Summary briefing

“There needs to be care throughout”

Exploring the access of non-binary people, trans men and trans women to sexual health services in Scotland

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WAVERLEY care Positive about HIV, Hep C & Sexual Health in Scotland

Scottish Trans

Background

This project was developed to address the lack of evidence about trans people's experiences of engaging with sexual health services in Scotland.[1] We know that, globally, trans women are at higher risk of contracting HIV, with prevalence estimated at around 19% (Baral et al. 2012). There is some evidence to suggest prevalence levels may be similar among trans men (Stephens et al. 2011). Uptake of pre-exposure prophylaxis (PrEP) among trans people in Scotland has been low,[2] despite the disproportionate impact of HIV on trans women worldwide (Health Protection Scotland 2019).

Evidence shows that trans people in the UK are less likely to visit a sexual health clinic than their cis counterparts and are more likely to feel worried, anxious, and embarrassed when doing so (Government Equalities Office 2018). There is also evidence to suggest that some trans people are less likely to access HIV testing and more likely to have risky sex than the cis population (Hibbert et al. 2020; Wolton et al. 2018). We know that trans people face a range of barriers to engaging with sexual health services, including fear, a lack of trans competent care, and discrimination (Brookfield et al. 2019; Scheim and Travers 2017; Smith 2019). These barriers are compounded by the fact that trans people are more likely to experience other forms of marginalisation and vulnerability, such as high alcohol and drug use, intimate partner violence, and poor mental health (Scottish Trans Alliance 2016; Stonewall 2017; Stonewall 2018).

1 We use the term 'trans' (short for transgender) as an inclusive umbrella term for anyone whose gender identity does not fully correspond with the sex assigned to them at birth. We use the term 'cis' to refer to people whose gender fully corresponds with the sex assigned to them at birth.

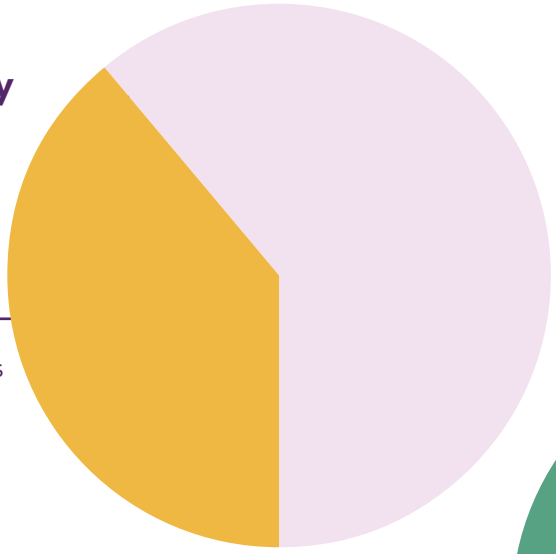
2 Pre-exposure prophylaxis (PrEP) is a medicine that is taken to prevent an HIV-negative person from acquiring HIV.

What did we do?

This peer-led project is the first national study of trans people's experiences of accessing sexual health services in Scotland.

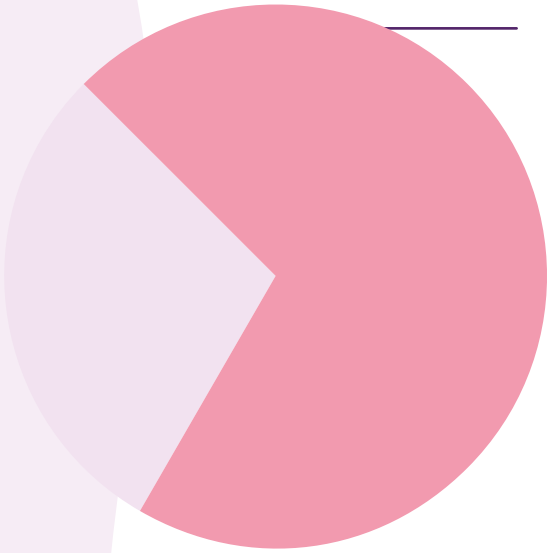
The project was carried out by a team of trans and cis researchers. We carried out a survey with 289 trans people across Scotland about their experiences of accessing sexual health services. We then carried out interviews and focus groups with 29 trans participants, to explore these experiences in more depth. Finally, we interviewed eight sexual health practitioners, to find out about their experiences of delivering sexual health care to trans people. We sought to identify factors that act as barriers or facilitators to trans people engaging with sexual health services.

