inclusion in the study. Identifying details (names, dates of birth, identity numbers and other information) of the participants that were studied should not be published in written descriptions, photographs, and genetic profiles unless the information is essential for scientific purposes and the participant (or parent or guardian if the participant is incapable) gave written informed consent for publication. Complete anonymity is difficult to achieve in some cases, and informed consent should be obtained if there is any doubt. For example, masking the eye region in photographs of participants is inadequate protection of anonymity. If identifying characteristics are altered to protect anonymity, such as in genetic profiles, authors should provide assurance that alterations do not distort scientific meaning.

The following statement should be included:

Informed consent: "Informed consent was obtained from all individual participants included in the study."

If identifying information about participants is available in the article, the following statement should be included:

"Additional informed consent was obtained from all individual participants for whom identifying information is included in this article."

Patients' consent and permission to publish

Studies on patients/clients or volunteers need approval from an ethics committee and informed consent from participants. These should be documented in your paper.

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Section Two: Empirical Paper

"Honestly, transwomen just look out for ourselves" Experiences of HIV Care in Sexual Health Clinics

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Abstract

Current literature suggests that globally, transwomen are at higher risk of contracting HIV than their cis-gendered peers. Experiences of discrimination and stigmatization compounded by gender identity when presenting to HIV-related services create disparities and reduced engagement. This research aims to identify barriers and examples of good care experienced by transwomen when accessing sexual health services for HIV care and the implications this has for their physical and mental well-being. Five transwomen who had accessed a variety of different UK sexual health clinics for care related to HIV were interviewed using a semi-structured approach. Interpretative phenomenological analysis was used to analyse the data. Four major themes were identified, which related to interpersonal experiences during care, practicalities of access, the importance of community, and political and systematic influences on HIV care. Transwomen viewed healthcare for HIV as necessary for their physical and psychological well-being. Yet this study highlights that there are many barriers to effective care for HIV via UK sexual health clinics. Barriers are exacerbated by the political context of HIV and gender identity in the UK, transphobia and poor provider knowledge. Understanding providers and flexibility of access to services are facilitators of care.

Keywords: Transwomen, HIV, Sexual Health, UK

Introduction

Transgender is an umbrella term for a person whose gender expression/ identity is different from the binary sex that they were assigned at birth (Reisner et al., 2016; Scime, 2019). Conversely, cisgender is used to refer to people whose gender identity/ expression is the same as the biological sex they were assigned at birth (Aultman, 2014). While UK-specific data is hard to verify, it is estimated that 0.3-0.5% of the global population is transgender (Reisner et al., 2016).

Transwomen are more likely than their cis-gendered peers to experience physical/ sexual violence, discrimination and substance misuse when presenting outside of the traditional gender binary (Hsiang, 2022; Moagi et al., 2021). The minority stress model suggests that these factors are exacerbated by transwomen's social environments and the extent to which this environment seeks to stigmatize their gender expression (Wilkerson et al., 2017). The concept of cisnormativity is one way in which transwomen's identities are oppressed within society and healthcare systems, as it suggests that there is one way of being female, namely by being assigned female at birth (Bauer et al., 2009). Prolonged exposure to stigma, discrimination, and hostile social environments presents barriers to transgender people accessing sexual health services (Wilson et al., 2013). Research perceives transwomen as having a higher need for sexual health services but are less likely to use them due to their unsuitability (Trujillo et al., 2022).

Sexual Health refers to a range of principles, including mental, physical, emotional, and socioeconomic factors, that promote sexual well-being across the lifespan (Douglas & Fenton, 2013; Woodcock, 2016). Access to sexual health is considered a human right (The National Strategy for Sexual Health and HIV, 2001) and should include the promotion of gender-affirming sexual healthcare (World Health Organization, WHO, 2006). Despite this,

transgender individuals report difficult experiences when accessing sexual health services, receiving poorer outcomes than cis-gendered people (Lampe & Nowakowski, 2021).

Transgender people are more likely to suffer from sexual health problems than their cisgender peers due to the above reasons (Reisner et al., 2016; McNeil et al., 2012). Human immunodeficiency virus (HIV) is one area of sexual healthcare in which trans-individuals, in particular transwomen, are disproportionately impacted. HIV is an infection that weakens the body's immune system by attacking white blood cells, leading to increased vulnerability to infections such as tuberculosis and some cancers (WHO, 2024). While there is currently no cure for HIV, transmission can be prevented via the use of pre-exposure prophylaxis (PrEP). PrEP is a medication that is taken by HIV-negative individuals which, when taken as prescribed, prevents the acquisition of HIV, even when exposed to the virus (Terrance Higgins Trust, 2023). Additionally, research has shown that early access to antiretroviral (ART) medication post-diagnosis can prevent HIV transmission (Quinn et al., 2000; Rodger et al., 2019), commonly referred to as U=U (undetectable=untransmittable).

Transwomen are at higher risk of contracting HIV (Baral et al., 2013; Herbst et al., 2008), which the minority stress model suggests is explained by risk factors that can increase transwomen's vulnerability, such as discrimination, substance misuse, and being more likely to engage in ‘’high-risk’’ sexual activities, such as commercial sex work (Brookfield et al., 2020; Woodcock, 2016). This can be linked to the burden of minority stress and stigmatization within society, exacerbated by the lack of access to safe housing and healthcare (Glick et al., 2020; Wilkerson et al., 2017). Accessing reproductive and sexual health often requires the disclosure of a sexual history that might be judged by a health professional, as well as invasive and potentially traumatic examinations. Avoidance of these services due to minoritization may prevent transwomen from accessing testing, and therefore, they may miss out on early access to ART that would allow them to engage in safe sex.

Unequitable access to PrEP for transwomen within the UK has been acknowledged (Coukan et al., 2023). However, little consideration is given to the drivers behind this. Understandably, transwomen may avoid seeking treatment for HIV if they feel that sexual health services have a negative attitude towards trans-individuals (Hibbert et al., 2020). There is a general lack of consideration and understanding of the sexual health needs of transwomen (Safer et al., 2016; Suchak et al., 2015). In particular, there is a lack of understanding regarding the differences between gender and sexuality (Bauer & Hammond, 2015). The concept of cisnormativity perpetuates the conflation of sexuality and gender identity (Bauer et al., 2009), contributing to a more rigid understanding of sexuality and gender identity

Differences have been found between how transmen and transwomen utilise and engage with sexual health services, with poorer sexual health found among transwomen (Gil-Llario et al., 2021). It is therefore important to consider the sexual health needs and barriers to access for transwomen as a separate group. However, this is difficult to achieve as research often groups gay men and transwomen together (Rocha et al., 2023) when discussing HIV care seeking and adherence to PrEP. In the UK diagnosis of HIV rose between 2021 and 2022, with new HIV transmission growing more rapidly within the population of transwomen (Kirwan et al., 2021).

The care-seeking experiences of transwomen accessing preventative and active care for HIV within the UK have been neglected, with Whelan et al. (2023) highlighting the lack of UK-based research into transwomen's engagement with PrEP. Further research is required to explore how transwomen engage with sexual health services in the UK as the government draws closer to its commitment to zero new transmissions of HIV by 2030 (Department of Health and Social Care, 2021). Therefore, this study aims to use a qualitative approach to identify barriers and facilitators to transwomen’s engagement with sexual health services

when accessing preventative and active treatment for HIV and the implications this has for physical and mental well-being.

Method

Design

This study aimed to understand transwomen's experiences of healthcare related to HIV. Interpretative Phenomenological Analysis (IPA) (Smith et al., 2022) was chosen as it allows for an in-depth exploration of participants' lived experiences and sense-making of a given phenomenon (Smith & Osborn, 2015); while balancing the development of an experiential account that seeks to understand this at both a group and individual level. Through the use of hermeneutics, IPA has been described as allowing researchers to be alongside and walk in participants' shoes (Shaw et al., 2014).

Participants

IPA requires a small homogenous sample; therefore, a sample of between five-ten participants was aimed for (Smith, 2004; Smith et al., 2022). Inclusion criteria for this study stipulated participants must be over 18, self-identify as a transwoman, and have accessed a UK-based sexual health clinic in the last three years for preventative and/or active healthcare for HIV.

Participants were recruited via social media, which was supported by a number of UK-based HIV and gender identity charities. Targeted recruitment was conducted through local NHS trans-specific sexual health services.

Participants interested in participating expressed their initial interest by contacting the principal researcher via email. In response, the researcher provided the participant information sheet and consent form and answered any questions. 12 participants expressed an interest and were invited to interview, of whom five accepted. Of the five who took part in this research,

two had accessed a private sexual health service (Ebele and Rosa), and three had accessed NHS sexual health services (Claire, Laura and Jodie). Participants were offered the choice to enter into a draw for a £40 voucher.

Ethical considerations

NHS ethical approval was obtained for this study (Chapter 4). During transcription, all identifying information (names, clinics, and places) was removed.

It was acknowledged that the interview may touch on distressing experiences. Confidentiality and its limits were discussed before starting the interview, and a distress protocol was developed for the study (Chapter 4). After the interview, participants were sent a debrief sheet containing information on national and local support services.

Data Collection

Semi-structured interviews were conducted mainly via Microsoft Teams, apart from one conducted by telephone due to technical difficulties. Recruiting remotely to encouraged participation across the UK. The principal researcher developed an interview schedule that employed open-ended questions. The interview schedule was constructed with the minority stress model in mind (Chapter 4). Experts by experience from a local LGBTQI charity reviewed and provided guidance on the language within the interview schedule. Follow-up questions were asked where appropriate to deepen the researcher's understanding of the participant's experience. Interviews were audio recorded and transcribed by the principal researcher (mean length: 54 minutes).

Analysis

Transcripts were analysed individually using the Smith et al. (2022) approach to IPA. This process contains five steps that are repeated for each transcript. First, the researcher

prepares to enter the participant's world by reading and rereading the transcript. Step two involves line-by-line exploratory noting by hand on the transcripts (Appendix 2-A). This aims to stay close to the data, identifying areas of concern (e.g. emotions, relationships and processes) for the participant. Next, experiential statements are constructed from the transcript and exploratory noting, marking a shift away from the transcript data. Physical copies of experiential statements were written on Post-it notes and were used in the next phase of developing personal experiential themes (PETS) (Appendix 2-B). This was done by clustering together experimental statements and noting patterns that emerged through the data set; at this stage, the transcript was used to ensure that the analysis stayed close to the participant's experiences. Finally, groups of personal experiential themes were grouped and named to establish PETS (Appendix 2-C). This process was repeated for each participant.

Once completed for every interview, each participant’s PETS were printed, cut up, and highlighted according to the participant. The lead researcher grouped

PETS across the data set and noted emerging patterns and divergences (Appendix 2-D). The research team discussed the naming of PETs to ensure they answered the research question. PETS were excluded at this point if they did not contribute to answering the research question. Once the main researcher felt that these groupings embodied shared experiences, group experimental themes were decided.

Results

Four themes were identified during analysis: (1) Interpersonal Experiences of accessing Healthcare for HIV, (2) The Practicalities of Accessing Healthcare for HIV, (3) “Honestly, transwomen like kind of just look out for ourselves.”: The importance of Connection to the Community, and (4) Political and Systemic Influences on HIV Healthcare.

Theme 1: Interpersonal Experiences of Accessing Healthcare for HIV

All five participants contributed to this theme, describing a range of interpersonal experiences that acted as both barriers and facilitators to them accessing HIV healthcare through sexual health clinics. Ebele, Laura and Jodie inferred how their experiences with power and control within sexual health services affected their engagement. Laura equated attempting to access preventative care for HIV to engaging in battle. *"This is not me talking to my doctor. A person who I trust and has my best interest at heart. This is like me participating in information warfare"* Laura's experiences with the power professionals hold fostered mistrust about their underlying agendas and attitudes towards her. Instead, Laura viewed this as a battle to access the care she needs and requires to stay safe and protected:

> *fundamentally,…. you're speaking to someone who,…. based on the way they interact with you could like change your life quite drastically. Right. Like if I go into my PrEP appointment and they decide not to give me PrEP and then I get HIV from some risky thing that I do.*

Here, Laura expressed recognition of the power imbalance in clinical relationships and her fear that should she upset a clinician, they have the power to deny access to treatment, increasing her vulnerability to acquiring HIV. Jodie also shared this experience as she was denied care based on her gender identity when accessing vaccinations to begin sex work. *"And he very lordly, told me that no, we only give that to girls. We don't give that to men who have sex with men"* Here, the clinician misgendered Jodie. The minority stress model suggests that misgendering is a unique stressor that increases psychological distress (McLemore, 2018). Jodie shared this experience of psychological harm; however, the clinician is still viewed as holding power. Jodie felt that if she argued, he could remove further elements of her healthcare. In contrast, Ebele's experiences showed how the return of control and power can facilitate positive relationships with sexual health services. *"before she informed the doctor, she consulted me first asked me if I was ok with her sharing the*

information to the doctor and yeah, I accepted" By asking for consent to share Ebele's HIV and gender identity status, there was a conscious effort to promote the sharing of power, within the patient-provider relationship that enabled the building of trust.

Four participants reported feeling the need to hide parts of their identity to prioritize their need to access healthcare for HIV. Rosa experienced racial discrimination while accessing a HIV test but prioritized her identity as a transwoman over her identity as a black woman to receive the care she needed.

> *"the racial discrimination for me … I didn't feel any other thing because I didn't care about how people felt. It was more how I felt because I felt normal was actually accessing the service there, so I didn't really care. I felt a little bit comfortable, but I could feel that, … I would have been more accepted if I was White."*

While Rosa acknowledged that her experience would be different if she was white, her access to the service felt normal as a transwoman, and, at that time, this seemed to be more important. Despite this prioritization of her trans identity, Rosa *"toned down"* her appearance to avoid judgment. Laura shared this experience of hiding parts of herself, hiding her identity as a transwoman to facilitate access to PrEP. *"You're early enough in transition to go into the PrEP appointment and just be like, do you know what today I'm a boy like if that will get me the medication. I'm a boy right now."* By hiding her trans identity within sexual health services, she reduced the barriers she may experience in accessing PrEP. This prioritization of preventive care for HIV was shared by Jodie, who advised

> *It's better to power through all the bad mental health and stigma and all that stuff. And make sure you're protected … my advice is suck it up. Get the test. It's more important than … Whatever is being perceived in that moment.*

Perceptions of staff's attitudes towards gender identity were considered important to all participants. In particular, the need to be seen and understood by professionals when accessing sexual health services. This sense of feeling understood as a transwoman within the NHS was considered an empowering experience for Laura. *"she just, like, not only kind of was like a good person to speak to, but also like, understood my position as a sort of trans person in the NHS, like very intuitively and clearly"* Laura transitioned from the active battling relationship to a more equal understanding relationship with the service/ clinician, helping to facilitate Laura's feeling comfortable accessing care. Ebele also felt empowered by a service that she felt "*recognized and included"* her as a transwoman. While for both Claire and Ebele, this came from a felt sense of the provider, Rosa provided a more concrete example of how a nurse facilitated this. *"she it broke down for me and made it easy for me"*

In general, all five participants could identify staff members' positive attitudes that facilitated their access to healthcare for HIV. Claire, in particular, views sexual health services as more empathetic parts of the NHS than other disciplines.

> *They were nice, they used the right pronouns thing, they kind of responded as if they understand the experience of whatever I'm talking to them about if I need something. As I say, like the sexual health clinics are by far the easiest part of the NHS I've had to engage with.*

Feeling understood and supported enabled Claire to feel that she could access care for HIV and trust she would be treated fairly when compared to other parts of the system. However, the impact was still felt when staff consciously or unconsciously displayed harmful behaviour. Laura describes staff who display these attitudes as *"they need some fucking sensitivity training".* Laura was angry at the lack of empathy for transwomen and their place within the NHS and accessing care for HIV. She elaborated further:

I've like rationalized a lot of that as to being like understandable for the for the clinicians, for the individuals who are doing it. But no, it's bullshit. Like it sucks. I I hate it, it's upsetting. It's stressful. It often acts as a barrier to me going and getting the care that I need because it's an additional like stressor.

