

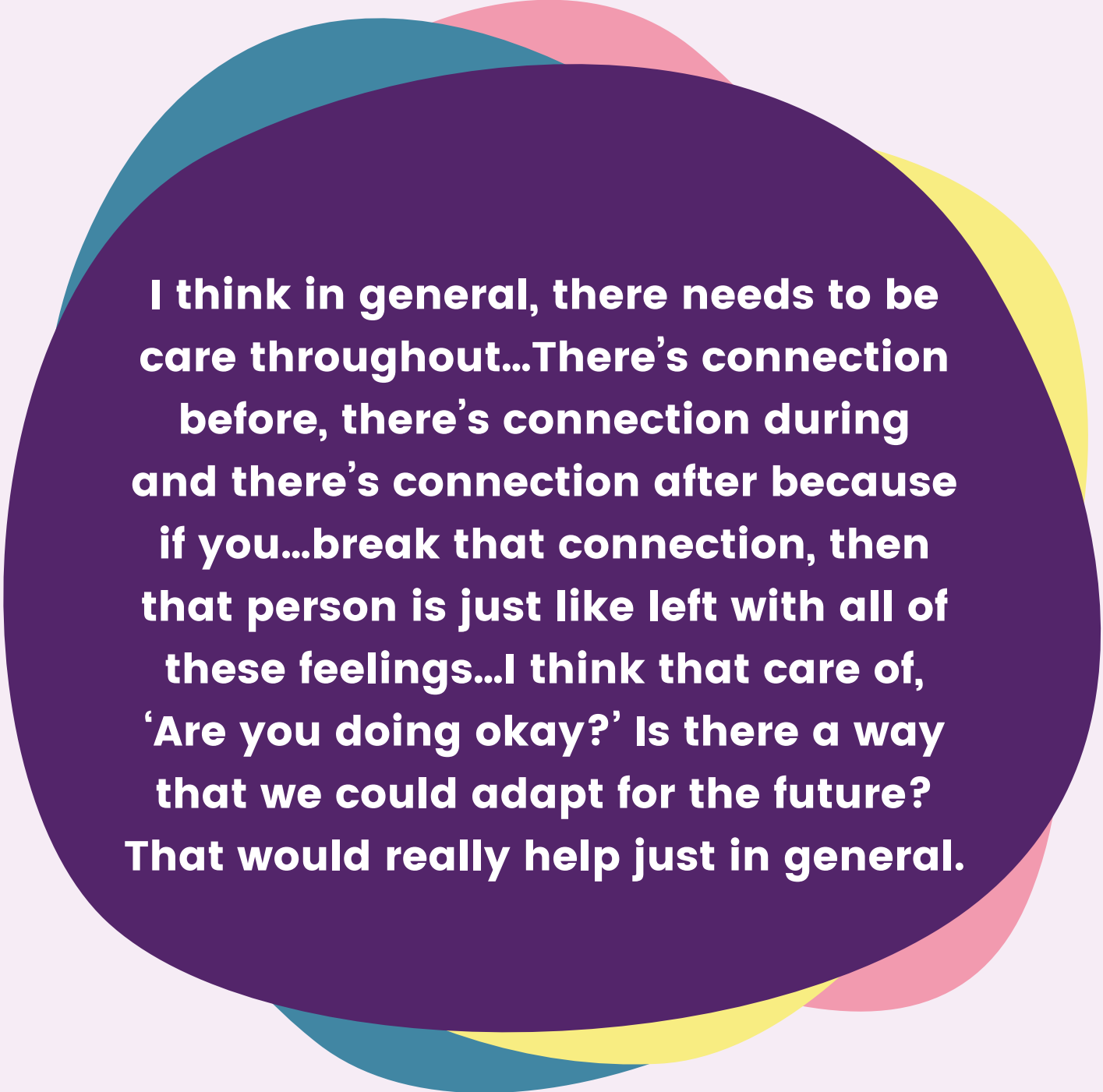


# “There needs to be care throughout”

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

Oceana Maund, Ruth McKenna, and Oliver Wain





**I think in general, there needs to be care throughout...There's connection before, there's connection during and there's connection after because if you...break that connection, then that person is just like left with all of these feelings...I think that care of, 'Are you doing okay?' Is there a way that we could adapt for the future? That would really help just in general.**

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Thank you to all of our trans participants, for their willingness to take part in this research and for sharing their perspectives and experiences. We recognise that many of the topics raised by the research were sensitive and sometimes difficult to talk about, so we very much appreciate the openness and candour of those who participated in this project. We promise that we will do our utmost to address the issues raised by our participants, using our resources and influence to try to improve trans people's access to sexual health services.

Thank you to all the NHS staff who participated in this project. We appreciate the time staff took to talk to us about their knowledge and experiences, and to share areas where they would like to access further training and information. We commit to using the findings of this research to develop guidance and information resources on the delivery of trans-inclusive sexual health services.

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# Introduction

**This report explores trans people's access to sexual health services in Scotland. There is limited evidence on trans people's access to sexual health services, particularly in the UK.**

Yet we know that globally, trans women are at higher risk of contracting HIV and are more likely to be diagnosed late (National AIDS Trust 2017). 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). This peer-led project builds on the small pool of existing research on trans people's access to sexual health care and is the first national study of trans people's experiences of accessing sexual health services in Scotland. The research is based on the findings of a national survey with 289 trans people, focus groups and interviews with 29 trans participants, and interviews with eight sexual health practitioners.