The survey

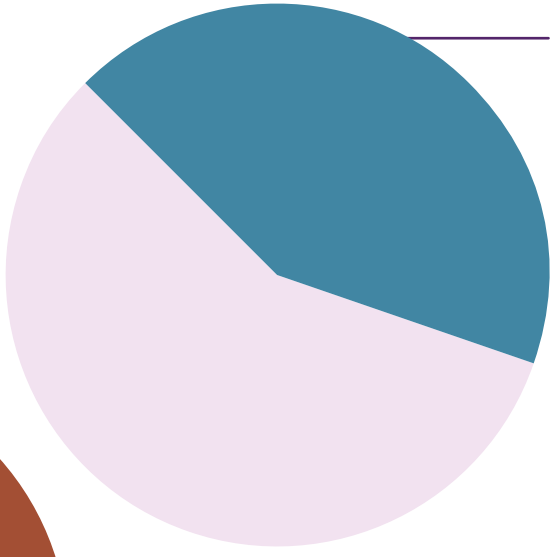


39%
of respondents had visited a sexual health clinic in the past two years

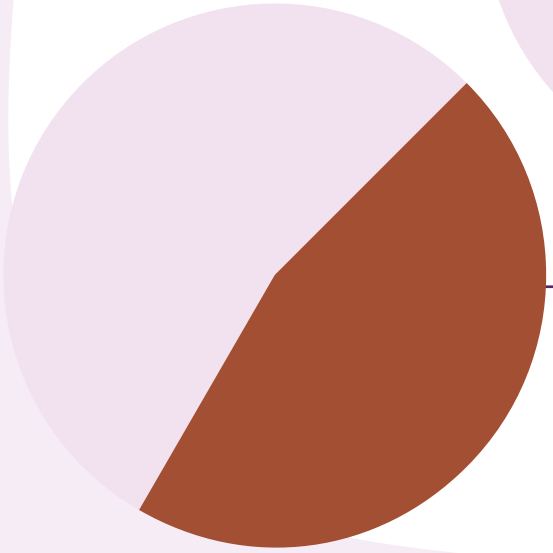
64%
of those who attended did so to access STI testing



71%
of respondents had heard of PrEP before



43%
of respondents agreed that the NHS PrEP criteria were trans inclusive



46%
thought that non-binary people should be explicitly included in the NHS PrEP criteria

What did we find out?

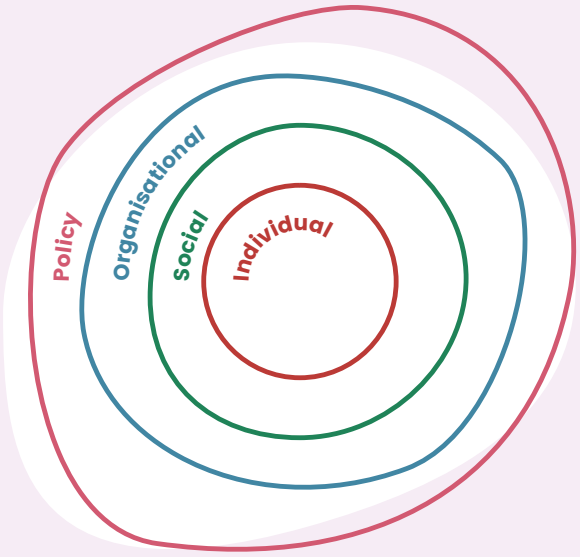
The survey

Our survey produced several positive findings, but also highlighted areas for improvement. The first part of the survey asked participants about their experiences of accessing sexual health clinics in Scotland. There were differences in the experiences reported by trans women, trans men, and non-binary participants. While 80% of trans women and 69% of trans men who had attended a sexual health clinic felt it was inclusive towards trans people, only 36% of non-binary people agreed. However, 90% of non-binary respondents said that they had been offered treatment appropriate for their anatomy, compared to 67% of trans men and 75% of trans women.