Negative interactions with staff acted as a barrier to Laura accessing PrEP and screening for HIV. Instead, she put off care until she had to, increasing her vulnerability to HIV. Exposure to misgendering and transphobic language impacted Jodie for weeks. *"I came away from that meeting, absolutely furious … Very, very upset with umm the service and the world really. And [it] … affected me mentally … for a few weeks afterwards"*

Overall, this theme highlights that good care and clinicians with positive attitudes towards both HIV and transwomen can facilitate access to services and encourage continued engagement. Conversely, overt power imbalances and gender-related traumatization within services are significant barriers. To manage these barriers, participants expressed the need to hide parts of themselves which impact their mental health and risk disengagement from sexual health services and care-seeking for HIV.

Theme 2: The Practicalities of Accessing Healthcare for HIV

Sub-theme 1: The convenience of accessing healthcare

This theme relates to the convenience of accessing sexual health services for HIV as a practical barrier and facilitator to HIV healthcare. This was cited by four participants (Laura, Claire, Jodie and Rosa).

Two participants discussed the convenience of their daily PrEP regime as impacting their relationship with HIV care and sexual health services. After eight months of being

misadvised, Jodie talked about how changing from event-based PrEP to daily PrEP changed her view on taking PrEP.

> *Deciding … to take a booking [for sex work] just being able to chuck the pills down my neck as I'm getting ready. Umm, was convenient. So … I saw this lack of convenience in in this new regime where I'd have to plan a week beforehand*

The new regime took much more planning and didn't coincide with her life, making her more hesitant and promoting her disengagement from both PrEP and sex work. Laura shared this experience of PrEP dosage being inconvenient, as she feels she wanted to access "*period dosage"* although this came more from her perception of her risk profile. While both expressed frustration with the lack of convenience associated with their PrEP regime, their responses were very different. Jodie withdrew, although this may be more related to the service's mistake and the resulting lack of trust. However, Laura continued to take PrEP despite the lack of convenience as she recognised that protection is essential.

Claire didn't share concerns regarding her PrEP regime as inconvenient but rather about choosing to access services that were *"closest or easiest to get to"* when she felt that she needed PrEP quickly. Claire prioritized the need and convenience of accessing drop-in services, facilitating her access to PrEP and PEP. This prioritization of convenience to access promotes nomadic relationships with sexual health services, implying that transwomen may not build relationships with sexual health services over time and visa versa. Conversely, while Claire prioritized clinic attendance based on physical convenience, Rosa deliberately went out of her way to access care due to fears about homophobia. *"I had to travel from my own place to (TOWN Name). [to make sure] … I was … safe due to my sexuality"* While this suggests that convenience is an essential factor in deciding to access healthcare related to

HIV, it indicates that this is balanced against the possibility of harmful or discriminatory experiences.

Sub-theme two: Lack of staff knowledge as a barrier to accessing services

Professionals lack of knowledge within sexual health services regarding the needs of transwomen accessing preventive care for HIV was viewed as a barrier to accessing and building trusting relationships with professionals. Jodie speaks about her loss of trust after being misadvised by a doctor at the clinic.

> *"she said you can't take event-based PrEP. She said you, your protection is massively converged and I went. What do you mean? And she said, well, you should have been advised on your PrEP regime as if you were a woman."*

There is a sense of disbelief from Jodie at the removal of her protection from HIV. This experience is compounded by her doctor's lack of knowledge about the interactions between PrEP and gender-affirming hormones. Her doctors prescribed PrEP based on Jodie's genitals, rather than her gender, not considering the interaction with her gender-affirming hormones. Jodie was reportedly unprotected for months, subsequently influencing her trust in sexual health services. Claire also talked about the lack of knowledge within sexual health services regarding the interaction of hormones with PrEP.

> *"I have had some technical questions about the interactions with my hormones. ... and those have been slightly more complicated. Like there was a brief from Terrance Higgins flagging a risk between one of the trans hormones and PrEP ... I asked about it and the consultant got a bit confused"*

Through this experience, Claire's inclusivity labour increased as she wet from being a patient to becoming an educator/ expert for her clinician. This role reversal changed the patient-

provider relationship, placing the burden of knowledge onto transwomen. Laura talked about the experience of becoming an expert and losing her trusting relationship with doctors.

> *it sucks. It sucks to … go into a sort of space where you know there's a doctor who is supposed to be specialized on, like people fucking and queer and stuff like that, you know?..... And and it's prescribing a medicine specifically available most to people who have the kind of sex that I have and to not know like how that works and just kind of get's in the way.*

There was a sense of frustration from Laura at the lack of understanding from professionals regarding gender identity and PrEP. This is linked with the reasonable expectation that doctors prescribing PrEP should know about it. This theme can be connected to transwomen's erasure from sexual health policy and the medical education curriculum (Hana et al., 2021).

Sub-theme three: Access to PrEP and services is viewed as a lottery

Laura and Claire were the only participants who explicitly described this experience, but it was a powerful experience of access to PrEP being viewed as a lottery. Laura viewed access to services as "luck" as she described playing the system to access care. *"we don't have any appointments callback like next week. Maybe if you know your nice to them then they'll tell you what day they released the appointments on"* this is another example of power dynamics, and transwomen's experience of having 'play by the rules' to access care. Claire also talked about the lottery of access to PrEP and the long wait times during drop-in services. *"I remember … clinics being really busy and me being a bit stressed cause you know, you sit around thinking I've been there like 5 hours, but I need this ASAP because it's effectiveness is super time dependent."* lack of certainty in HIV care interferes significantly with everyday life. This theme highlights that sexual health services are not consistent in their

approach to the provision of access to care for HIV, leading to uncertainty and the feeling that trying to access care is a lottery.

Overall, this theme highlights that there are multiple ways in which sexual health services contribute towards practical barriers preventing or hindering access to HIV healthcare. Transwomen experience multiple barriers and uncertainty, and the role reversal from patient to expert not only hinders access and diminishes trust in the professional relationship but also perpetuates existing power imbalances.

Theme 3: "Honestly, transwomen like kind of just look out for ourselves.": The importance of Connection to the Community

Four participants highlighted the various ways in which connections to the broader trans community influenced their access to healthcare for HIV. These connections both facilitated and created barriers to accessing services. Two participants made direct statements about how having connections to the trans community was required to learn how to access sexual health services. Laura said:

> *That means that some people who have that going on who aren't, you know, connected to other people who tell them that's how it works, will not know, and they will then, … miss out on screenings, miss out on treatment that they otherwise need because they don't realize that that's something that they can do.*

Here Laura points out that transwomen who are not connected within the community may miss out on HIV screening and treatment as they may not be equipped with the information they need to access sexual health services. While for Laura this experience of disconnectedness and lack of knowledge was seen as a general experience, Claire explicitly linked this experience to transwomen's stage of gender transition. *"But you might be early in your transition and not know about trans services".* For Claire, the experience of not

knowing how to access trans-specific services is pinpointed as coming from being early in her transition, this may potentially come from being comfortable to access trans-specific services at this stage of gender transition. This idea of the community passing on the knowledge of how to access healthcare associated with HIV is part of a more expansive feeling of the NHS and sexual health services not meeting the needs of transwomen. For Laura, this is central to her experiences of accessing services: "*The NHS sexual health services should all have Grindr accounts. I think that like probably just an awareness of the like social spaces that that the patients occupy that are not right, you know,"*

Laura doesn't feel that the NHS has an understanding of the social context and spaces that transwomen occupy creating barriers that the community compensates for by passing on knowledge and raising awareness internally. In particular, she feels that the community views open discussions around *"risk profiles"* as important. This passing on of knowledge creates supportive, solid bonds within the community, experienced by Ebele as *"family"*, suggesting these bonds go beyond that of normal friendship and are rooted in far more of an emotional experience that is created through the shared experience of gender identity and HIV.

Jodie reflected on the importance of this connection to family/community outside in mitigating the impact of when services cause iatrogenic harm:

> *Maybe if I was in a different place in my life, maybe if I was doing the work I was doing, but I didn't have somebody I cared about in my life..... Maybe I would have been more heavily maybe maybe it would have been enough to make me not go back.*

Jodie echoed the narratives of both Laura and Claire in her worries that not having someone to encourage and support her to continue accessing care could have resulted in her disengaging from sexual health services and preventative HIV care. Laura sums up the

importance for connection and community with *"I think honestly, transwomen like kind of just look out for ourselves."*.

Overall this theme captures a disconnect between sexual health services and transwomen that is fueled by the burden of care access being levelled at transwomen. This disconnect is circumvented by relying on the community's support to navigate sexual health services to ensure they receive the adequate/ care that they are entitled to. This seems to be a shared experience by participants in this study. Access to knowledge and supportive bonds created by the community/ family provide support/ strength to remain engaged with services that provide life-saving treatment despite the harm caused by interactions with these services.

Theme Four: Political and Systemic influences on HIV healthcare

Political and systemic influences on sexual health services and narratives around HIV were present in some form in the experiences of all participants. These experiences are categorized into three subthemes.

Sub-Theme 1: Transgenerational trauma from the HIV/AIDS crisis lives on

Participants viewed their healthcare needs for HIV through the lens of transgenerational trauma caused by the HIV and AIDS crisis in the 1980s and 1990s. Jodie explicitly names this experience of accessing sexual health services as being wrapped in *"systematic transphobia, homophobia and and generational trauma'* For Jodie, her experiences accessing care for HIV via sexual health services were compounded by her experiences of transphobia and the perpetuation of transgenerational trauma which she later categorizes as being driven by transphobic and homophobic language within sexual health services. While Claire doesn't directly name the transgenerational trauma of the HIV and AIDS crisis, she does explore how growing up in the wake of the crisis impacted her perceptions of HIV and sex. *"I was quite paranoid about HIV because I grew up in that kind*

of 90s early 00s era like umm.. like the full-on 80s paranoia had passed, but those attitudes were still very present" The legacy of the HIV and AIDS crisis was still very prevalent for Claire during her early experiences with HIV and sexual health services. This fear around HIV was further compounded in sex education, where cis-heteronormative relationships were privileged *"the only other sex ed I had was be worried about AIDS and wear condoms. So I was paranoid in my kind of sexual encounters".* This demonstrates that Claire's experience of sex education was influenced by cultural politics and that this impacted her sexual development and well-being.

It was not just history influencing participants' experiences of HIV care, but also the current narratives around HIV and gender that are perpetuated within mainstream media as experienced by Ebele. "*[I was] scared because … I have researched and I've seen conversations on TV about the prevalence of HIV, especially among transwomen"* For Ebele, ongoing narratives and media portrayals of HIV and transwomen increased fear and anxiety about her risk profile and the possibility of a positive HIV test. While Ebele doesn't link this fear directly to the HIV/ AIDS crisis, media narratives are still rooted within the homophobic narratives that existed at that time. Thus suggesting that historical political influences around the HIV and AIDS crisis still act as a barrier to care seeking and care provision within UK sexual health services.

Sub-theme 2: The system is not built to support transwomen

The three participants that accessed NHS sexual health services felt that these services were often not set up to meet the needs of transwomen. This sense of being left out of services was articulated in a variety of ways both political and systemic. There was a shared experience of sexual health services not being available when participants felt they needed them. Laura and Claire both talk about how sexual health services being closed on a Sunday

created a barrier to them accessing PEP. While PEP is available via A&E in the UK, this isn't always a seamless process, with a time-sensitive medication being gatekept by an already overstretched service. Claire talked about how accessing PEP via A&E is "awkward''. Laura felt that this setup was ridiculous. "*for some reason the GIC [Gender Identity Clinic] is shut on a Sunday like as though people don't do like most of their hooking up on Saturday night."* Laura's experiences of sexual activity on a Saturday night was indicative of most people, not just transwomen. She felt that sexual health services are not in tune with the realities of sex lives, which may increase the risk of HIV transmission and unconsciously prevent access to preventative care for HIV as a result.

As well as services not being available when transwomen feel that they require them, some participants described feeling that gender identity was an afterthought in most sexual health services. Jodie talks about how forms used by services promote linguistic erasure of trans identities *"transgenderism ... an afterthought ... on that on their form. I was a male and I was male who was transgender"* This example of cisgenderism implied a gender binary that excluded trans identity, creating a healthcare environment that didn't signify safety when it is most needed. Laura seemed resigned to the experiences outlined by Jodie and has little hope for services adapting to meet the needs of transwomen. *"the world is not designed for us. So you just have to kind of slot into whatever category you are when you're when you're interacting with the system. That's sort of like conflates gender and sex too much"* Of significance, however, these experiences were not shared by the two participants who accessed private sexual health services. Rosa describes an "*inclusivity mindset"* towards transwomen, giving her confidence that they would be able to care for her needs. This demonstrated that there are sexual health services that have adapted to meet the needs of transwomen accessing care for HIV, but that these services currently come at a cost. Learning

and sharing good practices from these services should be encouraged, and services should adapt to facilitate transwomen accessing care for HIV.

In the UK, transwomen were initially excluded from PrEP guidelines. Two participants discussed how this exclusion from PrEP influenced their interactions with services and their relationship with HIV. Laura talked about the change in guidelines. *"I can't remember when this happened, but I know that the guidelines changed. So it wasn't just like gay men anymore It was also like transwomen, and I was like ohh look, I'm back in again".* Laura used humour to deflect away from the consequences of the erasure of transwomen within health policy for HIV, her sense of transwomen being fashionable links with Jodie's sense above that transwomen are often an add-on or afterthought within services. Claire echoed Laura's sentiments about accessing PrEP on the NHS as necessary to increase safety, and discussed how this has changed her relationship with PrEP. *"I mean the difference in the last 10 years is that I don't have to buy it from some dodgy website like the doctor gives it."*

This theme demonstrates that sexual health services provisions for preventative care for HIV are not designed with transwomen in mind. Instead, transwomen are an afterthought in this process, and the psychological impact of this affects how they interact with services. However, it also shows that services are adapting to facilitate access to HIV healthcare for transwomen, and learning from these services should be explored further.

Discussion

The results of this study describe the barriers and facilitators faced by transwomen when accessing preventative and active healthcare for HIV through sexual health services.

Theme One showed how interpersonal dynamics reinforce power within sexual health services that discriminate against transwomen, forcing them to present their identity in a 'palatable' way in order to ensure their needs are met. One participant prioritizes the needs of

her trans identity over their racial identity in the face of racial discrimination in order to access HIV testing. Interestingly, other participants prioritized access to preventative care for HIV over their trans identity. Other transwomen in the literature have not shared this experience, suggesting that transwomen prioritize their female identity over seeking healthcare care for HIV, even if rates of willingness to engage with PrEP are high (Pacífico de Carvalho et al., 2019; Sevelius et al., 2016; Sevelius et al., 2014). While it is not clear if this is present in other areas of research, participants in this study expressed a strong commitment to HIV testing and PrEP. Therefore it is possible that this could have played a part in their decision to prioritize access to safe sex. Especially within the UK context of having previously been excluded from PrEP access.

Research has shown that sexual health and HIV providers have favourable views toward transwomen accessing care for HIV (Auerbach et al., 2020; Gould, 2022; Lacombe-Duncan et al., 2021). Findings from this study demonstrate that good care and clinicians with positive attitudes towards both HIV and transwomen do facilitate access to sexual health services and encourage transwomen to engage in preventive and active care. However, the experiences of interacting with transphobic, homophobic or apathetic providers seemed to negate this for some participants in the study. Lefkowitz and Mannell (2017) found that sexual health providers in the UK displayed transphobic or homophobic attitudes towards trans youth, with experiences similar experiences being reported in this study. More importantly, transwomen in this study did delay access to healthcare due to worries about discrimination and stigmatisation, which is consistent with the literature (Seelman et al., 2017). Clinical psychology has a role to play in reducing transphobia in sexual health services via trauma-informed training and the provision of reflective practice, helping to reduce barriers for transwomen accessing care.