The research was a partnership between Waverley Care and Scottish Trans Alliance, combining our respective expertise in sexual health and trans people's access to health care. Waverley Care offers help and advice to people

who need support with HIV, hepatitis C and sexual health across Scotland. We make sure no one faces HIV or hepatitis C alone, and work to make talking about and taking care of sexual health a part of everyday life. Through our work, we tackle health inequalities, encourage people to get tested, and reduce HIV, hepatitis C and sexual health stigma. Scottish Trans Alliance is the Equality Network project to improve trans equality, rights and inclusion in Scotland. We work to ensure that policy makers, equality organisations, other employers and service providers are more informed about how to improve trans equality, rights and inclusion through policy and good practice development. Scottish Trans Alliance works to make sure trans people are more informed, equipped and supported to engage with equality organisations, policy makers, service providers and employers. We also work to increase accurate and positive visibility of trans people's experiences in Scotland.

## Parameters of the research

This research focuses on the experiences of trans people accessing sexual health care via NHS sexual health clinics. Occasionally, we refer to participants' experiences of accessing sexual health services via the third sector. As we discuss further in the report, the research did not focus on access to sexual health care via GPs.

The research primarily focuses on access to sexually transmitted infection (STI) prevention, testing and treatment, contraception, and screening services. The research does not look at access to gender identity services, most of which are located within sexual health services in Scotland<sup>1</sup>.

It is worth noting that data collection for this project was carried out in 2019. Therefore, the data does not account for the impact of the COVID-19 pandemic and resulting changes in the delivery of health services. The pandemic has prompted an expansion in the remote delivery of health care services, such as

video consultations and HIV self-testing. While some of the research findings and recommendations are relevant to the physical environment of the sexual health clinic, the majority are applicable no matter how services are delivered.

## A note on language

In this report 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.<sup>2</sup> Throughout the report, we use the term 'trans' to refer collectively to trans men, trans women and non-binary people. Where we are only talking about the experiences of one of these groups of trans people, we make this explicit.

Sometimes, it is important to be able to discuss the differences in experiences of trans people and people who are not trans. In this report we use the term 'cis' to refer to people whose gender fully corresponds with the sex assigned to them at birth.

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1 There are four gender identity clinics for adults in Scotland, located in Glasgow, Edinburgh, Inverness and Aberdeen. With the exception of the Aberdeen clinic, these gender identity clinics are located within sexual health services.

2 Some people feel that their gender identity cannot be defined by the expected binary terms of 'man' or 'woman'. Instead, they experience their gender in another way. Typically, we refer to this group of people as being 'non-binary'. The term non-binary refers to a person: identifying as either having a gender which is in-between or beyond the two categories 'man' and 'woman', as fluctuating between 'man' and 'woman', or as having no gender, either permanently or some of the time (Scottish Trans Alliance 2016a). Some people may feel closer to either masculinity or femininity, but do not identify as male or female. In such cases, people often describe their gender identity as 'trans masculine' and 'trans feminine'.

Trans people use a diverse range of terms to describe their identities, and language in this area is always evolving. It is generally good practice to mirror the language that people use to describe themselves and, if you are unsure about a term someone uses, to respectfully ask them what it means to them.

## Summary of findings

Our quantitative findings suggest that many trans people have had positive experiences of engaging with sexual health services, albeit with room for improvement in several areas. Our qualitative findings explore these experiences in more depth, using a socio-ecological model of access to health care to explore the individual, social, organisational and policy level factors that either facilitate, or present a barrier to, engagement with sexual health services.

Our findings show that trans people face a range of barriers to engagement with sexual health services. These include fear and anxiety, as well as challenges in interpreting gendered sexual health information to understand levels of risk. Misgendering from service providers, a lack of professional knowledge of trans people's sexual health needs, and limited access to accurate and reliable information are additional barriers. Transphobia within the press, politics, and public opinion also affects access to services.

Our participants also told us about factors that helped and facilitated them to access sexual health services. These included: care, compassion and understanding from sexual health practitioners, support from peers to attend appointments, and community involvement in the delivery of sexual health information and services.

The provision of accessible and non-gendered services, with face-to-face and digital access options, also facilitated people to engage.

Findings from our interviews with sexual health practitioners suggested that most lacked training in trans people's sexual health needs, but that they wanted to access this. Several practitioners told us that they wanted to deliver high-quality care to trans people, but did not always have relevant information to hand or know how to ask questions in a sensitive and inclusive way. Practitioners reported particularly limited knowledge or experience of engaging with non-binary people.

## Report structure

The first chapter of the report provides an overview of the context within which this research took place. We discuss the provision of sexual health care to trans people across the UK, as well as the limited evidence on trans access to sexual health services. Chapter 2 outlines the project methodology, describing the survey, focus groups and interviews carried out with trans

people, as well as our interviews with sexual health practitioners. Chapter 3 describes our quantitative findings. Chapters 4 to 7 present our qualitative findings, exploring barriers and facilitators to engagement with services at the individual, social, organisational and policy levels. Chapter 8 presents findings from our interviews with sexual health practitioners, while chapter 9

concludes the report and sets out our recommendations. We intend this report to be of practical value to trans people, as well as to sexual health practitioners and policy makers. Therefore, while sharing difficult experiences and barriers to engagement, we have also sought to emphasise the factors that enable people to access and engage with sexual health services.

## Introductory reflections from Oliver Wain, peer researcher

I initially considered the idea of researching trans access to sexual health services in 2017, after a particularly eye-opening experience of accessing a sexual health service myself. I was surprised by the lack of knowledge about trans sexual health and tried to find out this information through my own research. I found all of the resources wanting and was unable to find much research literature on best practice in transgender sexual health.