We also asked survey respondents about PrEP. A small number of participants (n=29) told us that they met the NHS PrEP eligibility criteria. Given the small size of this group, we have broken these findings down by number, rather than percentage. Seven respondents had tried to access NHS PrEP and five had been prescribed PrEP. 22 people said that they were eligible for PrEP but had not tried to access a prescription. Six of those told us that they did not know about PrEP or how to access it. Six told us they were afraid of discrimination or that they would not be able to access PrEP because of their gender identity. Five did not feel that they were at risk of acquiring HIV or that they needed PrEP, despite the criteria indicating that this was the case. Three cited practical barriers, such as travel or organising time off work, and two people did not provide reasons.

Interviews and focus groups with trans people

Our qualitative findings suggested several factors that act as facilitators or barriers to trans people accessing sexual health services. We used a socio-ecological model of access to healthcare to organise our findings, exploring barriers and facilitators at the individual, social, organisational and policy levels of trans people's lives.



> ***I do not feel comfortable attending these services as they [almost always misgender] me[.] There is very little knowledge of trans and non-binary identities and it can feel humiliating to try and validate myself to someone looking at a very dysphoria-inducing part of my body.***

Individual factors

Fear

Participants told us that fear about how they would be treated prevented them from attending sexual health services. For some, this was based on previous, poor experiences when attending clinics, such as being misgendered. For others, fear was based on the perception that they would be treated poorly. Several participants explained that the experience of taking about body parts or having a physical examination would be too difficult, and could induce feelings of gender dysphoria.

Feeling cared for

The people we spoke to said that experiencing genuine care and concern from a practitioner could help to alleviate fears when accessing sexual health services. Participants said that

they wanted to feel like practitioners understood the different ways that trans people were marginalised and the trauma that many had experienced. Several participants said that they wanted to feel that their questions and concerns were listened to and not minimised.

Understanding of risk

Participants told us that they lacked access to tailored information to enable them to understand how sexual health advice applied to their circumstances. This was especially the case if risk factors or prevention options were communicated with reference to gender, rather than anatomy. Participants cited PrEP as an example of this, with many non-binary participants unable to understand whether they would be eligible for PrEP, despite reporting potentially high-risk sexual behaviour. When participants had access to information that helped them to understand risk and prevention options, they were better able to engage with services.

> ***As a non-binary person, I would find it challenging to understand whether or not I am eligible under the [NHS PrEP] criteria above, and would find it even more challenging if my sexual partner(s) were also non-binary.***

Energy to self-advocate

Participants explained that their ability or energy to self-advocate mediated whether they engaged with sexual health services. As practitioners often lacked specific knowledge of trans sexual health needs, participants told us that they had to expend time and energy researching trans sexual health and making their needs understood to practitioners. Several participants told us that they either did not provide full information to practitioners, or did not attend sexual health clinics at all, because it was too difficult to make their needs understood.

Social factors

Peer support

Our participants said that it could help to have a friend or partner with them during sexual health appointments, and this helped to overcome feelings of fear and anxiety. Some participants said that they had not been allowed to bring a companion into appointments with them in the past, which was a barrier to engagement. General Medical Council (2013) guidance notes that doctors should comply with a reasonable request to have a friend or relative present during an intimate examination.

Access to reliable information within the community

Many of our participants accessed sexual health information from trans community spaces online. While people valued these sources of information, especially given the lack of alternatives, some expressed concern about the validity of information they found online. Although participants wanted to see trans people involved in the dissemination of sexual health information, several said that they would like to access information about trans sexual health via 'official' and reliable sources, such as NHS websites.

> ***Google is great but sometimes you're asking a bunch of people and you get a bunch of answers and they're all well-meaning but some of them aren't as helpful as others.***

Involvement of trans people in service delivery

As mentioned above, several participants said that they would be more likely to engage with sexual health services if trans people were involved in service delivery. Some participants had attended sexual health services staffed by trans people in other countries and felt this had been an enabler to engaging with care. Some participants suggested that it would be helpful to have trans people involved in sexual health clinics in non-clinical roles, such as providing support and advocacy.

Organisational factors

Access options

The people we spoke to said that having a range of different access options facilitated engagement with sexual health services. This included attending face-to-face consultations, as well as having the option of accessing services online and, in relation to screening and testing, by post. Participants felt this would make services more accessible for people with disabilities, as well as those who faced other barriers to attending clinics. Participants highlighted that clinics should always be physically accessible.