Participants identified that sexual health professionals seemed to have little to no knowledge and training regarding the interaction of gender-affirming healthcare and HIV. This is supported by studies conducted outside the UK context, mainly within Canada and the USA (Lacombe-Duncan et al., 2021; Munro et al., 2017). Lack of knowledge led to participants feeling like they had to educate their sexual health staff and resulted in the loss of the trusting relationship with staff. This supports findings from Gould (2022) that providers feel that they rely on transwomen to educate them, with this study showing that the burden is felt in return. For one participant, this lack of knowledge left her unprotected from HIV after being misadvised on her PrEP regime, validating transwomen's concerns regarding provider knowledge about interactions with feminizing hormones and PrEP (Baldwin et al., 2021; Sevelius et al., 2014). Research has shown that PrEP can have psychological benefits by reducing anxiety, and allowing people to live their lives (Heyes et al., 2023). However, this research has not been conducted in the context of transwomen. Thus, targeted provider education is required to boost knowledge within sexual health services to facilitate transwomen accessing healthcare associated with HIV.

This study draws out how transwomen use their own community to mitigate the inclusivity labour of accessing services not built for their needs. Research shows that transwomen rely on recommendations for inclusive services from within the community (Lacombe-Duncan et al., 2021; Newman et al., 2021). Participants in this study shared this experience, with a lack of community during their early transition cited as contributing to anxiety that acted as a barrier to HIV care. One participant who had received a diagnosis of HIV found support groups run by other transwomen to be a powerful and welcoming experience. Interestingly this in contrast with research findings involving transwomen living in the USA, where transwomen living with HIV felt they were targeted by other transwomen

in the community (Wilson et al., 2013)It is not known why this difference occurs, and more research is needed into the building of supportive communities among gender minorities.

Participants in this study encountered language they felt erased their feminine identity, this was viewed as insulting and a barrier to accessing sexual health services. The minority stress model suggests that misgendering is a unique stressor that increases psychological distress (Dolan et al., 2020) and may contribute towards care avoidance (Kcomt et al., 2019). Explicit misgendering in sexual health services overtly perpetuates heteronormative violence in the form of linguistic erasure (King, 2016). This erasure of transwomen's feminine identity demonstrates the oppressive power held by clinicians in sexual health services providing HIV care. Transphobic language experienced by participants in this study highlights a broader issue with research within the field of transwomen and HIV. The term men who have sex with men (MSM) was coined in the '90s to move the stigma around HIV transmission from being sexuality based to being behavior-based (Young & Meyer, 2005). More recently, in research, transwomen have been grouped with MSM (Rocha et al., 2023), conflating ideas that they have similar risk profiles for HIV and, more importantly, erasing transwoman's female identity. However, research has shown that transwomen and MSM have different HIV risk profiles (Bowers et al., 2012). This suggests that difficulties in recruitment for research studies, as well as access to sexual health services, may be down to the use of this terminology in connection with transwomen.

There is a dearth of research in the UK context on transwomen's engagement with HIV treatment and prevention. Of the literature that does involve transwomen, population samples are often not separated, making it hard to establish the specific needs or experiences of transwomen (Whelan et al., 2023). As indicated in theme 4, transwomen's engagement with sexual health services is interlinked with the narratives of HIV and the political landscape within the UK. Participants felt that HIV pathways were not set up with transwomen in mind

due to their initial exclusion from health policy for accessing PrEP. This was partly due to HIV policy and language being focused on gay men. The UK is considered a hostile place for gender minorities (Dyer, 2022; Horton, 2024), with the NHS getting caught in the middle of a toxic public discourse around the rights of transwomen (Murray, 2022). The recent publication of the Cass review advocates for the stripping away of gender-affirming care and privileges and promotes the idea of "cis-supremacy" within the NHS (Horton, 2024, p.21). Given that, participants in this study emphasized their commitment and need to prioritise HIV care over the psychological pain caused by distressing sexual healthcare interactions, the possibility that healthcare becomes an even more unsafe environment for transwomen, has the likelihood to lead to increased psychological distress.

Strengths and Limitations

While efforts were made, only five participants were recruited, meaning that it is difficult to ensure that data saturation has been reached within this study. Although it is possible an extended recruitment period may have resulted in more participants, it was not possible in the context of the current study. However, participants were recruited from a wide range of different sexual health services across England and Scotland. This is important as there is a dearth of literature focused on the experiences of transwomen accessing healthcare for HIV who are living in the UK, and what research does exist is often London-centric. While IPA can be conducted with a smaller sample for novice researchers, Smith et al. (2022) also emphasize that quality is balanced over quantity within participants' experiences. While the research may not be generalisable to the whole trans-population, participants have provided rich data about their experiences.

A limitation of this study is that demographic information for participants was not collected, which may have affected the heterogeneity of the sample. However, this was done to reduce steps and barriers, promoting engagement with the research within a marginalised group within health research. Yardley (2000) highlights the need for sensitivity to the theoretical context within qualitative research; this study's context is informed by the minority stress model and social context provided by experts by experience (EBE). However, HIV-specific models could have been drawn on, such as theories of internalised HIV stigmatization (Ferguson et al., 2022). Drawing on the EBE's experiences to shape the interview questions may have introduced their own biases towards HIV care in the UK, into the research. Having a trans scholar involved in the work would have been beneficial. However, this was not possible at this time.

The use of IPA as a methodology in this study allows the research team to walk in participants' shoes (Shaw et al., 2014); this was important as the primary researcher and the research team are cis-women. While IPA may help to mitigate some of this, due to universal experiences of being a woman in healthcare settings, the research team may have missed some more nuanced experiences within the language and references made by participants due to these being solely part of their experiences as transwomen. Therefore, reflexivity was important, with the main researcher drawing on trans-feminist approaches to research reflection and journalling to notice and challenge assumptions. Additionally, it is recognised that the study was conducted within the broader context of a transphobic discourse within the UK at this time, which may have impacted recruitment.

Clinical Implications

Consideration should be given to all paperwork within sexual health services, with particular attention given to the use of gender-affirming pronouns. Secondly, mandatory

targeted education should be provided to all sexual health staff regardless of the frequency with which they interact with transwomen. Clinical psychologists have a role to play in providing trauma-informed care training to our sexual health colleagues, empowering them to care for trans people and educating them on the psychological impact of accessing healthcare experienced by transwomen. Crucially, this should include how trauma from accessing other healthcare services may shape transwomen's engagement with sexual health services (e.g. avoiding care, or presenting as “difficult”). The BITTEN framework for trauma-informed healthcare may be a viable model to use in this instance (Selwyn et al., 2021). Not only this but clinical psychologists are well placed to help transwomen overcome psychological barriers to accessing HIV care. Finally, professional bodies and NHS Trusts should consider the balance of power held by clinicians and the risk this poses when held by transphobic clinicians. In particular, how this contributes to PrEP access inequality in the UK.

Future Research

Future research should be trans-led with more inclusivity of trans scholars and advocates. This research identified that barriers and facilitators to transwomen accessing healthcare related to HIV via sexual health clinics are wrapped up in the broader political and social context of the UK. It is important to note that the transwomen who engaged with this study are still engaging with services despite these barriers to accessing care, however this is at the cost of their psychological well-being. Further research may wish to focus on two main avenues: 1) The experiences of transwomen in the UK who are not engaging with HIV care and 2) A focus group focused paper bringing together both transwomen and sexual healthcare providers within the UK, with the aim of developing a shared narrative of HIV care for transwomen.

Conclusion

This study highlights that there are many barriers and facilitators to transwomen accessing sexual health services in the UK for healthcare related to HIV. While there is an outward perception for many that sexual health services are inclusive spaces in comparison to other areas of healthcare, services are still far from perfect and, for many, come with the dilemma: prioritise your identity and well-being or prioritise your health, but you can't have both. As this is not a choice experienced by cis-gendered individuals, it represents a clear inequality, and the minority stress model supports how the experiences of transwomen in sexual health services contribute to psychological distress.

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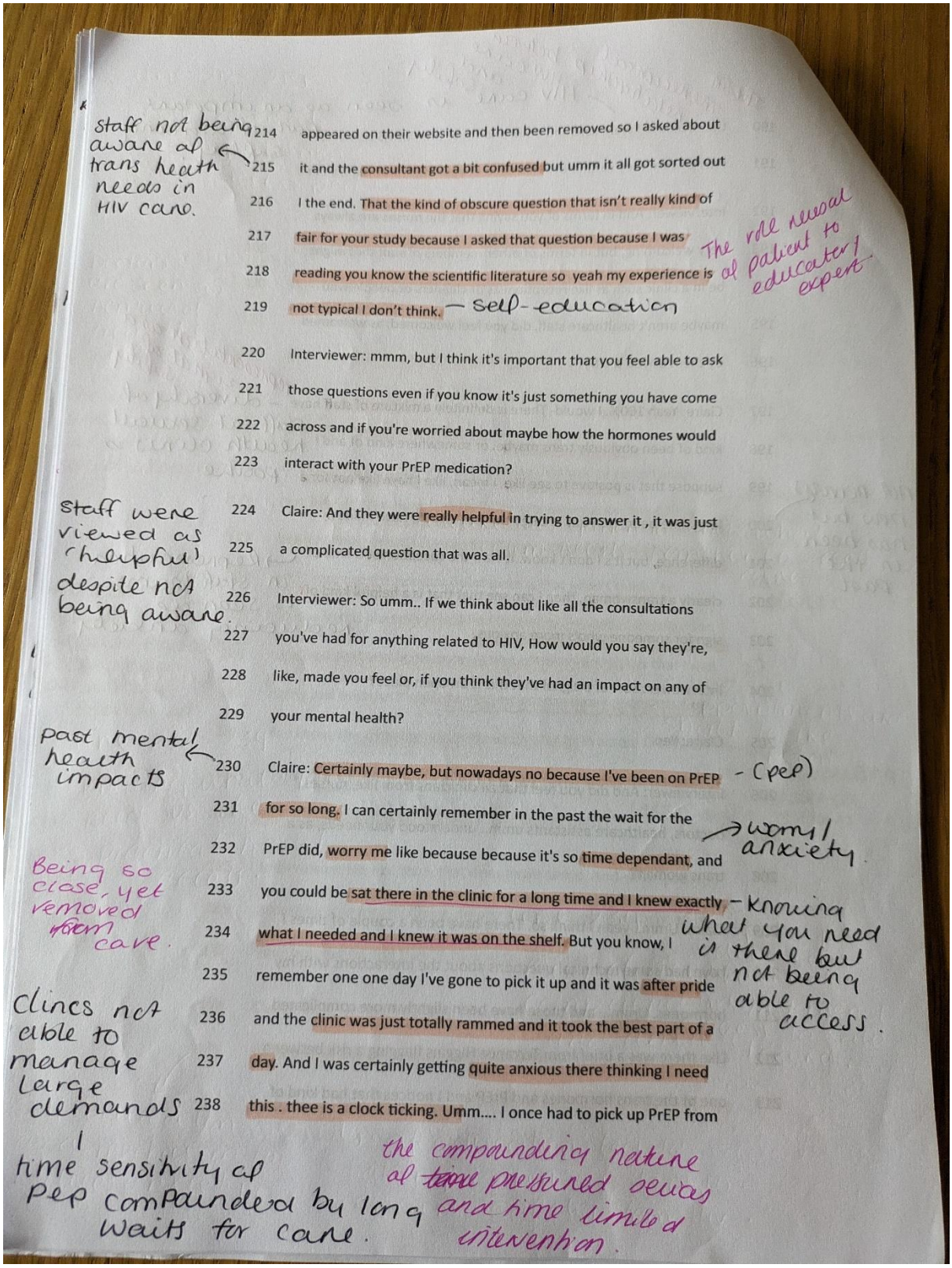
Appendix

Appendix 2-A Example of Exploratory noting (Black) and Experiential Codes (Pink) for Claire.



Appendix 2-B Development of Personal Experiential Themes (Claire)

Appendix 2-C Excerpt of Final Collection of Personal Experiential Themes (Claire)

Theme five - Access to healthcare for HIV

- ***The mental health impacts of accessing healthcare related to HIV***

  Busy sexual health services compound worry and fear (lines 38 – 39/ 234 – 238)

  Impact of waiting (line 337 -338)

  Experience of being different (line 96)

- ***Learning from the system and community***

  Navigation of the system becomes easier over time (lines 253 – 256)

  Community connection is important to collate knowledge on how to access care for HIV (lines 112 – 113)

  Stage of transition and age are linked to the stress of accessing PrEP (line 9)

  Knowing what you need vs the practicalities of access (lines 232 – 234)

  Ensuring certainty (340 – 342)

  Delays for care as a shared community experience (lines 345 -349)

- ***Convenience of accessing healthcare for HIV***

  Service access is dedicated by necessity and need (lines 65 -66 / 69)

  Trans-specific services allow for accessing holistic care (lines 81 – 88)

  Convenience promotes nomadic relationships with sexual health services (lines 142 – 144)

  Development of new ways to access encourage care-seeking (lines 153 – 158)

  Convenience of fitting healthcare for HIV into daily life (lines 49 – 53)

Appendix 2-D Development of Final Group Experiential Themes.

Appendix 2-E: Formatting Guidelines for the International Journal of Transgender Health

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Section Three: Critical Appraisal

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This thesis has explored the experiences of transwomen accessing physical healthcare settings from two novel perspectives. Firstly, this thesis presented a meta-ethnography of published qualitative research concerning the perceptions and biases of physical healthcare providers toward transwomen. Secondly, this thesis conducted a qualitative empirical study exploring the experiences of transwomen accessing UK sexual health services for healthcare related to HIV. The following critical appraisal aims to discuss a broad overview of the findings of both research papers presented and in this thesis. I will reflect critically on limitations, challenges, and my positionality within the research, exploring aspects of the research not discussed elsewhere. Finally, I will share the overall considerations and implications I considered /gained while conducting this research.

Summary and Overview of Findings

The literature review included 17 studies exploring the experiences of physical healthcare providers from a variety of disciplines. Papers were synthesised using a meta-ethnographic approach (Noblit & Hare, 1988) with four main themes identified: (1) Healthcare Providers' Perceptions Exist in the Context of a Cisnormative System, (2) The Acceptability of Transphobic and Marginalising Attitudes among Healthcare Providers, (3) Expected ways for Transwomen to exist, and (4) Education and Communication.

The empirical research paper utilised a qualitative approach to explore transwomen's experiences of accessing sexual health services for HIV care. Five participants were interviewed via semi-structured interviews, giving in-depth accounts of their own experiences accessing a range of HIV-related care, including PrEP, PEP, testing and post-diagnostic support for HIV via UK sexual health clinics. In particular, attention was given to barriers and facilitators of this experience. The data was analysed using Interpretative

Phenomenological Analysis (IPA) (Smith et al., 2022). Four main themes emerged during analysis: (1) Interpersonal Experiences of accessing healthcare for HIV, (2) The Practicalities of Accessing Healthcare for HIV, (3) “Honestly, Transwomen like kind of just look out for ourselves.”: The importance of Connection to the Community, and (4) Political and Systemic influences on HIV Healthcare.