When I asked members of the trans community about how they managed their sexual health needs, many of my friends relayed similar issues in accessing sexual health information and looking after their sexual health. I began creating rough guidelines for myself, based on different online resources that I had found. I used this information as the basis to have discussions with my local sexual health clinic about trans sexual health needs, raising issues such as trans-inclusive language use in relation to contraception. My concern around a lack of trans-inclusive sexual health provision fell on the ears of Oceana Maund from Scottish Trans Alliance, who later became my co-collaborator and peer researcher on this project. We worked together to present a workshop at the 2018 Scottish Trans Alliance conference on sexual health for all trans people: trans men, trans women and non-binary people. The workshop revealed that many trans people had difficulty accessing appropriate and relevant information about their sexual health, and faced numerous barriers to accessing sexual health services.

Through my involvement with the NHS Lothian Transgender Stakeholder Group, I became aware of a new research project starting at Waverley Care, coordinated by Ruth McKenna. Given the lack of evidence about trans access to sexual health services, particularly in Scotland, both Oceana and I had separately made contact with Waverley Care about the need for more focus on trans sexual health needs. To my delight, Waverley Care agreed that this was a key area that would be valuable to investigate further, and the research project developed from there.

Reflecting on our research findings, I was most surprised by the specific barriers that the Scottish non-binary population face to accessing sexual health services, such as misgendering. It was apparent that there were unmet needs specific to this group, and at times it was difficult to hear the distressing experiences some participants shared. This is also reflected in the NHS PrEP criteria, which does not explicitly include non-binary people. This leaves many non-binary people feeling confused and excluded. I was pleased to see our efforts to engage with a wide and diverse community resulted in a diverse group of participants. Trans women were less numerous in our groups which led me to wonder whether the burden of gynaecological health issues played a role in increased engagement from trans men, trans masculine and non-binary individuals. I have been particularly happy to see some of the key findings from our engagement with the trans community are also reflected in the findings of interviews with clinicians – primarily that more training for clinicians is a desirable outcome for all involved.



# Chapter 1. Background and context

This chapter provides an overview of the context within which this research took place, as well as a brief summary of existing literature on trans people's sexual health needs and access to sexual health services.

## 1.1. Existing research

Research on trans people's sexual health needs and access to sexual health services is limited, particularly in the Scottish context. Globally, we know that trans women are disproportionately affected by HIV, with prevalence levels estimated to be around 19 % (Baral et al. 2012). There is some evidence to suggest that HIV prevalence may be of similar levels among trans men (Stephens et al. 2011).

Data from Public Health England (2019) shows that 152 trans people accessed HIV care in 2018. Of those 152, 128 were trans women, <30 were trans men, and <5 identified in another way. As Jaspal et al. (2018) note, it is not possible to accurately estimate HIV prevalence among trans people in the UK because there is a lack of census data on the trans population. The authors note that HIV prevalence may well be lower in the UK than internationally, because there are lower rates of undiagnosed HIV in the UK.

Evidence from England and internationally indicates that some trans people may be less likely to access HIV testing and more likely to have risky sex than the cis population. In a survey on LGBT sex and lifestyles, Hibbert et al. (2020) found that trans participants were less likely to have ever taken an HIV test than cis respondents. Half of those

participants who reported condomless anal sex had never taken an HIV test. Reviewing an outreach testing service at a trans sex-on-premises venue in London, Wolton et al. (2018) reported high incidence of unprotected sex among those accessing testing. A case note review of trans women attending a London-based sexual health clinic found very high rates of STIs and unprotected anal sex among attendees, although lower HIV prevalence than expected (Dufaur and Bayley 2016). Approximately 18% of women attending the clinic undertook sex work. Research with trans men in Ontario found that of those who identified as gay, bisexual or men who had sex with men, 43% had never been tested for HIV (Bauer et al. 2013). Nine per cent reported high risk sexual behaviours and 16% had exchanged sex for money or goods.

Both Hibbert et al. (2020) and Wolton et al. (2018) found low awareness of PrEP among trans respondents. However, in a qualitative study with trans people in Edinburgh, Smith (2019) found that respondents were well informed about their sexual health needs and HIV prevention, including PrEP. Although Smith's research is a small and localised study, it is one of the only studies on trans sexual health in Scotland. Smith found that trans people faced a range of barriers to accessing PrEP including stigma, lack of knowledge and training among sexual health service providers, practical constraints, and a lack of inclusivity within services.

International research has identified several factors that may influence trans people's access to PrEP, including: levels of community awareness about PrEP (Kuhns et al. 2016; Oldenburg et al. 2016), tailored information about PrEP and its side effects (Rael et al. 2017; Rowniak et al. 2017), and availability of trans competent sexual health care (Rowniak et al. 2017; Wood et al. 2017). Klein and Golub (2019) advise that the practice of grouping trans women and trans feminine non-binary people with cis gay and bisexual men and men who have sex with men (GBMSM) should be stopped. Finally, comment has also been made on the need for further research and guidance on PrEP use and efficacy among trans people, taking into account factors such as vaginal atrophy during testosterone therapy, interactions between PrEP and hormonal therapies, and the needs of trans men who have receptive vaginal and anal sex (CliniQ 2015; Rael et al. 2017).

Many of the barriers trans people face to accessing PrEP also affect access to sexual health services more widely. A national survey by the UK Government Equalities Office (2018) found that trans respondents were less likely than cis respondents to have previously accessed sexual health services, as did Hibbert et al. (2020). The UK Government Equalities Officer found that trans people experience greater difficulty and anxiety when accessing sexual health services than cis people, reporting that trans respondents were less likely than their cis counterparts to describe access

to sexual health services as 'easy' or 'very easy' (p.195). The findings also highlighted that the most common reason for trans respondents not having accessed services was that they were worried, anxious, or embarrassed about doing so.