> ***It needs to be accessible in terms of different ways of actually contacting [services]. I book all of my GP appointments using the mobile app that I've got. A lot of people much prefer to make telephone appointments. A lot of people would much prefer to be able to just go in and make an appointment at the reception, at the front desk, and you need to have all those sort of options to make it truly accessible.***

The clinic environment

Participants said that the environment within services influenced engagement, with an overly clinical environment described as a barrier to accessing services. Participants said they would like clinic waiting areas to be relaxed and welcoming, with consideration given to the impact of bright lights and noise on those who experience sensory overload. Some suggested it would be positive to have a separate, quiet waiting area.

> ***I would like to go to a place with beanbags and maybe has more of a sensory consideration, with low lights and colours.***

Gendered environment and resources

Participants said that gender-neutral clinic environments facilitated engagement. This included things like making sure gender-neutral toilets were available, as well as ensuring intake forms or online registration forms asked about gender in a trans inclusive way. Participants also said that leaflets, posters, or online resources should communicate information with reference to anatomy and kinds of sex, rather than gender, so that people could better understand how information applied to their circumstances.

Link with gender services

Participants talked about the link between gender services and sexual health services, noting that this could be a barrier to engagement. In Scotland, gender services are part of sexual health services, which means they are usually located in the same building as other sexual health services and use the same clinical electronic records system (the National Sexual Health System, or NaSH). A person's record of having accessed wider sexual health services is viewable to staff working in gender services, and vice versa. Participants said there should be separate waiting area for gender service appointments, as some felt the location of gender services within wider sexual health services sexualised trans identities and made people less likely to engage. Participants also said there should be transparency about the shared use of NaSH, to ensure people knew who could access their patient record and for what purpose. Several of our participants said they would prefer to access sexual health services under a pseudonym, to prevent linkage with their sexual health record, and would like there to be more transparency around how they could do this.

> ***I find it quite uncomfortable to be honest. I don't know, I feel under more scrutiny going to the gender clinic than***

> ***I would if it was separate from the sexual health clinic because there's a bunch of non-gender related patients there that are just there for their own thing like everyone else is, it's not their fault, but it does kind [of] put me on edge a bit more than if it was just a gender clinic.***

Specialist knowledge

Participants said that they wanted practitioners to know about and understand trans people's sexual health needs. One participant reported an experience where a practitioner had provided inaccurate information about PrEP dosing for trans men, while another talked about the challenges of accessing accurate advice about condom use. Participants said it was an enabler to accessing care if practitioners were knowledgeable and confident in providing sexual health care to trans people.

Practitioner approach

As mentioned earlier, the people we spoke to said that a sexual health practitioner's approach could help overcome barriers to engagement. Our participants wanted practitioners to check their name and pronouns at the start of appointments, and not to make any assumptions about the gender of their sexual partners or the kind of sex they had. Related to the previous point, participants said it made a positive difference if practitioners displayed a willingness to go and find out information they did not know, rather than expecting the patient to educate them about trans sexual health needs.

> ***The person that took me was great. Additionally, she asked about historical sexual abuse as routine checking, and when I told her I had been a victim but it was years ago, she said I was still welcome to help if I wanted. She asked my pronouns and didn't say anything further, just treated me as normal.***

Policy factors

Transphobia

Participants talked about transphobia within society, particularly linked to hostile political, media, and public opinion around reform of the Gender Recognition Act 2004 (GRA). While participants said this created anxieties about engaging with any public services, some highlighted that they felt even more cautious about engaging with sexual health services because of the intimate and sensitive nature of such services. Participants said that practitioners could help by showing that they were visible trans allies. This could include wearing a trans ally badge, making their pronouns visible, or displaying a trans flag.

> ***Any time I speak to a new stranger, whether it's just someone in a shop, a new colleague or someone I am talking to about more intimate things like health, there's always that lingering question in the back of your head – is this person transphobic? Does this person think I [shouldn't] exist?... When you're just in a shop that's fine, it doesn't really matter, but when you're giving intimate details to someone it can be really, really scary.***

Austerity

Some participants talked about the barriers created by austerity and the impact this had upon waiting times within sexual health services. While this is a barrier that affects the wider population, the impact is arguably more significant upon already marginalised populations, who face additional barriers to engagement.

Interviews with sexual health practitioners

We also used a barrier/facilitator model to understand the findings of our interviews with sexual health practitioners. We used this approach to understand factors that enabled sexual health practitioners to deliver trans inclusive care, as well as barriers to delivering such care.