While not surprising, both papers proved the reciprocal experiences of the other. The systematic review showed strong evidence that physical healthcare providers hold transphobic views of transwomen, while transwomen shared experiences of transphobia in the empirical research. Transphobia was evidenced and reported in ways such as misgendering and denial of healthcare. While the experiences of transphobia shared by transwomen in the empirical paper add to a growing body of literature on this experience by gender minorities within healthcare settings (Heng et al., 2018), the overt transphobia reported in the studies within the systematic literature review was perhaps more surprising in its flagrancy at times. Participants in the synthesized papers were self-selected for participation, and they did not seem to be concerned when sharing their views publicly, implying that the transphobic views they expressed were normalized within the systems and cultures within which they worked. Healthcare systems and the researchers potentially created a sense of safety for these views to be aired without fears of regulatory repercussions during the primary research.

This ignited a debate within the research team regarding the ethics of papers included in the meta-synthesis. Participants in the original papers frequently expressed opinions that could be construed as malpractice or against professional codes of conduct. However, it is unclear if the researchers of the primary research papers challenged these views; if they did, it was not commented on in the discussion sections. While I can understand researchers not wanting to prohibit important findings, there are examples of researchers interjecting and

correcting participants that are misgendering transwomen (Auerbach et al., 2020). As a research team, we discussed whether some quotes were too unequivocally offensive to reprint. This felt like an uncomfortable position to be in and opened a more extensive debate on the responsibilities of researchers to break confidentiality in such instances. The nature of qualitative research with healthcare professionals means that there is always the possibility for the disclosure of malpractice or iatrogenic harm. With the introduction of hate crime laws, it is possible that comments such as these could be construed as illegal; therefore, it is something all research projects should consider and have a protocol for. However, I wonder how this affects openness to research and the sharing of experiences and, thus, our ability to address and rectify unacceptable attitudes as a society. In future research/ clinical practice, I would follow Auerbach et al.'s 2020 lead and challenge, where appropriate, harmful attitudes.

Strengths and limitations

The majority of systematic reviews drawing together physical healthcare providers' perceptions of gender minorities group them under the label LGBTQ+ (Stewart & O'Reilly, 2017). This suggests an assumption of homogeneity of the experiences across gender and sexual minorities. As far as I am aware, this is the first review to avoid the homogenization of gender minorities and focuses solely on the perceptions of transwomen when accessing services. While this is a strength of the paper, it was difficult to find papers that contained enough first-order constructs that directly pertained to transwomen. This was due to many of the papers captured in the search strategy using the umbrella of LGBTQ+ or transgender without discrimination between transwomen and transmen.

To date, little is known about transwomen’s engagement with HIV healthcare in the UK. Some studies have looked at PrEP acceptability within Cis- and trans- women in the UK. However, these studies have usually had very small numbers of transwomen within their data

(Whelan et al., 2023). The empirical paper presented here is the first UK study to qualitatively explore transwomen's experiences of accessing sexual health services specifically for HIV-related healthcare. While most research into transgender individuals' experiences is London-centric, this paper's interview strategy of conducting interviews via telephone and Microsoft Teams allowed for participants across England and Scotland to participate, providing an inclusive view of transwomen's experiences, not restricted by geography. This adds to a gap in the research, with important clinical implications, regarding access to preventive and active HIV healthcare as the UK continues its commitment to no new transmission of HIV by 2030 (Department of Health and Social Care, 2021).

A strength of this research is that all participants were offered the option to receive a summary of the paper after it was finalized. Research has suggested that transgender individuals feel that research robs them of their stories/ experiences, with findings rarely shared back with them (Owen-Smith et al., 2016). I struggled during theme production with this feeling of "*doing to*", and I reflected in my thesis journal that "*it is hard to do justice to the stories that all my participants shared, it feels like I am leaving parts out" (19/04/2024).* This was linked to the tension between identifying data that helped to answer the research question versus leaving out parts of their experiences that did not directly speak to the research aims but still felt important.

Recruitment

Whilst it did meet the minimum recruitment target for IPA, there is no denying that the sample was small, and thus, there needs to be some caution in generalizing findings. Having said that, as there is a lack of research in this area, it is still important to listen to what has been noted in this study. Difficulties with recruitment, as well as reflections on them, are addressed below.

There are many understandable reasons why it can be difficult for transwomen to feel safe and confident in engaging with research, such as the country's context and acceptability of transwomen's identities in society (Escudero et al., 2015) and mistrust in research (Owen-Smith et al., 2016). This difficulty had been anticipated early on by the research team due to the social and political discourse around transwomen in the UK at this time. The closing of the Tavistock Clinic, alongside the systematic stripping back of gender-affirming healthcare, has contributed to an environment of mistrust, with the potential for prospective participants to be wary of our intent with this research. Therefore, multiple recruitment routes were decided to reach the required recruitment numbers. The agreed routes were via gatekeepers (NHS trans-specific sexual health service), transgender and HIV 3rd sector organisations and social media. I will reflect on the challenges posed by each of these methods.

Collaboration with the gatekeeping service and developing a PIC agreement took a long time (7 months). This led to frustrations about how NHS research and development departments often require lots of red tape on top of ethics, and this can often feel like the process is being repeated. This process was frequently outside my control, which was frustrating as time passed. Whilst there is an undoubted need for processes that ensure research is ethical and safe, this could be a barrier to important research, especially research conducted within a tight time frame.

Establishing connections with transgender and HIV charities/ organisations involved identifying services and contacting them to ask if they would share the recruitment poster. I also visited some local services in person. In total, I contacted 50 organizations across the UK. Only seven organisations emailed back to agree to pass on recruitment details. I found this incredibly demolarising and my reflective log at one point reads as *"exhausted" (19/12/2023).* I was contacted by one charity that had seen a poster, and they offered to share it on their social media pages, which was gratefully accepted. While I understand

organizations desire to protect transwomen from potentially harmful stigmatisation, I was surprised when some explicitly told me they did not want to talk about HIV. During an interview, a participant asked me if I had contacted charities to increase recruitment; I had the following reflection:

> *There is some vindication in my surprise regarding services' lack of desire to talk about HIV or give their patrons a choice to discuss this. Laura [pseudonym] finding this strange makes me wonder if there are some transwomen within these charities who want to talk about HIV and the power that is held by gatekeeps in controlling the narrative (14/03/2024)*

The turning point in recruitment came when the research was accepted for dissemination by the Gender Identity Research and Education Society (GIRES) in February 2024. GIRES has strict rules about only partnering with research studies conducted by trans scholars or who have had expert-by-experience involvement in the design. I am very grateful to our expert-by-experience who gave me their time and advice on study design, language, and recruitment.

Our search strategy for the systematic review could be argued to be too narrow due to our decision to exclude words with transphobic connotations. As a research team, we recognised the advice of our expert by experience regarding the trans community's reclaiming of words that have previously been used to oppress and marginalize them. However, due to splits in the community over acceptable language and advice from the American Psychological Society that some terms should only be used if explicitly claimed by the individual first (American Psychological Association, 2024), we decided to use language that would be considered most used in healthcare settings. In part, this decision also offered some level of safety for me to reduce distress at reading papers that, from the start, are aligned with

transphobic and derogatory views. Despite this, the review still produced papers that demonstrated distressing and unacceptable examples of transphobia.

Critical Stance and Reflections

The empirical paper used IPA (Smith et al., 2022) as its methodology, which can be argued to be centered within the structure of critical realism (Bhaskar, 1978). Critical realism acknowledges that reality exists outside of the human consciousness (Tikly, 2015) but that the factual truth of reality is subjective to the social structures that have informed participants' lives (Stutchbury, 2022). This study aimed to understand how transwomen subjectively experienced the shared phenomenon of accessing sexual health services for HIV-related healthcare. Therefore, as IPA methodology requires a detailed examination of transwomen's subjective lived experiences and development of meaning-making, the critical realist stance was considered compatible with this study (Jeong & Othman, 2016). This allowed participants' experiences of oppressive social structures to be viewed as truth, as the critical realist approach acknowledges that multiple truths of the same experiences are conceivable.

While the research team identified as white cis-women, the use of IPA as a methodology for the empirical paper allowed the research teams to 'walk in participants' shoes' (Shaw et al., 2014) while acknowledging that we could not fully understand the trans experience. The use of IPA as a methodology speaks to the trans-feminist approach, which advocates for researchers to speak to transwomen's experiences, not generally about them (Johnson, 2015). While the researcher interprets the participants' sense-making of a given phenomenon, IPA also seeks to remain as close to the participants' experiences of reality as possible (Smith & Osborn, 2015).

Personal Reflections

This research has been conducted at a time when there is a lot of toxic discourse in UK society about the validity of transwomen's identities. This has come not only from the public and media through discourses around transwomen's places in sport and access to safe spaces. But also from a government that seeks to roll back access to gender-affirming care and uses transwomen's identities as a joke to score points in the House of Commons (Walker, 2024) in the presence of a bereaved family whose beloved trans daughter had been murdered. This made me consider how unsafe it must feel to stick your head up as a transwoman, not only to share your experiences with an individual associated with an organization that is rolling back gender-affirming care, but to also talk about HIV, which is highly stigmatized.

While it was not part of my findings, I was struck that several of my participants still equated a diagnosis of HIV with a death sentence. This was despite them telling me that they knew logically that there were treatments now available for HIV that allowed you to live a "normal'' life. I wonder if this is why participants held such strong commitments to continuing to engage with sexual health services even in the face of traumatic interactions. I wonder if transwomen's exclusion from HIV awareness campaigns that have mainly focused on gay men has meant they have missed out on crucial messaging about HIV and opportunities for reassurance.

Throughout this process, I was vividly aware of my presence in the research as a cis-woman. I was asked during thesis presentations if I felt my gender played a part in my research. Upon reflection, my identity as a woman created a sense of safety for my participants than if I were male. Even if they commented on their surprise that I was not a transwoman. After Rosa's interview, I felt uncomfortable with her thanking me at the end of the interview for being willing to research this as it was important to her. Looking back, I

realize that this may be the only space she has been offered to talk opening about HIV and her trans identity. But I found my position of power in this dynamic inherently uncomfortable. Transwomen are women, with Bauer and Hammond (2015) suggesting that those who have a deeper understanding of women's experiences in healthcare will have a solid foundation from which to start. While I am not a transwoman, I carry with me my own experiences as a cis-woman both working in and accessing healthcare, which produced some shared experiences that I identified with during interviews and analysis.

Through this process of reflecting on my cis-identity within trans research, I came across the trans-feminist approach to research methodology and reflection (Johnson, 2015), which I have found very useful. The trans-feminist approach recognises the multiplicity of the experience of being a woman, be that trans or cis, and encourages reflection and critical appraisal of your own motivations and position of power. Most importantly, in my experience, the trans-feminist approach encourages reflections that may be associated with feelings of being uncomfortable as a cis-person in trans research. My discomfort is reflected in this entry from my thesis journal.

> *I am more anxious after this discussion than I was before! While I understand her point that there is no homogeneity of language used by transwomen and each individual is different, I am anxious about the possibility of causing accidental harm. (24/06/2022)*

While I felt that my approach to the research was in keeping with the trans-feminist approach, I did worry about causing accidental harm through naivety associated with my cis-identity. As a trainee clinical psychologist, I am used to reflecting on power within clinical relationships. The presence of the power imbalance between my cis-identity and my participant's trans-identity cannot be avoided; having transwomen on the research team would have mitigated this power imbalance and potentially increased feelings of safety for participants. However, I

feel this process of reflection has helped me process my place not only with the research but as a cis-gendered clinician.

Clinical implications

Both papers have many clinical implications, not just for sexual health services but also for the profession of Clinical Psychology. As briefly mentioned in the empirical paper. Developing the BITTEN Model (Selwyn et al., 2021) to understand trauma encountered in healthcare services and inform other care areas could be helpful in incorporating it into sexual health services. The BITTEN model proposes that previous encounters of **B**etrayal and exposure to trauma can **I**ndicate to patients the potential for trauma-related **T**riggers, impacting **T**rust in healthcare providers and shaping patients' future **E**xpectations and **N**eeds of healthcare (Selwyn et al., 2021). All these factors above were described in some shape or form by transwomen accessing sexual health services in the empirical paper. This model demonstrated how exposure to transphobia, like that outlined in the systematic review, brings around the mistrust that transwomen described in the empirical paper. However, this model was tested and developed on cis-gendered college students. Therefore, clinical psychologists have several roles in adapting and evaluating the BITTEN model to incorporate transwomen's healthcare experiences. One such way may be to adjust the BITTEN model as a way of formulating transwomen's experiences in healthcare systems.

Transwomen in this study did not feel that sexual health services were accessing the community where they exist and thought that the NHS had little awareness of the space transwomen occupy in society. While one participant jokes about the NHS having a Grindr profile for campaigns and contact tracing, it is a valid point. How can we expect transwomen to place themselves at risk of trauma accessing services when services do not appear to be making efforts to include transwomen in their campaigns? This exclusion of transwomen

from NHS and sexual health services campaigns around HIV perpetuates the narrative around HIV and gay men (which is a harmful stereotype in itself). HIV can and does affect everyone; globally, 51% of people living with HIV are women (Terrence Higgins Trust, 2022), with new diagnoses of HIV in heterosexual people overtaking those of gay men in the UK in 2020 (Terrence Higgins Trust, 2022). It is estimated that globally 20% of transwomen are living with HIV (Baral et al., 2013). Therefore, more needs to be done by sexual health services to be visible and present in the trans community, and HIV campaigns and advertisements become more representative alongside proactive outreach into communities that historically have not been considered high risk. This could be done in several ways, from the NHS downloading Grindr to building up strong connections with transgender researchers and advocates in their area.

Future research

The empirical paper's sample size was small for the level expected for a doctoral thesis (Smith et al., 2022). Although this raises questions regarding the quantity of data gathered, Smith et al. (2022) reinforce that data quality should be considered over quantity. All participants shared rich, in-depth narratives of their experiences accessing sexual health services for care related to HIV. Transwomen in this study had also accessed a range of sexual health services (Private, NHS, online, trans-specific and sexual health services attached to a gender identity clinic) from across the UK. Conversely, the meta-synthesis included 17 papers, which research has shown is about the average included in meta-ethnographies (Soundy & Heneghan, 2022). These papers were from across the globe, capturing physical health healthcare providers' perspectives of transwomen from both Western and collectivist cultures. However, as only three papers came from non-Western cultures, it is possible that this was limited by the decisions not to include papers not written in English and the removal of transphobic slurs from the search strategy. This limits the

generalizability of both the empirical and meta-synthesis outside the UK and Western cultures. It is widely accepted that different cultures have differing opinions on gender identity (Mazzuca et al., 2024), which is situated within their social, political and religious structures. Future research may therefore seek to draw together research on how transwomen are perceived by healthcare providers within non-western cultures.

Transwomen's experiences accessing and engaging with healthcare for HIV are still deeply misunderstood within the UK. While this empirical study is a start, it cannot fill the gap that has been neglected around transwomen's engagement with HIV within the UK context. Both papers should be used as a starting point for future research on transwomen's experiences with HIV. This group remains clinically relevant to the trajectory of HIV transmission (Kirwan et al., 2021) yet is under-represented in research in the UK. While this study focused on transwomen currently accessing services, it would be interesting to hear about the experiences of transwomen not engaging with HIV testing, PrEP or active treatment. Canadian research (Lacombe-Duncan et al., 2021) has focused on bringing together both transwomen and sexual healthcare providers' perspectives on service access, creating a shared narrative; I would be interested in the results of this within a UK context.

It is interesting to note that several participants said that they were surprised that I was not a transwoman. While my identity as a cis-woman woman was openly conveyed to participants, and they did not feel that this prevented them from participating, I think it opens a broader discourse around trans scholars/clinical psychologists within research. The academia and clinical psychology professions are perceived as elitist careers (Telling, 2020; Reynolds, 2022), with class and socioeconomic factors viewed as preventing access. It is, therefore, possible that this may act as a barrier to transwomen entering these professions. From conducting this research, I believe that all further research in this area should be trans-led with more inclusivity of trans scholars and advocates. Not only would this potentially

open up recruitment, but it would allow research to be directed towards areas of HIV care that the trans community feels are more pertinent to their experiences.