International qualitative evidence provides insight into some of the reasons trans people may be less likely to engage with sexual services and why they may experience anxiety and worry when doing so. A systematic meta summary of qualitative evidence on barriers to accessing sexual health services among trans and male sex workers found that stigma, low levels of sexual literacy, concerns about confidentiality, and structural barriers all influenced access to services (Brookfield et al. 2019). A qualitative study with trans GBMSM in Ontario found that a lack of trans-competent care operated as a barrier to engaging with HIV and STI testing, while trusted service providers and the integration of testing with ongoing monitoring for hormone therapy facilitated engagement (Schein and Travers 2017). In one of the few studies with trans people in rural areas, Harb et al. (2019) found that trans people in the US Midwest identified the availability of trans-competent care, distress around engaging with sexual health services, and the environment/setting of services as influencing their access to sexual health services.

Many trans people experience other vulnerabilities and forms of

marginalisation, which can compound barriers to engagement with sexual health care. Much existing research on trans sexual health documents high levels of drug and alcohol use (Dufaur and Bayley 2016; Hoffman 2014), mental health concerns (Herbst et al. 2008; Smith 2019) and history of sexual/physical abuse (Dufaur and Bayley 2016; Herbst et al. 2008). This reflects wider research showing that trans people are at high risk of experiencing sexual or physical violence (Coulter et al. 2017; Stotzer 2009). Trans people in the UK are more likely than the general population and other LGB people to experience intimate partner violence (Stonewall 2018). They also have high levels of poor mental health (Stonewall 2017) and report high levels of alcohol and drug use (Glynn and van den Berg 2017; Scottish Trans Alliance 2016b).

## 1.2. Sexual health provision for trans people

In Scotland, trans people can access sexual health care via NHS sexual health services, as well as their GP. In certain areas of the country, some sexual health services – such as STI testing – can be accessed via third sector organisations,

such as Waverley Care and Terrence Higgins Trust. Third sector sexual health services are generally targeted towards communities that are disproportionately affected by STIs, or who experience barriers to accessing sexual health services.

There are two sexual health services in the UK specifically for trans people. CliniQ in London is a trans-led community interest company that delivers sexual health and wellbeing services to trans people and their friends and families. CliniQ is run in partnership with Kings College Hospital, as well as other third sector organisations.<sup>3</sup> Similarly, ClinicT is a sexual health clinic for trans people based in Brighton and Hove Sexual Health and Contraception Service.<sup>4</sup>

Chalmers Sexual Health Centre in Edinburgh recently ran a service also called ClinicT, which was aimed specifically at trans people. The clinic ran for around six months and was then withdrawn. Staff we interviewed at Chalmers said that uptake of clinic appointments had been low and, when people did book appointments, there were often no-shows. Trans people who attended our Edinburgh focus groups felt that uptake of clinic appointments had been low because people were not aware of the service. Focus group

3 CliniQ: <https://cliniq.org.uk/>

4 ClinicT: <http://brightonsexualhealth.com/service/clinic-t/>

participants said that the service was not advertised within the community and, indeed, several participants did not know that there had been a trans-specific clinic at Chalmers. Part of the rationale for initiating this research project was therefore to gather evidence about what kind of service delivery people would like to access, and whether this would be via integrated NHS sexual health services, a trans-specific NHS service or another kind of service.

As a final point, it is worth drawing attention to the British Association for Sexual Health and HIV (BASHH) 'Recommendations for integrated sexual services for trans, including non-binary, people' report (BASHH 2019). These recommendations were produced by a group comprising clinicians, academics and third sector organisations from across the UK. They cover all aspects of engagement with sexual health services, including service design considerations such as environment, registration process and health promotion literature, as well as clinical aspects such as assessing risk, examinations, HIV, PEP and PrEP, and contraception. We accept the BASHH (2019, p.4) definition of an inclusive and welcoming sexual health service as:

*one that actively tries to reduce barriers to trans people...It tried to avoid essentialising ideas about gender (for example that someone with a uterus is always female) or binary thinking (for example, that everyone will fit into the traditional categories of 'male' and 'female').*

We refer to the BASHH guidance throughout the report, highlighting where our findings and recommendations chime with this existing guidance.

## 1.3. PrEP

Pre-exposure prophylaxis (PrEP) is a medicine that is taken to prevent an HIV-negative person from acquiring HIV. Since July 2017, PrEP has been available via the NHS in Scotland. PrEP is free at the point of use to people who are at high risk of acquiring HIV through sex. Eligibility is assessed using a universal and risk criteria, which are as follows:

### 1.3.1. Universal criteria

The person must be:

- Over 16
- Resident in Scotland
- HIV negative
- Able to attend the clinic for regular three monthly review including for monitoring, sexual health care and support and to collect prescriptions
- Willing to stop NHS funded PrEP if the eligibility criteria no longer applies

### 1.3.2. Risk criteria

One of the following criteria must also be satisfied:

- Current sexual partners, irrespective of gender, of people who are HIV positive who have a detectable viral load.