Training and information

Most of the practitioners we spoke to said they would like to access more training on trans people's identities and sexual health needs. There was particularly limited experience and knowledge of non-binary identities, and so this is an area that should be addressed by training. Practitioners said that they wanted to deliver good care, but were anxious about causing offence or harm if they asked questions in the wrong way. Practitioners felt that they would benefit from guidance around how to ask questions about gender, pronouns, and sexual history in a trans inclusive way.

I think myself and certain other colleagues feel very confident, relatively! I think others don't feel confident at all and really would appreciate some more training, which we have internally asked for.

I worry about offending people...I'm a nurse and the bottom line is I make people feel better. I don't want people to walk away from here thinking that, 'I can't believe she said that to me', or anything like that.

Patient-led, non-judgemental approach

Pactitioners explained that using a patient-led approach, relying on open and non-judgemental questions, and acknowledging a service user's expertise about their own life and identity, resulted in better experiences for people accessing services. It also enabled the practitioner to find out more information about the person's history and their reason for attending services. Practitioners explained that not making assumptions about a patient or their sexual history was essential to providing good care.

What I would usually do, would be to explain the process of what we're doing; that I need to take swabs from whatever bits are active... What I usually say is, 'I need to do the swab in what's active. What do you have? What do I need to do to make sure I give you the best service?' – and I've gone through everything. I don't want to assume anything, really.

Time and preparation

Practitioners acknowledged that having the time to read a person's notes prior to a consultation was beneficial. This could provide essential information about a person's identity and experiences prior to the appointment, and could help avoid making assumptions, as well as the patient having to repeat information.

What are our recommendations?

The Scottish Government should:

- Ensure that trans people's access to sexual health services, including HIV prevention, is identified as a priority area in the next Sexual Health and Blood Borne Virus Framework and associated funding streams.
- Bring forward reform of the Gender Recognition Act 2004 to ensure trans people can more easily gain legal recognition of their gender identity.
- Show leadership on upholding trans people's existing equality, inclusion and human rights, especially ensuring sex/gender data fields always record trans people's lived identities and that trans people are not misgendered when using single-sex services.

NHS sexual health services should:

NHS service design: waiting rooms and registration

- Ensure waiting areas are not segregated by gender.
- Have separate waiting areas for patients attending gender identity services in clinics that also house general sexual health services.
- Ensure toilets are not segregated by gender. Single-user, gender neutral, accessible toilets should be provided as standard.
- Ensure posters, leaflets, and any resources in waiting areas or on service websites are trans inclusive, with references made to anatomy and kinds

of sex (e.g. cervix, prostate, penetrative anal sex), rather than gender.

- Explore changes that could be made to waiting areas to make them less clinical and more accessible and comfortable, potentially providing a separate quiet waiting space.
- Paper or digital registration forms or should ask about gender using the following two-part format:

1a. How would you describe your gender?

- ☐ Male
- ☐ Female
- ☐ In another way

1b. Do you consider yourself to be trans?

- ☐ Yes
- ☐ No

Trans is a term used to describe people whose gender is not the same as the sex they were registered at birth

- Make clear on paper or digital forms that patients can access services using a pseudonym.
- Make public commitments to equality on service websites and on a poster/leaflet in service waiting areas. This should include examples of good practice and reasonable adjustments that people with protected characteristics can expect from staff.
- Ensure that the complaints or feedback procedure is promoted to patients on service websites and on a poster/leaflet in service waiting areas.

Training and staffing needs

- Ensure all staff involved in the delivery of services, including clinical, reception, and support staff receive equality and diversity training, which includes accurate and appropriate information about gender diversity. This training should be delivered by a trans person or trans advocacy organisation.
- Work in partnership with trans advocacy organisations to ensure clinicians and other practitioners access training and resources on good practice when providing sexual health services to trans people.
- Consider providing additional training to clinical staff and other practitioners on trauma informed care, neurodiversity, and the needs of sex workers.
- Explore employment options for trans staff to deliver clinical or non-clinical services, such as patient liaison or support roles.