Conclusion

This is the first study to qualitatively explore transwomen's experiences of accessing healthcare for HIV via sexual health clinics in the UK, providing a unique insight into care seeking for HIV for transwomen. Both papers within this review identify the complexity around gender identity and HIV healthcare, in particular, the intertwined nature of these experiences within the broader social and political discourse. On a personal note, it has been a privilege to be trusted to share the stories of the transwomen within my study, and I have learnt so much throughout this process. Mostly, I have learnt just how much I do not know and how much work remains to be done. As I move into my clinical career, I hope to continue to amplify the voices of trans and non-binary clients within the services I work in and to use my power as a clinical psychologist to advocate for equal access to healthcare across the board.

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Appendix 3-A: Formatting Guidelines for the International Journal of Transgender Health

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Contents

- Publication Charges
- Copyright Options
- Complying with Funding Agencies
- My Authored Works

About the Journal

International Journal of Transgender Health is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

International Journal of Transgender Health accepts the following types of article:

- Articles

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*Citations received up to 9th June 2021 for articles published in 2018-2022. Data obtained on 23rd August 2023, from Digital Science's Dimensions platform, available at https://app.dimensions.ai **Usage in 2020-2022 for articles published in 2018-2022.

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All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, prepared by the International Committee of Medical Journal Editors (ICMJE).

Article Types

Articles

- Should be written with the following elements in the following order: abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list)
- Should contain a structured abstract of 250 words.
- Read making your article more discoverable, including information on choosing a title and search engine optimization.

- While the journal has no word limit for submissions, manuscripts published are typically no more than 8000 words, all inclusive.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use American spelling style consistently throughout your manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”.

Please note that long quotations should be indented without quotation marks.

Formatting and Templates

Papers may be submitted in Word format. Please do not submit your paper as a PDF. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

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When reporting studies that involve human participants, authors should include a statement that the studies have been approved by the appropriate institutional and/or national research ethics committee and have been performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.
If doubt exists whether the research was conducted in accordance with the 1964 Helsinki Declaration or comparable standards, the authors must explain the reasons for their approach, and demonstrate that the independent ethics committee or institutional review board explicitly approved the doubtful aspects of the study.
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Ethical approval: "All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards."
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For studies with animals, the following statement should be included in the text before the References section:
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If applicable (where such a committee exists): "All procedures performed in studies involving animals were in accordance with the ethical standards of the institution or practice at which the studies were conducted."
If articles do not contain studies with human participants or animals by any of the authors, please select one of the following statements:
"This article does not contain any studies with human participants performed by any of the authors."

"This article does not contain any studies with animals performed by any of the authors."
"This article does not contain any studies with human participants or animals performed by any of the authors."

Informed consent
All individuals have individual rights that are not to be infringed. Individual participants in studies have, for example, the right to decide what happens to the (identifiable) personal data gathered, to what they have said during a study or an interview, as well as to any photograph that was taken. Hence it is important that all participants gave their informed consent in writing prior to inclusion in the study. Identifying details (names, dates of birth, identity numbers and other information) of the participants that were studied should not be published in written descriptions, photographs, and genetic profiles unless the information is essential for scientific purposes and the participant (or parent or guardian if the participant is incapable) gave written informed consent for publication. Complete anonymity is difficult to achieve in some cases, and informed consent should be obtained if there is any doubt. For example, masking the eye region in photographs of participants is inadequate protection of anonymity. If identifying characteristics are altered to protect anonymity, such as in genetic profiles, authors should provide assurance that alterations do not distort scientific meaning.
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Informed consent: "Informed consent was obtained from all individual participants included in the study."
If identifying information about participants is available in the article, the following statement should be included:
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In order to ensure the public availability of the results of randomized controlled trials, the International Committee of Medical Journal Editors has suggested that

all such trials should be registered. In common with many other leading journals, International Journal of Transgenderism has decided to follow this policy. We will not review any paper submitted to us reporting a randomized clinical trial unless the trial was registered in a public trial registry from the date it commenced recruitment or, if recruitment started before 31 December 2008, we require that the trial was registered no later than 31 December 2008.
All manuscripts reporting randomized controlled trials should have the following sent with them or they will be returned to the authors.
i) A check list and flow chart in accordance with the CONSORT guidelines which can be found at http://www.consort-statement.org. Please send in the checklist as a supplementary file and include the flow chart as Figure 1 in the manuscript.
ii) The trial protocol is to be submitted as a supplementary file. This will not be published, but it is needed to appraise and peer review the paper.
iii) The registration number of the trial and the name of the trial registry in which it was registered. Please add these to the last line of the paper's structured abstract. Trials that began enrolment of patients after 1 January 2009 must be registered in a public trials registry at or before the onset of enrolment to be considered for publication in International Journal of Transgenderism. Trials that began enrolment prior to 31 December 2008 must have been registered no later than that date. Our criteria for a suitable public trial registry are: free to access; searchable; identification of trials by unique number; free or minimal cost for registration; validation of registered information; inclusion of details to identify the trial and the investigator within the registered entry (including the status of the trial); research question; methodology; intervention; and funding and sponsorship disclosed.
If the research was paid for by a funding organization, the cover letter must contain the following three statements. If the research was not paid for by a funding organization only the third statement is required:
a. That the authors have not entered into an agreement with the funding organization that has limited their ability to complete the research as planned and publish the results.
b. That the authors have had full control of all the primary data.
c. That the authors are willing to allow the journal to review their data if requested.

References

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Checklist: What to Include

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25. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:
    For single agency grants
    This work was supported by the [Funding Agency] under Grant [number xxxx].
    For multiple agency grants
    This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].
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Please ensure that all research reported in submitted papers has been conducted in an ethical and responsible manner, and is in full compliance with all relevant codes of experimentation and legislation. All original research papers involving humans, animals, plants, biological material, protected or non-public datasets, collections or sites, must include a written statement in the Methods section, confirming ethical approval has been obtained from the appropriate local ethics committee or Institutional Review Board and that where relevant, informed consent has been obtained. For animal studies, approval must have been obtained from the local or institutional animal use and care committee. All research studies on humans (individuals, samples, or data) must have been performed in accordance with the principles stated in the Declaration of Helsinki. In settings where ethics approval for non-interventional studies (e.g. surveys) is not required, authors must include a statement to explain this. In settings where there are no ethics committees in place to provide ethical approval, authors are advised to contact the Editor to discuss further. Detailed

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Authors are further encouraged to cite any data sets referenced in the article and provide a Data Availability Statement.

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Updated 30th April 20

Section Four: Ethics Section

Ethics application for research paper: 'Honestly, transwomen just look out for ourselves." Experiences of HIV Care in Sexual Health Clinics

Crystal Webster

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Word Count: 6000

All Correspondence to be sent to:

Crystal Webster

Doctorate in Clinical Psychology

Health Innovation One,

Lancaster University,

Bailrigg,

Lancaster,

LA1 4AT

Email: c.webster@lancaster.ac.uk

Prepared for submission to: International Journal of Transgender Health (see appendix 2-E for author guidelines)

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters) Experiences of Trans women accessing healthcare for HIV

1. Is your project research?

(●) Yes ( ) No

2. Select one category from the list below:

( ) Ionising Radiation for combined review of clinical trial of an investigational medicinal product

( ) Ionising Radiation and Devices form for combined review of combined trial of an investigational medicinal product and an investigational medical device

( ) Clinical investigation or other study of a medical device

( ) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice

( ) Basic science study involving procedures with human participants

( ) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitativemethodology

(●) Study involving qualitative methods only

( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific projectonly)

( ) Study limited to working with data (specific project only)

( ) Research tissue bank ( ) Research database

If your work does not fit any of these categories, select the option below: ( )
Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation? ( ) Yes (●) No

b) Will you be taking new human tissue samples (or other human biological samples)? ( ) Yes (●) No

c) Will you be using existing human tissue samples (or other human biological samples)? ( ) Yes (●) No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

[✓] England

☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

◉ England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which applications do you require?

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ HM Prison and Probation Service (HMPPS)

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

○ Yes ◉ No

5. Will any research sites in this study be NHS organisations?

◉ Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out the research e.g. NHS support costs) for this study provided by a NIHR Biomedical Research Centre (BRC), NIHR Applied Research Collaboration (ARC), NIHR Patient Safety Translational Research Centre (PSTRC), or an NIHR Medtech and In Vitro Diagnostic Co-operative (MIC) in all study sites?

Please see information button for further details.

○ Yes ◉ No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ◉ No

The NIHR Clinical Research Network (CRN) provides researchers with the practical support they need to make clinical studies happen in the NHS in England e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, information from your IRAS submission will automatically be shared with the NIHR CRN. ***Submission of a Portfolio Application Form (PAF) is no longer required.***

6. Do you plan to include any participants who are children?

○ Yes ◉ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ◉ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
This project forms part of a doctoral thesis for the qualification of a Doctorate in Clinical Psychology. The Trainee (Student) is supervised by a member of staff of the DClinPsy team at Lancaster University, who will act as the Principal Investigator for the study.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ◉ No

Integrated Research Application System
Application Form for Research involving qualitative methods only

IRAS Form (project information)

Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms) Experiences of Trans women accessing healthcare for HIV

Please complete these details after you have booked the REC application for review.

REC Name:
North West - Greater Manchester East Research Ethics Committee

REC Reference Number:	**Submission date:**
23/NW/0113	23/03/2023

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Trans women's experiences of accessing healthcare for HIV via UK-based sexual health services.

A2-1. Educational projects

Name and contact details of student(s):

Student 1

Title	Forename/Initials	Surname
Miss	Crystal	Webster

Address: Doctorate in Clinical Psychology
Health Innovation one
Sir John Fisher Drive, Lancaster University

Post Code: LA1 4AT

E-mail: c.webster@lancaster.ac.uk

Telephone

Fax

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Doctorate in Clinical Psychology (DClinPsy).

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

Title	Forename/Initials	Surname
	Dr Katy	Bourne
Address	Doctorate in Clinical Psychology	
	Health Innovation One	
	Sir John Fisher Drive, Lancaster University	
Post Code	LA1 4AT	
E-mail	k.bourne@lancaster.ac.uk	
Telephone		
Fax		

Academic supervisor 2

Title	Forename/Initials	Surname
	Dr Rachael	Eastham
Address	Faculty of Health and Medicine	
	Health Innovation One	
	Sir John Fisher Drive, Lancaster University	
Post Code	LA1 4AT	
E-mail	r.eastham1@lancaster.ac.uk	
Telephone		
Fax		

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Miss Crystal Webster	☑ Dr Katy Bourne ☐ Dr Rachael Eastham

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- ○ Student
- ◉ Academic supervisor
- ○ Other

A3-1. Chief Investigator:

Title Forename/Initials Surname

	Dr Katy Bourne
Post	Clinical Psychologist/ Research Supervisor
Qualifications	
ORCID ID	
Employer	Lancaster University
Work Address	Doctorate in Clinical Psychology Health Innovation One Sir John Fisher Drive, Lancaster University
Post Code	LA1 4AT
Work E-mail	k.bourne@lancaster.ac.uk
* Personal E-mail	
Work Telephone	
* Personal Telephone/Mobile	
Fax	

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project? *This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.*

Title Forename/Initials Surname

Address	Head of Research Quality and Policy Lancaster University
Post Code	LA1 4YT
E-mail	
Telephone	
Fax	

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	N/A
Sponsor's/protocol number:	N/A
Protocol Version:	N/A
Protocol Date:	
Funder's reference number (enter the reference number or state not applicable):	N/A
Project website:	N/A

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)"

section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ◉ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

Transgender women are more likely to test positive for human immunodeficiency virus (HIV) than the general population. Healthcare for HIV in the UK may be accessed via several routes, including sexual health clinics. We are interested in looking at the experiences of trans women who have accessed care for HIV through sexual health clinics to better understand their experiences in services. In particular, we are keen to learn more about what facilitates or prevents access to services and how well their needs are met when they do access services. We aim to interview 6-12 trans women who have accessed care for HIV in the UK in a sexual health clinic in the last three years. Many of the healthcare services that have been designed specifically for trans people are in London. Due to this, the majority of the research into HIV in the UK is London-Centric, and we aim to recruit a geographically-diverse sample.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Consent/ recruitment
If the recruitment is via one of the NHS Trusts or third part charities, then posters will be disseminated via public spaces (e.g waiting rooms, website). First contact with the research team will be made by the participant, who will provide the research team with their details and consent for their details to be used by the research team. This allows participants to take part without their NHS team being aware. Upon consultation with an LGBTQ+ charity in Lancashire, they suggested that members of the LGBTQ+ community may be less willing to take part in research if there is a fear that what they say will be reported back to their care team in a way that is identifiable.
If participants are recruited via social media, then they will approach me in order to provide their details and give their consent for their details to be used by the research team.
At the start of the interview, then participants will be informed that if the researcher feels that they are at risk of harm to themselves or others then the interview will be paused and the researcher may have to break their confidentiality. This will be done as per the distress protocol and in consultation with the wider research team.
Once the study has been completed then participants will be asked at the end of their interview if they wish to receive an anonymised copy of the report. Anonymised data will be stored securely for 10 years as per Lancaster University policy.

Risk to participants
The interview is not expected to cause participants any significant distress. However, it is possible that some participants may have had experiences during their care which may have caused them distress. If a participant discloses that they or others are at any risk of harm, then the interview will be terminated and the researcher, who is a mental health professional, will risk assess as to appropriate action to be undertaken as per the risk protocol (e.g. researcher will liaise with research supervisor before reporting to onward sources such as safeguarding.
Consultation with a Lancashire-based LGBTQ+ charity has allowed the research team to consider the use of inclusive language in participant documents.

Risk to Research Team

Where interviews are being conducted by a lone member of the team, particularly in person, then the researchers will adhere to Lancaster University and Lancashire and South Cumbria Foundation Trust's policies for lone working. Teams check-in spaces will be provided after interviews with the academic supervisor, regardless of the method of interview, in order to provide a debrief space for the researcher should it be required. Regular supervision with both academic and field supervisors will continue throughout the duration of the project.

Data Storage
All electronic data will be encrypted and stored securely on the Lancaster University cloud One Drive storage. Only the research teams will have access to participants' data. Paper consent forms will be scanned and then destroyed. Interview data will be kept on secure Lancaster university cloud storage and will be destroyed once anonymised transcripts are produced to protect participants anonymity and confidentiality.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply*:

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☑ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

How do trans women experience accessing health care and treatment for human immunodeficiency virus (HIV) via sexual health clinics in the UK?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.* N/A

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

The word transgender is an umbrella term for a person whose gender expression/ identity is different from the binary sex that they were assigned at birth (Stonewall, 2022).

Transgender people are more likely to suffer from sexual health problems than their cisgender peers (Reisner et al. 2016; McNeil et al., 2012). Human immunodeficiency virus (HIV) is one area of sexual healthcare in which trans individuals, in particular trans women, are disproportionately impacted. Globally, trans women are at higher risk of contracting HIV, with up to 19% of trans women currently living with HIV (Baral et al., 2013). This is even greater in highincome countries, and it is estimated that in the UK 21.6% of trans women are living with HIV (Baral et al, 2013).

In the UK access to pre-exposure prophylaxis (PrEP) and HIV health care is provided via sexual health clinics; this is important as the taking of PrEP can prevent infection of HIV if taken as clinically indicated (McCormack et al., 2016). It is understandable that transgender people may avoid seeking treatment for HIV if they feel that sexual health services have a negative attitude towards trans individuals.

Suchak, Hussey, Takhar & Bellringer (2015) noted that there is no mention of trans-specific sexual health needs in the Community Sexual and Reproductive Health Curriculum for Health [CSRH] Professionals. Since this paper was published the curriculum has been updated, however, the management of transgender sexual health problems was still only listed as 5 bullet points (CSRH, 2020, p.23). This lack of consideration for transgender people's needs is contrary to the principles of sexual health and creates health inequality for trans women, reflecting the social inequalities they experience in wider society.