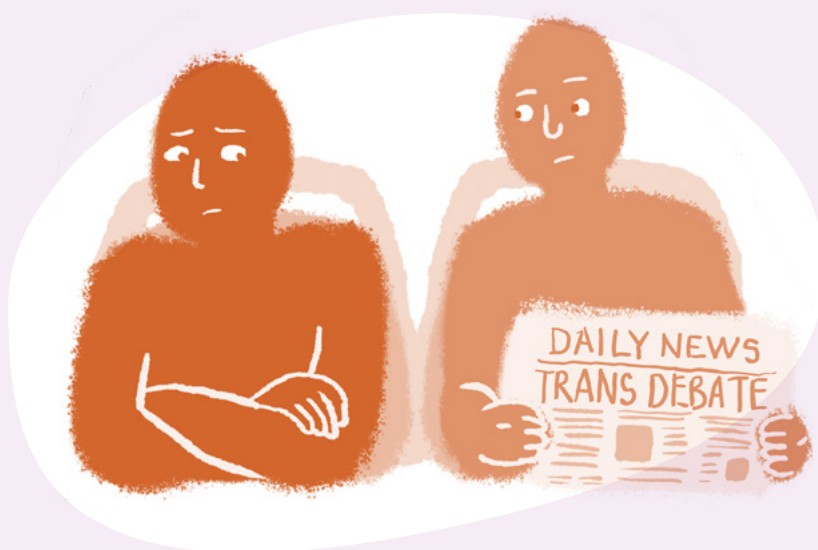
- Cis and transgender gay and bisexual men, other men who have sex with men, and transgender women with a documented bacterial rectal STI in the last 12 months.
- Cis and transgender GBMSM, and transgender women reporting condomless penetrative anal sex with two or more partners in the last 12 months and likely to do so again in the next three months.
- Individuals, irrespective of gender, at an equivalent highest risk of HIV acquisition, as agreed with another specialist clinician.

Both trans men and women are explicitly mentioned in the NHS PrEP criteria, and we know that trans people are at higher risk of acquiring HIV (National AIDS Trust 2017). However, uptake of NHS PrEP among trans people in Scotland is nonetheless low. Of 3354 people who were prescribed PrEP between 1 July 2017 and 30 June 2019, only 17 (0.5%) were trans (Health Protection Scotland 2019).

## 1.4. Transphobia and reform of the Gender Recognition Act 2004

As a final note, it is worth highlighting the context in which this research took place. We carried out this project during

a time of increased public focus on trans rights, linked to the ongoing debate around reform of the Gender Recognition Act (GRA) 2004. Since 2004, the GRA has allowed some trans people to change the sex on their birth certificate, providing them with formal legal recognition of their gender. However, the current process to do this is lengthy, intrusive and humiliating. It requires trans people to have a formal diagnosis of 'gender dysphoria', to have lived in their 'acquired gender' for two years, and provide evidence of this to a gender recognition panel.



In recognition of the need to reform this process, both the Scottish and UK Governments announced proposed reforms to the GRA in 2017. The Scottish Government published a draft Gender Recognition Reform Bill in 2019 and launched a second consultation, inviting views on the draft bill. Both consultations have resulted in sustained and often hostile public, political and media engagement with trans people and their rights. Much of this debate has

expanded far beyond the parameters of the GRA, focussing on whether to roll backwards the degree to which society and services currently recognise trans men, trans women and non-binary people in line with how they are living, rather than as their sex assigned at birth. This has created an increasingly hostile environment in which trans people have to navigate their daily lives.

Evidence suggests a worsening environment for trans people in the UK. 2017 research by Stonewall found that 41% of trans people and 31% of non-binary people had experienced a hate crime or incident in the previous 12 months because of their gender identity (Stonewall 2017). The same research

found that 40% of trans people and 52% of non-binary people have adjusted the way they dress because they fear discrimination or harassment. Recent freedom of information requests to police forces in Scotland, England and Wales indicate an 81% increase in hate crimes against trans people. Police Scotland recorded 92 hate crimes against trans people in the year up to March 2019, in comparison with 76 crimes two years earlier (BBC 2019). As we discuss later in this report, some of our participants cited transphobia as influencing their engagement with services. It is therefore worth bearing in mind the wider – and often hostile – context within which this project took place.



## Chapter 2. Methodology

This chapter describes the research methods used to gather and analyse information about trans people's access to sexual health services, as well as highlighting ethical considerations and the limitations of the project.

## 2.1 Research methods

We used a peer-led approach to carry out this research. Peer-led research is an approach whereby people who have personal experience of the topic under investigation are directly and equally involved in the design and delivery of research (Burns and Schubotz 2009). In practice, this meant that our project was co-designed and delivered by a core team of two peer project coordinators, one a trans man, and the other a non-binary person, as well as a cis project coordinator.

The first stage of the research was a national survey, exploring trans people’s experiences of accessing sexual health services in Scotland. We carried out the survey to enable a larger number of people to participate, to provide a means for anonymous participation, and to gather quantitative evidence about people’s experiences. The survey contained a combination of closed and open-ended questions. It was hosted on Survey Monkey and shared via social media and community and professional networks. We also attended several Pride events during 2019 to promote the survey. We incentivised responses by providing a prize draw for three £50 vouchers. The survey remained open

between April 2019 and August 2019, and we received 289 valid responses after data cleaning.

The second stage of the research was a series of focus groups in Glasgow and Edinburgh, facilitated by the peer engagement officers. We ran one focus group for trans women and trans feminine people, one for trans men and trans masculine people, and two for non-binary people. We also carried out a small number of interviews with people who could not, or did not want to, attend focus groups. 28 people participated in focus groups, while an additional participant took part in an interview. Two focus group participants also took part in follow up interviews, as they wanted to share more information about their experiences. Appendix 1 contains basic demographic information about our participants.

We recruited focus group participants from survey respondents who had agreed to follow up contact, as well as publicising the groups among community networks. The groups were held on weekends and evenings during September 2019. Focus group participants received £20 in cash, in recognition of their time and contribution to the research.<sup>5</sup> We also paid travel expenses and provided food and refreshments at each group.