Clinicians and other sexual health practitioners should:

- Ask patients for their name and pronouns as part of routine enquiry.
- Avoid making assumptions about a person's gender or sexual activity, instead asking open questions such as "can you tell me about the gender of your partner(s)" and "can you tell me about the sex you have with your partner(s)?"
- Be transparent with patients about the use of NaSH within both gender identity services and in wider sexual health services.
- Ensure familiarity with BASHH (2019) recommendations for integrated sexual health services for trans, including non-binary, people, which contain clinical guidance on: vaccination, PEP, PrEP and HIV, vaccinations, investigations, and contraception.
- Ensure familiarity with General Medical Council guidance on intimate examinations, specifically paragraph 10 on reasonable requests to have a friend or relative present during an examination.

NHS national PrEP stakeholder group should:

- Produce detailed tailored PrEP guidance for trans people in consultation with the community, explaining eligibility and risk factors in relation to anatomy and different sexual activities.

Third sector sexual health/ BBV organisations should:

- Seek funding for and produce bespoke sexual health information resources for trans people, on priority topics such as PrEP and HIV prevention, STI and HIV risk factors, and testing.
- Work in partnership with trans advocacy organisations to deliver outreach BBV and STI testing in community spaces and events, such as Trans Pride.
- Work in partnership with trans advocacy organisations and NHS services to deliver sexual health information sessions for trans people.
- Seek funding to provide community-based sexual health services to trans people, based on models of community-based and peer-delivered models of care currently available to other communities disproportionately affected by HIV, such as GBMSM. This should include employment options for trans practitioners.
- Ensure all general sexual health information resources are trans inclusive, with risk factors and prevention strategies described with reference to anatomy and types of sex, rather than gender.

Trans advocacy organisations should:

- Seek funding for and deliver training to sexual health practitioners on providing trans-inclusive services, working in partnership with third sector sexual health/BBV organisations.
- Work in partnership with third sector sexual health/BBV organisations to provide sexual health advocacy and peer support to trans people engaging with NHS sexual health services.
- Work in partnership with third sector sexual health/BBV organisations to deliver sexual health information sessions for trans people and to hold events for sexual health service providers and community members to explore and share best practice.
- Consider developing and administering a 'charter' scheme to enable sexual health services to show they have developed trans-inclusive policies and trained their staff to be knowledgeable and confident in delivering sexual health services to trans people.

Appendix 1: Participant information

Participant number	Group attended	Age	Health Board area
Participant 1	Trans women/trans feminine people	45-54	NHS Lothian
Participant 2	Trans women/trans feminine people	18-24	NHS Greater Glasgow and Clyde
Participant 3	Trans women/trans feminine people	45-54	NHS Highland
Participant 4	Trans men/trans masculine people	25-34	NHS Tayside
Participant 5	Trans men/trans masculine people	25-34	NHS Greater Glasgow and Clyde
Participant 6	Trans men/trans masculine people	18-24	NHS Greater Glasgow and Clyde
Participant 7	Trans men/trans masculine people	55-64	NHS Lothian
Participant 8	Trans men/trans masculine people	25-34	NHS Lothian
Participant 9	Trans men/trans masculine people	Not given	Not given
Participant 10	Trans men/trans masculine people	Not given	Not given
Participant 11	Trans men/trans masculine people	Not given	Not given
Participant 12	Trans men/trans masculine people	Not given	Not given
Participant 13	Trans men/trans masculine people	Not given	Not given
Participant 14	Non-binary group 1	25-34	NHS Greater Glasgow and Clyde
Participant 15	Non-binary group 1	18-24	NHS Greater Glasgow and Clyde
Participant 16	Non-binary group 1	35-44	NHS Greater Glasgow and Clyde
Participant 17	Non-binary group 1	25-34	NHS Greater Glasgow and Clyde
Participant 18	Non-binary group 1	Not given	Not given
Participant 19	Non-binary group 1	Not given	Not given
Participant 20	Non-binary group 1	Not given	Not given
Participant 21	Non-binary group 1	Not given	Not given
Participant 22	Non-binary group 2	25-34	NHS Lothian
Participant 23	Non-binary group 2	35-44	NHS Lothian
Participant 24	Non-binary group 2	18-24	NHS Lothian
Participant 25	Non-binary group 2	18-24	NHS Lothian
Participant 26	Non-binary group 2	25-34	NHS Lothian
Participant 27	Non-binary group 2	35-44	NHS Lothian
Participant 28	Non-binary group 2	Not given	Not given
Participant 29	Interview	25-34	NHS Greater Glasgow and Clyde

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