Encountering barriers when accessing sexual health services can decrease trans women's willingness to seek care and openness to services. This is exacerbated by reports of misgendering and the use of dead names by staff within these services (Hibbert et al., 2020). This research aims to identify barriers and examples of good care experienced by trans women when accessing sexual health services for HIV, and the implications this has for physical and mental well-being. This may help to inform service design and staff training to help move sexual health services toward being more inclusive.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

Design
This study will collect qualitative data and analyse data using interpretative phenomenological analysis (IPA).

Recruitment
Participants will be recruited via two routes:
In the first instance, participants will be recruited through an NHS trans-specific sexual health service and via existing relationships with LGBTQ+ charities. Posters will be sent to these organisations to share with potential participants. in the case of the NHS service, an existing database of trans women will be emailed the research poster and advised to contact the research team directly if they have questions or wish to take part.
Any interested participants will be asked to contact the research team directly using the information provided on the poster. Once contact has been made by the potential participant, the research team will email the interested potential participant the participant information sheet and consent form. They will be asked to sign the consent form and send it back to the research team prior to an interview date and time being agreed upon. Participants will be able to choose between, phone, Microsoft teams, and face-to-face interviews. Although face-to-face interviews may be restricted based on participant location.

Data Collection
The aim of this study is to collect data on the experiences of trans women accessing sexual health clinics for healthcare related to HIV in the last three years. Semi-structured interviews will be conducted to explore participants' experiences. The data will then be analysed using IPA, allowing analysis to focus on individual experiences.

At the same time in an attempt to capture a range of experiences, participants will be recruited using social media groups. The poster will be disseminated with group admin permission. Potential participants can contact the researcher directly to express interest via the information provided on the poster. At this point, the research team will email interested potential participants the participant information sheet and consent form.

Participants
All participants will be aged 18 or over and self-identify as a trans woman or trans femme. Participants will also have accessed a UK-based sexual health service for care relating to HIV in the last three years.

Stakeholder involvements
Experts by experience have been involved in the study design. Members from a Lanchaire-based LGBTQ+ charity consulted with the main researcher prior to the creation of documents regarding inclusive language and plans for recruitment.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

☑ Design of the research
☐ Management of the research
☐ Undertaking the research
☐ Analysis of results
☐ Dissemination of findings ☐ None of the above

Give details of involvement, or if none please justify the absence of involvement.
Experts by experience have been involved in the study design. Members from a Lancashire-based LGBTQ+ charity consulted with the main researcher prior to the creation of documents regarding inclusive language and plans for recruitment.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

☐ Blood
☐ Cancer
☐ Cardiovascular
☐ Congenital Disorders
☐ Dementias and Neurodegenerative Diseases
☐ Diabetes
☐ Ear
☐ Eye
☐ Generic Health Relevance
☐ Infection
☐ Inflammatory and Immune System
☐ Injuries and Accidents
☑ Mental Health
☐ Metabolic and Endocrine
☐ Musculoskeletal
☐ Neurological
☐ Oral and Gastrointestinal
☐ Paediatrics
☐ Renal and Urogenital
☐ Reproductive Health and Childbirth
☐ Respiratory
☐ Skin
☐ Stroke

Gender: Male and female participants

Lower age limit: 18	Years
Upper age limit:	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Participants will self-identify as trans women or trans-femme, be 18 years or older, and have accessed a UK sexual health clinic for treatment related to human immunodeficiency virus (HIV) in the last three years.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Anyone who does not identify as a trans woman or anyone who has accessed a sexual health clinic for needs not related to HIV.
Anyone under the age of 18 will also be excluded from this study.
Unfortunately, as there is no funding for this study, we are unable to finance interpreters. Therefore individuals who are unable to speak conversational English to the level needed for the interview are not eligible to take part

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research,how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Responding to research advert and expressing interest.	1	0	10	Participant
Initial correspondence with potential participant	1	0	10-20	Main researcher (Crystal)
Consent form completed (remotely)	1	0	10-15	Participant
Consent form completed (in person)	1	0	10-15	Participant and main researcher (Crystal)
Participation in a 1:1 interview with a member of the research team. Questions around service access and care for HIV.	1	0	45-60	The main researcher (crystal) will conduct the 1:1 interview via either Microsoft teams, telephone or face to face.

A21. How long do you expect each participant to be in the study in total?

The study will be recruiting for approximately six months (January -June 2023). Participants will only be actively involved in the study for the interview which will last approximately 1 hour. Prior to this they will have as long as they need to decide whether or not to take part, and they will have 2 weeks after this to withdraw their data if they change their minds.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

The interview process is not anticipated to cause any significant distress to participants. However, some questions regarding service access may touch on subjects that participants may find sensitive in nature.

The interview schedule has been reviewed by the research team and stakeholders and is not indicated to be likely to lead to disclosures of risk (to self or others). Participants will be provided with general advice and ongoing support providers by using the participant's information sheet and debrief information. The main researcher's email address will be given as a point of contact. If a disclosure should be made then the lead researcher will discuss with research supervisor as well as discussing any concern with the participant before passing details onto the relevant services (e.g. GP, A&E, or in extreme circumstances the police). If the research team becomes concerned at any point then participants will be advised that their details may be shared with relevant services (police welfare checks). This will be decided by consultation with the academic supervisor. participants will be provided with the contact details of an independent member of the Lancaster University Staff team should they wish to discuss any concerns to make a complaint.
The researcher will take steps to minimize the burden on the participants by keeping the interviews to no more than an hour, and, where possible, arranging it at a time that suits them, and via their preferred medium (Face to face, video call, telephone).

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

◉ Yes ○ No

If Yes, please give details of procedures in place to deal with these issues:

The subject of sexual health can be sensitive and or embarrassing for participants to talk about. The participant information sheet provides enough information for participants to make an informed choice as to whether this is a study for them.
Participants do not have to answer questions they do not feel comfortable answering in the interview and can terminate the interview at any point without having to give a reason. Should participants become distressed or upset during the interview, they will also be given the option to pause and return to the interview.

A24. What is the potential for benefit to research participants?

There is no direct benefit to participants for participating, although they may enjoy giving feedback about services in order to improve them in the future. A £40 voucher draw will take place to thank participants for taking part. Participants will be asked if they wish to receive a copy of the final anonymised research paper.

A26. What are the potential risks for the researchers themselves? *(if any)*

It is not anticipated any member of the research team will come to any harm during the completion of this study. It is anticipated that most interviews will happen over the phone or virtually via Microsoft teams. Where a participant chooses to be interviewed 1:1 face to face, the main researcher will adhere to the Lancaster University lone working policy.
If the student experiences distress during the study they will be able to speak to their supervisors and they will receive regular supervision throughout the study

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Participants will be recruited via two routes:

1. In the first instance, participants will be recruited through an NHS trans-specific sexual health service and via linksestablished in the charity and voluntary sector by the field supervisor. Posters will be sent to these organizations to share with potential participants. For NHS participants at the PIC site, posters will be placed on walls in the clinic room. The identified PIC site has an existing database of trans and gender-diverse patients, to which they will send the advert directly. Any interested participants will be asked to contact the main researcher directly using the information provided on the disseminated poster. At this point, the research team will email interested potential participants the participant information sheet and consent form. This will target participants in the North of England.

2. At the same time in an attempt to capture a range of experiences, participants will be recruited using social mediagroups. The poster will be disseminated with group admin permission. Potential participants can contact me directly to express interest via the information provided on the poster. At this point, the research team will email interested potential participants the participant information sheet and consent form. This will help provide a wider geographical sample.

Once the completed consent form has been returned via email or post, the main researcher will schedule a 1:1 interview. The method of interview will be decided by the participant (e.g Microsoft Teams, Telephone, or face-to-face depending on geographical locations).

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

◉ Yes ○ No

Please give details below:
Staff at identified PIC sites may screen information of patients in order to determine who they direct adverts to.

A27-3. Describe what measures will be taken to ensure there is no breach of any duty of confidentiality owed to patients, service users or any other person in the process of identifying potential participants. *Indicate what steps have been or will be taken to inform patients and service users of the potential use of their records for this purpose. Describe the arrangements to ensure that the wishes of patients and service users regarding access to their records are respected. Please consult the guidance notes on this topic.*

Care team will direct patients towards advert only. It is up to potential participants to contact the research team directly.
Staff teams will not have direct contact with research team past sending of recruitment adverts.
Therefore staff teams will not know if any of their patients re actively participating in the research.
Staff may see final research paper but this will be anonymised and no identifiable information will be available.

A27-4. Will researchers or individuals other than the direct care team have access to identifiable personal information of any potential participants?

○ Yes ◉ No

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

◉ Yes ○ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

Posters will be disseminated to NHS sexual health clinics to be displayed in waiting rooms and posted on social media in LGBTQ+ groups.

A29. How and by whom will potential participants first be approached?

Potential participants will email the principal researcher via the email provided on the recruitment poster to convey their interest in participating. Then the main researcher will respond to the interest email with a copy of the participant information sheet and consent form for participants to consider.

A30-1. Will you obtain informed consent from or on behalf of research participants?

◉ Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be

done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

In the first instance, participants will be recruited through an NHS trans-specific sexual health service and via existing relationships with LGBTQ+ charities. Posters will be sent to these organisations to share with potential participants. In the case of the NHS service, an existing database of trans women will be emailed the research poster and advised to contact the research team directly if they have questions or wish to take part.
Any interested participants will be asked to contact the research team directly using the information provided on the poster. Once contact has been made by the potential participant, the research team will email the interested potential participant the participant information sheet and consent form. Participants will be encouraged to take their time to consider the information and ask any questions before proceeding.
They will be asked to sign the consent form and send it back to the research team via either email or post to Lancaster university, prior to an interview date/time being agreed upon. If for some reason this is not possible (e.g reasonable adjustment for disability) then verbal consent will take place over the phone/ video call and this will be recorded separately from the main interview. Participants will be able to choose between, phone, Microsoft teams, and face-to-face interviews. Although face-to-face interviews may be restricted based on participant location.

If you are not obtaining consent, please explain why not.

N/A

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

◉ Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

There is no specific time given for potential participants to decide whether to take part. They will be sent the participant information sheet and consent form after they express interest in participation. Interviews will be scheduled upon the return of the completed consent form.
Participants may be contacted again via email if recruitment becomes an issue, however, this is intended as a reminder rather than to coerce participation.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters)*

Participants will need to understand verbal explanations in English to participate in the interview, so they will be excluded if this is not possible. If someone were not able to understand written information (for example, visual impairment or reading age is not with information materials) then the participant information sheet would be read to them or copies provided in large font. Consent would be taken verbally and audio recorded.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

◉ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:
It will not be possible to monitor capacity as the participant will have no contact with the research team following the interview.

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Access to social care records by those outside the direct social care team
- ☑ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☑ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☐ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☐ Use of audio/visual recording devices
- ☑ Storage of personal data on any of the following:
  - ☐ Manual files (includes paper or film)
  - ☐ NHS computers
  - ☐ Social Care Service computers
  - ☐ Home or other personal computers
  - ☑ University computers
  - ☐ Private company computers
  - ☐ Laptop computers

Further details:
The research team will not be sent a database of contact details for potential participants from the PIC site. The PIC site will make the first contact and direct potential participants to contact the research team directly using the information provided on the poster if they wish to participate.

A37. Please describe the physical security arrangements for storage of personal data during the study?

Anonymised data will be stored on the main researchers' secure Lancaster University cloud storage (e.g onedrive). Data will only be accessed via password-protected laptops and will only be accessible by the main researcher and named supervisors.

Personal data on paper will be made electronic and then destroyed immediately afterward. Electronic personal data will be kept securely on the main researchers' secure Lancaster University cloud storage (e.g onedrive).

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

Participants will be asked to choose a pseudonym, or one will be randomly allocated to them. Transcripts will be anonymized, with any identifiable data being redacted/ removed (e.g place names, names of people, addresses). Anonymised transcripts will then be analyzed using Interpretative phenomenological analysis (IPA) with anonymized pseudonym-linked quotes being used in the final write-up.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Only the main researcher and named supervisors will have access to participants' contact information. This will only take place after consent has been obtained for participation.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

Data will be analysed by myself (Crystal Webster) at Lancaster University under the supervision of Dr. Katy Bourne and Dr. Rachel Eastham. Sections of anonymised transcripts may be analysed by the research supervisors and notes compared as per the process of IPA.

A42. Who will have control of and act as the custodian for the data generated by the study?

Title	Forename/Initials	Surname
	Dr Katy	Bourne
Post	Research Supervisor/ Clinical Psychologist	
Qualifications		
Work Address	Lancaster University	
	Health Innovation One	
	Sir John Fisher Drive	
Post Code	LA1 4YW	
Work Email	k.bourne@lancaster.ac.uk	
Work Telephone		
Fax		

A43. How long will personal data be stored or accessed after the study has ended?

- ○ Less than 3 months
- ○ 3 – 6 months
- ○ 6 – 12 months
- ○ 12 months – 3 years
- ◉ Over 3 years

If longer than 12 months, please justify:
Consent forms and transcripts will be stored for 10 years from study completion or publication date whichever comes last. These will be anonymised and kept separately. Audio recordings will be kept until the thesis examination at the viva and then destroyed. All other personal information (e.g sending participants a consent form/ copy of the results) will be destroyed within 6 months of the study completion.

A44. For how long will you store research data generated by the study?

Years: 10

Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

On completion of the thesis project, data will be transferred to the Lancaster DClinPsy research coordinator via OneDrive. The electronic consent forms and transcripts will be stored securely on the Lancaster University network (or Onedrive) by the research coordinator of the doctorate in clinical psychology programme under the direction of the academic supervisor (Katy Bourne) for 10 years and then deleted.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research? ◉ Yes ○ No

If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined.
Participants will be asked if they wish to be entered into a prize draw to win a voucher up to the value of £40, as a thank-you for their participation.

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ◉ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ◉ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ◉ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

○ Yes ◉ No

Please give details, or justify if not registering the research.
The research team is not currently aware of a suitable register.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

- ☑ Peer reviewed scientific journals
- ☑ Internal report
- ☑ Conference presentation
- ☐ Publication on website
- ☐ Other publication
- ☐ Submission to regulatory authorities
- ☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committeeon behalf of all investigators
- ☐ No plans to report or disseminate the results
- ☐ Other (please specify)

It is intended this study will be published as part of a Doctoral thesis paper. Services that agree to disseminate recruitment posters will be offered an anonymised summary of findings related to their service, upon request.

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

All personal data will be anonymised prior to data analysis and publishing of results.

A53. How and when will you inform participants of the study results?

If there will be no arrangements in place to inform participants please justify this.
Individuals will be invited at the end of the interview to contact the main researcher should they wish to be sent a copy of the final report.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- ☐ Independent external review
- ☐ Review within a company
- ☐ Review within a multi−centre research group
- ☑ Review within the Chief Investigator's institution or host organisation
- ☑ Review within the research team
- ☑ Review by educational supervisor
- ☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The Lancaster University research team reviewed the research proposal. Following approval, the study has been discussed with the academic and field supervisors. Study materials have also been reviewed by stakeholders. The Lancaster University sponsorship team has reviewed the research and its materials.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 10

Total international sample size (including UK): 10

Total in European Economic Area: 0

Further details:
A minimum sample of 6 and maximum of 10 participants will be recruited for the study.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

The study aims to recruit around 6-10 participants as recommended by Smith et al. (2009) for professional doctorates using IPA. This number of participants is also manageable in the timescale of the doctorate thesis.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The analysis will be conducted using guidelines from IPA (Smith et al., 2009). interviews will be transcribed and then analysed line by line, making note of emerging themes. Emergent themes will then be collated and grouped into categories. Continual re-reading will be used to ensure that individual experiences are reflected in the main themes. Bias will be reflected upon and sections of transcripts will be analysed by the wider research team and themes/ notes compared.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co−applicants, protocol co−authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

Title Forename/Initials Surname

Post
Qualifications
Employer
Work Address

Post Code
Telephone
Fax
Mobile
Work Email

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status: ◯ NHS or HSC care organisation Commercial status: Non-

◉

◯

◯

◯

◯

Legal representative for clinical investigation of medical device (studies involving Northern Ireland only)
Clinical Investigations of Medical Devices that take place in Northern Ireland must have a legal representative of the sponsor that is based in Northern Ireland or the EU

Contact person

Name of organisation
Given name
Family name
Address
Town/city
Post code
Country
Telephone
Fax
E-mail

A65. Has external funding for the research been secured?