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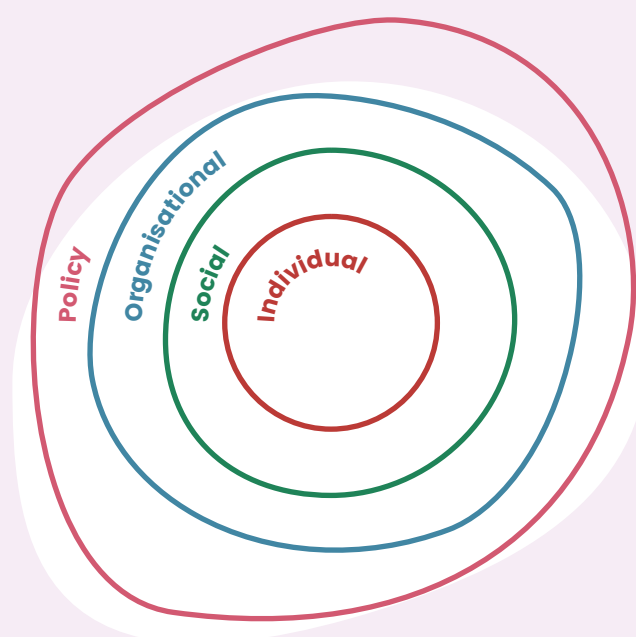
5 Reimbursement rates were approximately based on the Real Living Wage, which is currently £9.30 in Scotland.

We used a variety of methods to enable participation in the groups. These included open discussion using prompts and the use of Post-it Notes to share how participants felt about accessing services. We also carried out a visual mapping exercise to explore participants' 'ideal sexual health service'. This involved thinking about where they would like services to be based, who would be involved in delivery, what kinds of services they would be able to access, and how engaging with services would make them feel. This allowed us to explore what participants felt would facilitate or enable access to sexual health information and services, as well as providing a space to discuss challenges and barriers.

Finally, we carried out interviews with eight staff working in NHS sexual health services in Scotland. We recruited interviewees from NHS Greater Glasgow and Clyde, NHS Lothian and NHS Highland, to ensure a diversity of perspectives. Interviews explored practitioners' knowledge and confidence delivering services to trans people.

We engaged an external researcher to carry out data analysis, ensuring the timely progression of the research. The transcripts were analysed using thematic coding to identify dominant themes. The data were then refined by the project team to highlight the most significant themes.

Our qualitative findings are framed using a simplified socio-ecological model of access to health care. We adapt the model set out by McLeory et al. (1988) which, building on Bronfenbrenner (1977), proposed that health promotion interventions should address both personal and social-environmental influences on health. Specifically, the model suggests that interventions must address factors that influence health at the intrapersonal, interpersonal, institutional, community, and public policy levels. Modified socio-ecological models are widely used to understand public health issues and interventions, including in relation to sexual health (Latkin et al. 2013; Lewis et al. 2020; Lorimer et al. 2018). Our simplified model looks at the individual, social, organisational and policy factors that influenced our participants' engagement with sexual health services.



## 2.2. Ethical considerations

Various ethical considerations guided our research. We ensured that all participants provided informed consent. Survey participants received introductory information about the purpose of the project, data storage and use, and contact details. Consent to participate in the survey was presumed by return, although respondents were informed that they could withdraw their response by contacting the project coordinator. Focus group and interview participants were sent an information sheet ahead of the sessions taking place. These information sheets were reviewed at the start of the focus groups and interviews, and consent gathered using written forms.

We received approval from the relevant research governance teams at Sandyford

Sexual Health Services, Chalmers Sexual Health Centre and Highland Sexual Health Services in order to interview staff working in NHS sexual health services.

Our focus groups and interviews were audio-recorded and transcribed by an external transcription service. The audio-recordings were destroyed upon receipt of the transcripts. The transcripts were anonymised and stored on a private drive.

We recognised from the outset of the project that research can create and perpetuate unequal power dynamics between researchers and participants, especially when participants are from already marginalised groups (Nagore and Waterston 2018). We sought to ensure a more equal balance of power within the project, both by using the peer-led approach described above, as well as ensuring participants were adequately reimbursed for their time and labour.

### Carrying out ethical research as a peer researcher

I felt my prominent position as a community leader and activist within the trans community was both an asset and a challenge at various points of the research. I often reflected whether my friendships and relationships with members of the community who contributed to the research might help them feel more comfortable and reassured when discussing sexual and reproductive health issues, or whether it could be a barrier to discussing personal matters. To overcome this, I often reinforced the importance of consent and confidentiality – that participants' comfort was the most

important part of research. I also reiterated that any engagement in the research, topics discussed, or withdrawal from research would not affect the friendship or relationship I had with any participant, and there would be no judgement on such actions. I was aware that I had many personal assumptions about what the findings of the research might be, so I made a conscious and ongoing effort not to impress these views on participants and to be open to hearing other experiences and opinions.

As a disabled researcher, I had some anxiety as to whether I may find it difficult to pick up on subtleties of communication, but found this not to be the case. I was aware when focus group participants seemed to want to contribute, when time was needed for participants to discuss and air their frustrations about services as a whole, even if they were not specific to sexual or reproductive health. Often, because there is crossover between services, sexual health could not be discussed in isolation from gender services, for example. It felt beneficial to participants to allow discussions around gender services to occur, usually bringing a sense of mutuality and community among participants who did not know each other.

I also found in interviews it was not difficult to know when the conversation could be concluded naturally, or when it was valuable to the interviewee to allow them to air wider concerns about society and medical care, in relation to sexual and reproductive health. Having experienced significant healthcare inequalities, difficulties accessing care in many ways and insufficient services inappropriate to needs, it was important to allow participants a place to be listened to and give them a space to talk about topics that concerned them but were not often heard by those in service delivery.

It was personally important to me that we reimbursed participants for taking part and provided food and travel expenses. Trans people are often asked to commit our time and energy to research with no reimbursement. I would have felt much less comfortable promoting the project within the community without making sure we were fairly recompensing people for their participation.