Commercial

Academic

Pharmaceutical industry

Medical device industry

Local Authority

Other social care provider (including voluntary sector or private organisation)

Other

If Other, please specify: N/A

Contact person

Name of organisation Lancaster University

Given name

Family name

Address Head of Research Quality and Policy

Town/city Lancaster University

Post code LA1 4YT

Country United Kingdom

Telephone

Fa

E-mail sponsorship@lancaster.ac.uk

Please tick at least one check box.

☐ Funding secured from one or more funders

☐ External funding application to one or more funders in progress ☑ No application for external funding will be made

What type of research project is this?

◉ Standalone project

○ Project that is part of a programme grant

○ Project that is part of a Centre grant

○ Project that is part of a fellowship/ personal award/ research training award ○ Other

Other – please state:

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.* ○ Yes ◉ No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

Title Forename/Initials Surname

Organisation
Address

Post Code
Work Email
Telephone
Fax
Mobile

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/03/2023 Planned end date: 22/03/2024 Total duration:

Years: 1 Months: 0 Days: 22

A71-1. Is this study?

◉ Single centre
○ Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study 2

Does this trial involve countries outside the EU?

○ Yes ◉ No

A72. Which organisations in the UK will host the research?*Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

☐ NHS organisations in England 0
☐ NHS organisations in Wales
☐ NHS organisations in Scotland
☐ HSC organisations in Northern Ireland
☐ GP practices in England
☐ GP practices in Wales
☐ GP practices in Scotland
☐ GP practices in Northern Ireland
☐ Joint health and social care agencies (eg

community mental health teams)
☐ Local authorities
☐ Phase 1 trial units
☐ Prison establishments
☐ Probation areas
☐ Independent (private or voluntary sector)

organisations
☑ Educational establishments 1
☐ Independent research units
☐ Other (give details)

Total UK sites in study: 1

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

◉ Yes ○ No

A73-2. If yes, will any of these organisations be NHS organisations?

◉ Yes ○ No

If yes, details should be given in Part C.

A73-3. Approximately how much time will these organisations expect to spend on screening records and/or provision of information to potential participants, and how will the costs of these activities be funded?

The PIC site will be expected to spend no more than 30 minutes on the provision of information to potential participants. The PIC site has an existing database of trans women to which they will email the poster. Potential participants will then contact the researcher directly to enquire. There are no anticipated costs to the PIC site.

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

The research team will be in regular contact during the study to ensure it is progressing as planned. The trainee clinical psychologist involved in the study will receive regular supervision from thier supervisors.

A76. Insurance/ indemnity to meet potential legal liabilities

***Note:* in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland**

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University liability will apply.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only) ☑

Other insurance or indemnity arrangements will apply (give details below)

Lancaster University liability will apply.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

- ☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
- ☑ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

NHS indemnity will apply to participants recruited through NHS PIC sites. Lancaster University indemnity will apply for Non-NHS participants.

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

◯Yes ◉No ◯Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator Research site: Investigator Name identifier

IN1

NHS/HSC Site

Non-NHS/HSC Site

Forename	Crystal
Middle name	Elizabeth
Family name	Webster
Email	c.webster@lancaster.ac.uk
Qualification	Psychology/ Criminology BSC 1st class honours
Country	United Kingdom

Department of Clinical (MD...)

Institution name	Lancaster University
Department name	Psychology
Street address	Sir John Fisher Drive
Town/city	Lancaster
Post Code	LA1 4YT
Country	United Kingdom

Participant Identification Centres

PIC Type	Centre	Individual(s)
NHS (England)		
NHS (outside England)		
Non-NHS		

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to fulfil the responsibilities of the chief investigator for this study as set out in the UK Policy Framework for Health and Social Care Research.
3. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
4. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
5. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
6. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
7. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
8. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
9. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 2018.
10. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:

- Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
- May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
- May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
- Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
- May be sent by email to REC members.

11. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 2018.
12. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the Health Research Authority (HRA) together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after the issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

HRA would like to include a contact point with the published summary of the study for those wishing to seek further

information. We would be grateful if you would indicate one of the contact points below.

Chief Investigator

- Sponsor
- Study co-ordinator
- Student
- Other – please give details None

Access to application for training purposes *(Not applicable for R&D Forms) Optional – please tick as appropriate:*

☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by Dr Katy Bourne on 23/03/2023 08:49.

Job Title/Post:	Lecturer in Clinical Psychology
Organisation:	Lancaster University
Email:	k.bourne@lancaster.ac.uk

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co−sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The responsibilities of sponsors set out in the UK Policy Framework for Health and Social Care Research will be fulfilled in relation to this research.

Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.
8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

This section was signed electronically by An authorised approver at sponsorship@lancaster.ac.uk on 21/03/2023 20:17.

Job Title/Post:	Head of Research Quality and Policy
Organisation:	Lancaster University
Email:	

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific contentof the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the UK Policy Framework forHealth and Social Care Research.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlyingthe Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law andrelevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Dr Rachael Eastham on 22/03/2023 10:45.

Job Title/Post:	Senior Research Associate/Lecturer
Organisation:	Lancaster University
Email:	r.eastham1@lancaster.ac.uk

Academic supervisor 2

This section was signed electronically by Dr Katy Bourne on 23/03/2023 08:50.

Job Title/Post:	Lecturer in Clinical Psychology
Organisation:	Lancaster University
Email:	k.bourne@lancaster.ac.uk

Research Protocol

Trans women's experiences of accessing healthcare for HIV via UK-based sexual health services.

Crystal Webster, Lancaster University

Dr Katy Bourne, Lancaster University

Background

The word transgender is an umbrella term for a person whose gender expression/ identity is different from the binary sex that they were assigned at birth (Stonewall, 2022). Conversely the term cisgender is used to refer to people whose gender identity/ expression is the same as the sex organs they were assigned at birth (Aultman, 2014). While UK-specific data is hard to distinguish, it is estimated that the Trans community accounts for 0.3-0.5% of the global population (Reisner et al, 2016).

The minority stress model suggests that trans-people's mental and physical health is affected based on their social environment and the extent to which this environment stigmatizes the gender expression that is out of the traditional binary male and female norm (Wilkerson et al., 2017). It is well-documented that transgender people experience higher instances of physical and mental health difficulties (Moagi et al., 2021). Transgender youth are more likely than their cis-gendered peers to be subjected to violence, microaggressions, and bullying (Samaroo, 2017). This prolonged exposure to stigma, discrimination, and hostile social environments has been linked to increased thoughts of suicidal ideation and depression (Meyer, 2003; McNeil et al., 2012; Samaroo, 2017). As a result, transgender people are more likely to require support from mental and physical health services, but less likely to access services.

In particular, transgender people are more likely to suffer from sexual health problems than their cisgender peers (Reisner et al. 2016; McNeil et al., 2012). Human immunodeficiency virus (HIV) is one area of sexual healthcare in which trans individuals, in particular trans women, are

disproportionately impacted. Globally, trans women are at higher risk of contracting HIV, with a global meta-analysis suggesting that up to 19% of trans women are currently living with HIV (Baral et al., 2013). This is even greater in high-income countries, and it is estimated that in the UK 21.6% of trans women are living with HIV (Baral et al, 2013). This increased risk of contracting HIV may be explained by risk factors that can increase trans women's vulnerability such as discrimination, substance misuse, and an increased vulnerability of being involved with commercial sex work (Wylie & Woodcock, 2016; Brookfield et al., 2019). Accessing reproductive and sexual health often requires the disclosure of a sexual history that might be judged by a health professional, as well as invasive and potentially traumatic examinations (Brook et al., 2020; Hibbert et al., 2020; Lampe & Nowakowski, 2020).

In the UK access to pre-exposure prophylaxis (PrEP) and HIV health care is provided via sexual health clinics; this is important as the taking of PrEP can prevent infection of HIV if taken as clinically indicated (McCormack et al,. 2016). It is understandable that transgender people may avoid seeking treatment for HIV if they feel that sexual health services have a negative attitude towards trans individuals.

Suchak, Hussey, Takhar & Bellringer (2015) noted that there is no mention of trans-specific sexual health needs in the Community Sexual and Reproductive Health Curriculum for Health [CSRH] Professionals. Since this paper was published the curriculum has been updated, however, the management of transgender sexual health problems was still only listed as 5 bullet points (CSRH, 2020, p.23). This lack of consideration for transgender people's needs is contrary to the principles of sexual health and creates health inequality for trans women, reflecting the social inequalities they experience in wider society.

Encountering barriers when accessing sexual health services can decrease trans women's willingness to seek care and limit clinical openness to services. This is exacerbated by reports of misgendering and the use of dead names by staff within these services (Hibbert et al., 2020). This

research aims to identify barriers and examples of good care experiences by trans women when accessing sexual health services for HIV, and the implications this has for physical and mental well-being. This may help to inform service design and staff training to help move sexual health services toward being more inclusive.

Method

Participants

To be included in the study, participants will need to be aged over 18 and self-identify as a trans woman or trans femme. Gender-affirming surgery is not required to participate in this study. Participants will need to have accessed a UK-based sexual health service for health care relating to HIV in the last three years. This includes the following services: testing for HIV, accessing PrEP, receiving a diagnosis of HIV, and ongoing HIV treatment. People living with HIV will be in contact with services a minimum of every 12 months (most likely at least every 6 months), allowing their voices to be captured in the scope of the study. Participants will not be excluded based on where they are on their journey of transition; irrespective of whether they have had, or will ever choose to have, any type of gender-affirming surgery.

The study aims to recruit around 6-10 participants as recommended by Smith et al. (2009) for professional doctorates using IPA. This number of participants is also manageable in the timescale of the doctorate thesis. IPA allows an in-depth analysis of both individual and shared experiences across participants. Highlighting similarities and differences trans womans experience when accessing sexual health care in the UK.

Participants will be made aware of the voluntary nature of the study and the process involved in the study. Participants can choose to discontinue participation at any point without giving a reason up until 2 weeks after the interview has concluded. Once recordings have been transcribed and analysis has

begun withdrawing data will not be possible. Participants will be made aware of this in the consent, participant information sheet, and at the end of the interview.

Design

This study will be a qualitative approach aimed at exploring the experiences of trans women accessing sexual health clinics in the UK for healthcare related to HIV. Individual semi-structured interviews will be conducted by the research team. The interview schedule will consider a minority stress model perspective.

Specifically semi-structured interviews combined with Interpretative Phenomenological Analysis (IPA). IPA was chosen as it allows for an in-depth examination of personal lived experiences while positioning the researcher alongside the participant (Smith et al., 2009). As the research team are not part of the trans community, using an IPA approach will allow us to hold this in mind while exploring the experiences of trans women.

Experts by experience were approached during the initial planning stages of the study by the principal researcher to help promote the use of inclusive language.

Procedure

Recruitment

Participants will be recruited via two routes:

1. In the first instance, participants will be recruited through an NHS trans-specific sexual health service and via links established in the charity and voluntary sector by the field supervisor. Posters will be sent to these organisations to share with potential participants. Any interested participants will be asked to contact the research team directly using the information provided on the disseminated poster. At this point, the research team will email interested potential participants the participant information sheet and consent form.

2. At the same time in an attempt to capture a range of experiences, participants will be recruited using social media groups. The poster will be disseminated with group admin permission. Potential participants can contact me directly to express interest via the information provided on the poster. At this point, the research team will email interested potential participants the participant information sheet and consent form.

Consent

The participant will provide consent prior to the interview via the consent form. This can be done electronically and emailed back to me or posted prior to the arranged date of the interview. Prior to the start of each interview, participants will be consented again verbally. Participants can withdraw from the study at any point up until data analysis has begun. They do not have to provide a reason for withdrawal.

Data Collection

Data will be collected via semi-structured interviews lasting approximately 60 minutes. Interview questions will cover a range of themes associated with service access for healthcare for HIV and the minority stress model, with prompts guided by participants' responses. All participants will be given the opportunity to choose how they wish to be interviewed e.g. face to face, via Microsoft teams, or via telephone.

Analysis of Data

After each interview, the audio recording will be transcribed and any identifying information removed. The analysis will be conducted using IPA through the lens of the minority stress model. Transcripts will be analysed line by line, making notes of emerging theses. A number of transcripts will be analysed by the rest of the research team as well and then emerging themes compared across the research team. Emerging themes will be collated and developed into overarching categories.

Direct quotes from the transcripts will be used in the final write-up of the findings, however, these will be anonymised and corresponding pseudonyms will be used.

Dissemination

The research findings will be disseminated to participants and services involved in recruitment upon request. It will be submitted as my thesis and presented on the thesis presentation day at Lancaster University. It is also intended that the research will be published in peer-reviewed academic journals. There may be opportunities to present the paper at suitable conferences in the future.

Practical issues

The recruitment of participants will be taking place across a wide geographical area (North of England/UK-wide). This could make face-to-face interviews difficult, where possible and with agreement from participants, teams or telephone interviews will be used.

Ethical concerns

Risk to participants

The interview process is not anticipated to cause any significant distress to participants. However, some questions regarding service access may touch on distressing experiences experienced by the individual.

If the interview is conducted in person, the researcher who is a mental health professional will be mindful to observe for any viable signs of distress. In this event, the interview will be stopped, and the recording paused at that time. The participants distressed will be acknowledged, and they will be offered the option of a break or discontinuing the interview. After a break, the participant will be asked again if they wish to continue or stop the interview. Participants will be offered a debrief directly after the interview regardless of if they completed or stopped the interview.

If the interview is conducted by teams or by phone, it may be difficult to both assess distress and manage it when it arises. To help manage this participants engaging via teams and telephone will be asked to give their location at the beginning of the call, this is good safety practice regardless, as it means the researcher is better able to assist in the case of any unexpected or unrelated emergency. Participants will then be offered the same process as those conducting the interview face-to-face. If they wish to have a break or stop the interview. Participants will be offered a debrief directly after the interview regardless of if they completed or stopped the interview.

Regardless of the method of interview, if the interviewer becomes concerned at any point that the participant poses a significant risk of harm to themselves or others, then the interview will be stopped immediately. They will inform other members of the research team and take appropriate action in line with LSCFT risk management policy (e.g direction towards GP, A&E)

Risk to the research team

Where interviews are being conducted by a lone member of the team, particularly in person, then the researchers will adhere to Lancaster University's policy for lone fieldwork. If possible interviews will be scheduled to take place at Lancaster University in the first instance. The interviewer will ensure that the research supervisor is aware of the details of the interview (e.g Time, Date, Location, expected time back). Teams check-in spaces will be provided after interviews with the research supervisor, regardless of the method of interview. If the interviewer fails to attend this check-in, then attempts will be made to contact the interviewer. If contact cannot be made, then the relevant people and authorities will be informed.

Confidentiality and anonymity

All personal information collected as part of this study will be kept confidential. The data collected will be stored securely in line with the submitted data management plan. Only members of the research team will have access to the raw data from the study. Any other personal data collected by

the research through the study (e.g email addresses) will be kept confidential and will be kept in a password-protected file separate from interview data.

Audio recordings from the interviews will be kept securely and then destroyed after the thesis viva has been passed. Lancaster university keeps anonymised copies of interview transcripts for 10 years after the study completion date. At the end of this 10-year period, they will be securely destroyed. Research supervisor Dr. Katy Bourne will be responsible for the data during this time. Typed transcripts will be made anonymous via the removal of any identifying information and the use of a pseudonym. Participants will be given the option to choose their own pseudonyms.

Timeline for study completion

January- June 2023: Data collection and transcription of interviews

August- December 2023: Data Analysis and write up

January- March 2024: Complete the final write-up of the research paper

March 2024: Thesis Submission

The study will come to an end when one of the two following conditions are met, 1) the maximum number of participants needed have been recruited and transcription has taken place or 2) the minimum number of participants has been reached by the end of March 2024 and transcription has taken place.

References

Aultman. (2014). Cisgender. *Transgender Studies Quarterly*, 1(1-2), 61–62. https://doi.org/10.1215/23289252-2399614

Baral, Stefan D, Dr, Poteat, Tonia, PhD, Strömdahl, Susanne, MD, Wirtz, Andrea L, MHS, Guadamuz, Thomas E, PhD, & Beyrer, Chris, Prof. (2013). Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *The Lancet Infectious Diseases*, *13*(3), 214–222.

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Appendix

Appendix 4-A Interview Schedule

This interview schedule indicated topic areas to be discussed during the interview with example questions provided. The exact wording of questions will depend on individual participants' responses and will be guided by what participants deem to be important.

Introduction

- Introduce myself and revisit the participant information sheet and the purpose of the interview (To explore trans women's experiences of accessing care for HIV through sexual health clinics).
- Remind them about confidentiality and establish consent to proceed. ("All information you provide today will be kept confidential unless you disclose information regarding risk to yourself or others. In such an event, you will be informed regarding any action that will be necessary in order to ensure your safety and that of others. Are you happy to proceed with the interview?'')
- In the event that something happens, can you please tell me where you are doing this interview (if online or over the phone).
- Do you have any questions before we start?

In this section, I will ask participants how they would like to be referred to and if they would like to choose their pseudonyms.

1. My name is Crystal, and my pronouns are she/her. Sometimes during research people prefer not to use their real name and use a pseudonym instead. As part of the final report, you will be given or you can choose a pseudonym in order to protect your identity, I was just wondering if you wished for me to refer to you using the pseudonym during this interview. For the purpose of this interview, is there a name that you prefer that I use?
2. As part of anonymizing data for the final report, I will give you a pseudonym and I wondered if you wanted to choose your own. (If no: Is there a name you would prefer me not to use).

In this section, I will ask about the participant's experiences accessing sexual health services for HIV.

EXAMPLES:

Finding and accessing support

1. Why did you or do you go to a sexual health clinic for in relation to HIV? (e.g Testing, Prep, Diagnosis, checkups, active treatment).
2. Can you tell me about the process of finding a sexual health service? (PROMPTS: did you have anxieties about going? Was it easy to find?)
3. What kind of sexual health service did you engage with? (PROMPTS: Why did you choose that service)

4. How did you feel before you went along? (prompts about scared, apprehensive, comfortable- about what?)

Gender-specific questions and inclusivity section

5. How do you feel the service was set up to meet your needs? (PROMPTS: did you feel you had equitable access, was there literature that you identified within the waiting rooms?)
6. Did you feel that your safety was respected throughout your experience with the clinic? (e.g. did you have the opportunity to find out what to expect prior to attending? Did you feel the need to change your outward gender expression in order to receive safe care? What was the impact of this on you?)
7. Was the consultation/s inclusive of your identity? E.g. were you represented information/forms, the space and the attitude of the clinician etc
8. In the consultation/s did the clinician understand your needs? (PROMPTS: If so, then what enabled this? If not, then what prevented this?)
9. How did the consultation make you feel? How did it make you feel when you were there – e.g. included/excluded/erased (Follow up: how do you feel this impacted on your mental health?)
10. Was your sexual orientation and sexuality discussed as part of your consultation? If so, how was this managed? (e.g. conflicted with gender identity? Understood well?)

Round up section

1. Are there any aspects of your experience that worked well?
2. Ultimately do you think that you received different care as a trans person than a cis person would? And what impact does this have on you?
3. If you could do anything to improve sexual health services in the UK, what would be the most important change for you? And why?
4. What advice would you give to other trans women in your position and what would have liked professionals to know before attending the clinic?

Conclusion

At this point, the interview has concluded. The participant will be thanked for their participation. Participants will be invited to ask any further questions that may have arisen during the interview. I will ensure that the participant has not been distressed but the interview and if necessary signpost the participant to sources of support on the participant information sheet/ follow distress protocol.

Send out the debrief sheet and remind participants of resources of support that can be found on the participant info sheet.

Appendix 4-B Participant Information Sheet

Participant Information Sheet

Trans Women's Experiences of Accessing care for HIV via a sexual health clinic in the UK.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

My name is Crystal, and I would like to invite you to participate in this research project which forms part of my Clinical Psychology Doctoral research at Lancaster University, Lancaster, United Kingdom. Lancaster University is the sponsor for this project. Before you decide whether you would like to take part, it is important for you to understand why the research is being done and what your participation will involve so that you can make an informed decision about what's right for you. As part of my training, this research is a valuable opportunity for me to help contribute to the understanding of what would work best for trans women in clinical practice. Please take time to read the following information carefully. Please let me know if there is anything you wish to ask or if there is anything in this information sheet that is not clear. My email is: c.webster@lancaster.ac.uk

What is the study about?

The purpose of this study is to explore trans women's experiences of accessing health care for HIV via sexual health clinics in the UK, to gain a better understanding of their experiences in services. In particular, we are keen to learn more about what enables or prevents access to services: as well as how well you felt your needs were met when you accessed sexual health clinics.
Understanding these experiences will help inform how we can move from a cisgendered way of sexual healthcare to a more inclusive healthcare provision. It will also inform a gap in the understanding regarding the psychological impact current sexual health services in the UK have on trans women who access them.

Why have I been approached?

You have been invited to participate because you self-identify as a trans woman or trans femme. I am recruiting trans women and people who identify as trans femme aged 18 or older who have accessed healthcare of any kind for HIV via a UK sexual health clinic in the last 3 years.

Do I have to take part?

No. It's entirely up to you to decide whether you take part and you can withdraw from the process at any point up to two weeks after your interview. After two weeks, your data may have been incorporated into themes and it will no longer be possible to withdraw your individual contribution. You will not have to give a reason as to why you wish to withdraw.
Taking part in this study will not impact your access to healthcare, and your care team will not be made aware of your participation.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to complete an electronic consent form. Then you would be asked to attend an approx. 60-minute interview with myself. This can be either via phone, Microsoft teams, or face-to-face (depending on location). These interviews will be audio-recorded only. It is completely your choice if you choose to have your camera on during the interview, and you can request if the researcher has their camera on or off.
The interviews will ask you questions regarding your experience accessing service and may include themes such as the process of finding and accessing support as well as questions related to inclusivity and mental health.

Will my data be Identifiable?

The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them. All reasonable steps will be taken to protect your anonymity in this project. All your personal data will be confidential and will be kept separately from your interview responses.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, are at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this.

Will my data be stored securely?

The data collected for this study will be stored securely on university-approved secure cloud storage, and only the researchers conducting this study will have access to this data. Audio recordings from the interviews will be destroyed once the final project has been written up and it has been marked by the university. Any hard copies of transcripts will be kept in a locked cabinet and destroyed as soon as they are no longer required for data analysis.

Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to processing your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to the researcher on your particular study.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

What will happen to the results?

The results will be summarised and reported as part of my thesis and may be submitted for publication in an academic or professional journal in the future.

Are there any risks?

There are no risks anticipated with participating in this study. Your identifiable data will not be available to your NHS team. However, if you experience any discomfort following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

There is no direct benefit to taking part in this project, however, you may find participating interesting. There is also the opportunity to be entered into a prize draw for a £40 voucher as a thank-you for your participation.

Who has reviewed the project?

This study has been reviewed and approved by NHSREC and the Health Research Authority. This project has also been reviewed by Lancaster University sponsorship office.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher:

Crystal Webster (c.webster@lancaster.ac.uk)
Division of Clinical Psychology
Health Innovation One
Lancaster University
LA1 4YG

Or Dr Katy Bourne (k.bourne@lancaster.ac.uk)

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Title: Dr Ian Smith
Tel: 01524 592282
Email: i.smith@lancaster.ac.uk
Division of Clinical Psychology
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Dr Laura Machin Tel: +44 (0)1524 594973
Chair of FHM REC Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine

(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress
Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance.

Out in the Bay

Is a LGBTQI charity based in Morecambe that offers support and advocacy.

Samaritans

Samaritans offer mental health support and listening service. They are available 24 hours a day 365 days a year just call : 116 123

LGBT Consortium

Offers advice and directories for approved LGBT+ friendly services in your area. https://www.consortium.lgbt/

Gendered Intelligence

Has a directory of LGBT+-friendly and approved therapists.

https://genderedintelligence.co.uk/professionals/therapists-and-counsellors/directory.html

Appendix 4-C Poster

Appendix 4-D Consent Form

CONSENT FORM

Doctorate in Clinical Psychology | Lancaster University

Project Title: Transwomen's experiences of accessing care for HIV through sexual health clinics in the UK.

Name of Researchers: Crystal Webster (Trainee Clinical Psychologist), Dr Katy Bourne (Clinical Psychologist).

Email: c.webster@lancaster.ac.uk

Please initial each box

1. I confirm that I have read and understand the information sheet (version 2, February 2023), for the above study.	☐
2. I have had the opportunity to ask questions about the project and have had these questions answered satisfactorily.	☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time during my participation without giving any reason.	☐
4. I understand that if I withdraw within 2 weeks of taking part in my interview, I can request for my data to be deleted. However, after 2 weeks, I will no longer be able to request my data be deleted.	☐
5. I understand that I will be given a pseudonym to identify my contribution, and my name will not appear in any reports, articles, or presentations.	☐
6. I understand that any interviews will be audio-recorded and transcribed and that data will be protected on encrypted devices and stored securely.	☐
7. I understand that data will be stored according to University guidelines for a minimum of 10 years after the end of the study on Lancaster University-approved secure cloud storage.	☐
8. I agree to take part in the above study.	☐

_____ _____ _____

Name of Participant Date Signature

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Signature of Researcher /person taking the consent_____ Date _____

One copy of this form will be given to the participant and the original kept in the files of the researcher at Lancaster University

Consent forms can either be scanned and returned by email to : c.webster@lancaster.ac.uk

Or posted to: Crystal Webster, Division of Clinical Psychology, Health Innovation One, Lancaster University, LA1 4YG

Appendix 4-E Ethics Approval Letter

Health Research Authority

North West - Greater Manchester East Research Ethics Committee
3rd Floor, Barlow House
4 Minshull Street
Manchester
M1 3DZ

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

02 June 2023

Dr Katy Bourne
Doctorate in Clinical Psychology
Health Innovation One
Sir John Fisher Drive, Lancaster University
LA1 4AT

Dear Dr Bourne

Study title:	**Trans women's experiences of accessing healthcare for HIV via UK-based sexual health services.**
REC reference:	**23/NW/0113**
Protocol number:	**N/A**
IRAS project ID:	**316703**

Thank you for your letter of 23 May 2023, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: https://www.hra.nhs.uk/planning-and-improving-research/applicationsummaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at: https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvalsamendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research	V2	27 February 2023
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		27 February 2023
Interview schedules or topic guides for participants	V2	27 February 2023
IRAS Application Form [IRAS_Form_23032023]		23 March 2023
Letter from sponsor		07 March 2023
Other [Participant Debrief Sheet V3 IRAS ID 316703]	V3	04 May 2023
Other [Distress Protocol IRAS ID 316703]	V3	19 May 2023
Other [Safeguarding-Children-and-Adults-at-Risk-Procedures-andGuidance]	V1	19 May 2023
Other [IRAS 316703 ethics Amendments]	V1	19 May 2023
Participant consent form	V2	27 February 2023
Participant consent form [Consent From V3 IRAS ID 316703]	V3	04 May 2023
Participant information sheet (PIS)		
Participant information sheet (PIS) [Participant Information Sheet V3 IRAS ID 316703]	V3	04 May 2023
Research protocol or project proposal [Research protocol]	V2	27 February 2023
Research protocol or project proposal [Research Protocol IRAS ID 316703]	V3	19 May 2023
Summary CV for Chief Investigator (CI) [CV of Chief investigator]	V2023	17 March 2023
Summary CV for student [Student CV]	V 2023	04 May 2023
Summary CV for supervisor (student research) [Field Supervisor CV]	V1	01 May 2023
Summary, synopsis or diagram (flowchart) of protocol in non technical language	V2	27 February 2023
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Research Protocol IRAS ID 316703]	V3	19 May 2023

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and

the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/qualityassurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improvingresearch/learning/

IRAS project ID: 316703 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

PP – Dr Isabelle Butcher Chair

Email:gmeast.rec@hra.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Ms Becky Gordon

Dr Katy Bourne
Doctorate in Clinical Psychology

Health Innovation One
Sir John Fisher Drive, Lancaster University
LA1 4AT

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

22 June 2023

Dear Dr Bourne

HRA and Health and Care

Study title:	**Trans women's experiences of accessing healthcare for HIV via UK-based sexual health services.**
IRAS project ID:	**316703**
Protocol number:	**N/A**
REC reference:	**23/NW/0113**
Sponsor	**Lancaster University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **316703**. Please quote this on all correspondence.

Yours sincerely,

Natasha Bridgeman

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Ms Becky Gordon* **List of Documents**

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research	V2	27 February 2023
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		27 February 2023
Interview schedules or topic guides for participants	V2	27 February 2023
IRAS Application Form [IRAS_Form_23032023]		23 March 2023
Letter from sponsor		07 March 2023
Other [PIC agreement IRAS ID 316703]	V1	15 February 2023
Participant consent form	V2	27 February 2023
Participant information sheet (PIS)		
Research protocol or project proposal [Research Protocol IRAS ID 316703]	V3	19 May 2023
Schedule of Events or SoECAT	V1	27 February 2023
Summary CV for Chief Investigator (CI) [CV of Chief investigator]	V2023	17 March 2023
Summary CV for student [Student CV]	V 2023	04 May 2023
Summary CV for supervisor (student research) [Field Supervisor CV]	V1	01 May 2023
Summary, synopsis or diagram (flowchart) of protocol in non technical language	V2	27 February 2023
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Research Protocol IRAS ID 316703]	V3	19 May 2023

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
Activities at NHS organisations will involve PIC activity only, including the identification of participants, database searches and the mailing out of study documentation...(to be amended as appropriate).	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study in accordance with the contracting expectations detailed. Due to the nature of the activities involved, organisations will be expected to provide that confirmation to the sponsor: * Within 35 days of receipt of the local information pack	The sponsor has provided the appropriate model PIC agreement that it intends to use as a subcontract between participating organisations and NHS organisations acting as their Participant Identification Centres (PICs). The sponsor has provided the appropriate model PIC agreement that it intends to use between itself and NHS organisations acting as Participant Identification Centres (PICs).	Study funding arrangements are detailed in the Organisation Information Document.	The Chief Investigator will be responsible for all study activities performed at PICs.	The applicant has stated that local staff in participating organisations in England who have a contractual relationship with the organisation will undertake the expected activities. Therefore no honorary research contracts or letters of access are expected for this study.

	* After HRA/HCRW Approval has been issued. If the organisation is not able to formally confirm capacity and capability within this timeframe, they must inform the sponsor of this and provide a justification. If the sponsor is not satisfied with the justification, then the sponsor may escalate to the National Coordinating Function where the participating NHS organisation is located.				

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated they do not intend to apply for inclusion on the NIHR CRN Portfolio.