I firmly believe my position within the trans community as a peer helped dramatically improve engagement in all elements of our research, and feel this should be noted as a key factor in any future research. Like a shoal of fish, the trans community often work together to support each other. I felt participants were able to trust that the research would have tangible and effective outcomes if a trans person themselves was a part of the research – involvement of peers should be the standard in research with or about the trans community.

We sought to remain accountable to our participants throughout the research process and so invited all trans participants to an update session in February 2020. We presented our draft findings and recommendations. This session also enabled us to carry out respondent validation (Lewis-Beck, Bryman and Liao 2004), ensuring that our interpretation of findings reflected participants' experiences. This further enhanced the rigour and reliability of the findings.

Given the sensitivity of the research topic and the need to ensure anonymity, we have included minimal detail about participants throughout the report. We have not used pseudonyms, to ensure that a person's identity could not be pieced together using different extracts.

## 2.3. Limitations of the research

The report is based on research with a self-selected convenience sample and so is not representative of all trans people in Scotland. The lack of census data about the trans population in Scotland means that we cannot confirm how representative our findings are. As a percentage of our participants however, we note that trans women were underrepresented in our interviews and focus groups, and to a lesser degree in our survey data.

The extent to which the research represents those living in rural and remote areas is limited. While survey respondents reflect the geographic makeup of Scotland (approximately 60% respondents based in the Central Belt and 40% outwith this region), focus group participants were mostly based in Glasgow or Edinburgh. We found recruiting focus group participants outside the Central Belt challenging and, although we planned to carry out a group in Aberdeen, this did not go ahead due to cancellations. Therefore, while our survey findings provide insight into the experience of those living in rural and remote Scotland, there is further work to be done to fully understand the perspectives of trans people living in these areas.

Finally, it should be noted that our engagement with sexual health practitioners was limited to those working in sexual health services, as we did not have the capacity to carry out additional engagement with GP surgeries. Many of our trans participants told us that they sought sexual health care from both sexual health services and GPs, and so there would be value in future research exploring the knowledge and confidence of GPs delivering sexual health care to patients who are trans.



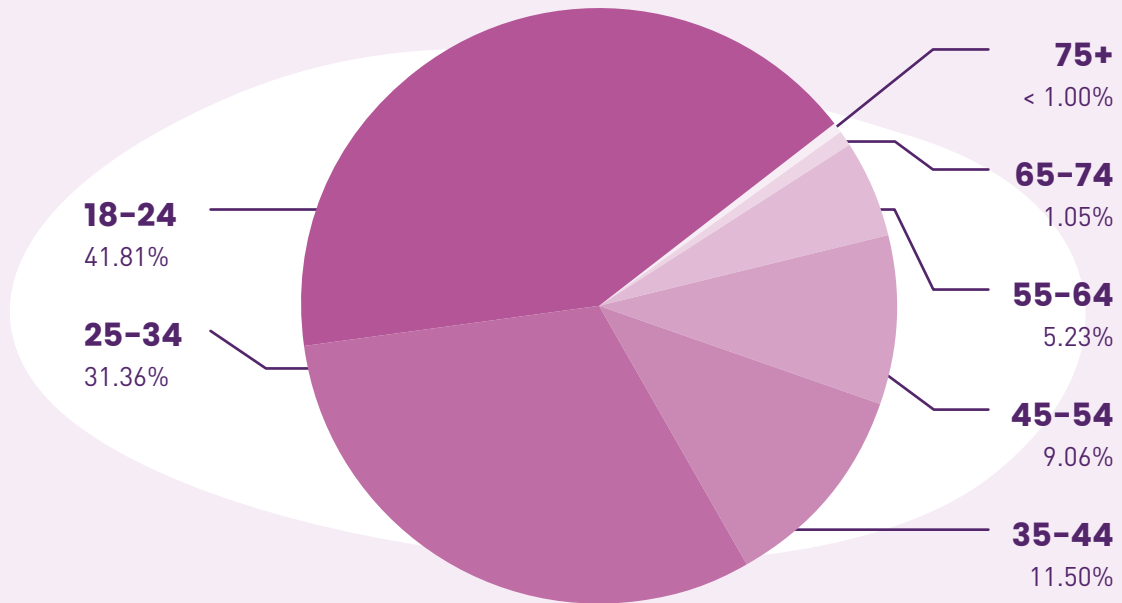
trans  
and  
nonbinary

## Chapter 3. Quantitative findings

This chapter presents a brief overview of our quantitative research findings, gathered through a survey with trans people across Scotland. Over three hundred people responded to our survey and, after data cleaning, 289 responses were included in the final response set.

## 3.1. Descriptive statistics

The age breakdown of respondents is shown below:



**Chart 1: Age of survey respondents**

21% of respondents were female and 30% male.<sup>6</sup> 41% were non-binary and 8% described their gender in another way. Of those who described their gender in another way, responses included 'genderqueer', 'gender fluid' and 'agender'.

19% of respondents were gay/lesbian, 42% bisexual and 7% heterosexual. 32% described their sexuality in another way, most frequently 'queer' or 'pansexual'.

Respondents were based across Scotland, with approximately 62% based in either NHS Greater Glasgow and Clyde or NHS Lothian. 22% were based in NHS Tayside, Grampian, Highland and Fife. The remaining respondents were based in other health board areas, with NHS Orkney the only health board area where we did not have at least one respondent.

<sup>6</sup> We asked people about gender using a two-part question. Firstly, we asked if people described themselves as 'male', 'female', 'non-binary' or 'in another way'. A second question asked whether this was the gender respondents were assigned at birth.

## 3.2. Engagement with sexual health services

The first substantive section of the survey explored respondents' experiences of accessing sexual health services. 39% of respondents had visited a sexual health clinic in the past two years, while 61% had not. This figure remained approximately the same when responses were broken down by gender identity.

We asked those who had not attended a sexual health clinic to tell us why this was, if they felt comfortable doing so. One hundred and thirty-three people provided further information. 36% of those said that they were not sexually active. 35% said that they did not need to, for example, because they were in a long-term monogamous relationship, or because they did not consider

themselves at risk of acquiring STIs. 24% described fears and anxieties relating to their gender identity; for example, how clinicians would talk about their body parts or whether they would be misgendered. Finally, 20% cited practical reasons, such as transport or logistical concerns.

Of those who had visited a clinic in the past two years, 94 people provided us with further details about their visit. 72% had done so in NHS Greater Glasgow and Clyde or NHS Lothian. 64% had attended for STI testing, 23% for contraception/STI prevention and 36% for other reasons, including; STI treatment, termination of pregnancy, and for care relating to sexual function.

We asked respondents to agree or disagree with a series of statements about their most recent visit to a sexual health clinic. We have broken down responses by gender identity as there was variation in experiences.

**Table 1: Trans men's experiences of attending sexual health clinic**

Statement	Agree	Disagree	Not applicable
Staff used the correct pronouns when talking to, or about, me	70%	22%	7%
I was misgendered by staff at the clinic	26%	70%	7%
I was offered tests or treatments that were appropriate for my anatomy	67%	15%	19%
Staff asked inappropriate questions	30%	70%	0
My privacy was respected	74%	19%	7%
Overall, I felt like the clinic was inclusive towards trans and non-binary people	69%	19%	12%

**Table 2: Trans women's experiences of attending sexual health clinic**

Statement	Agree	Disagree	Not applicable
Staff used the correct pronouns when talking to, or about, me	90%	10%	0
I was misgendered by staff at the clinic	15%	80%	5%
I was offered tests or treatments that were appropriate for my anatomy	75%	10%	15%
Staff asked inappropriate questions	25%	75%	0
My privacy was respected	90%	10%	0
Overall, I felt like the clinic was inclusive towards trans and non-binary people	80%	20%	0

**Table 3: Non-binary respondents' experiences of attending sexual health clinic**

Statement	Agree	Disagree	Not applicable
Staff used the correct pronouns when talking to, or about, me	41%	41%	18%
I was misgendered by staff at the clinic	44%	38%	18%
I was offered tests or treatments that were appropriate for my anatomy	90%	5%	5%
Staff asked inappropriate questions	15%	72%	13%
My privacy was respected	82%	13%	5%
Overall, I felt like the clinic was inclusive towards trans and non-binary people	36%	51%	13%

As the tables highlight, trans men, trans women and non-binary respondents reported different experiences of attending sexual health clinics. 90% of trans women and 70% of trans men agreed that staff used the correct pronouns when talking about them, compared to only 41% of non-binary people. This difference may be explained

by the fact that many non-binary people use gender-neutral pronouns. Pronouns are the way someone refers to you. The most commonly used pronouns are ‘she/her/hers’, normally used for women, and ‘he/him/his’, normally used for men. Non-binary people may use the singular ‘they/them/theirs’, or other gender-neutral pronouns such as ‘ze/hir/hirs’.

Similarly, 15% of trans women and 26% of trans men reported that they had been misgendered, compared to 44% of non-binary people. While 80% of trans women and 69% of trans men felt that the clinic they attended was inclusive towards trans and non-binary people, only 36% of non-binary respondents felt the same. As well as using gender-neutral pronouns, many non-binary people ask that they are referred to using gender-neutral language, such as “that person in a red jumper” rather than “that man in a red jumper”. As we discuss in chapter 8, few service providers have been provided with trans inclusion training and so are often unaware that some of their service users need them to use gender-neutral language in order to feel welcome and included.



In relation to testing and treatment and staff questioning, however, trans men and women reported poorer experiences. 67% of trans men and 75% of trans

women said that they were offered tests or treatment appropriate for their anatomy, compared to 90% of non-binary respondents. Similarly, only 15% of non-binary respondents said that staff had asked them inappropriate questions, compared to 25% of trans men and 30% of trans women.

### 3.3. Knowledge of and access to PrEP

The second substantive section of the survey explored respondents' knowledge of and access to PrEP. 71% of survey respondents had heard of PrEP before, while 29% had not.

We asked respondents to assess their circumstances against the current NHS PrEP universal and additional eligibility criteria. 55% of the 240 respondents who answered the PrEP section of the survey told us that they met the universal eligibility criteria.<sup>7</sup> 22% of those who met the universal criteria also told us that they met at least one of the additional PrEP criteria, as detailed in the table below. These findings are broken down by number, rather than percentage, given the small cohort of respondents (29 people). Respondents could select more than one criteria.

7 Resident in Scotland, over the age of 16, able to attend for regular three-month reviews, confirmed HIV negative test, willing to stop taking PrEP when no longer eligible.

**Table 4: Additional NHS PrEP criteria met by respondents**

Statement	Respondents
Current sexual partners, irrespective of gender, of people who are HIV positive who have a detectable viral load.	2
Cis and transgender gay and bisexual men, other men who have sex with men, and transgender women with a documented bacterial rectal STI in the last 12 months.	10
Cis and transgender gay, bisexual men and other men who have sex with men, and transgender women reporting condomless penetrative anal sex with two or more partners in the last 12 months and likely to do so again in the next three months.	18
Individuals, irrespective of gender, at an equivalent highest risk of HIV acquisition, as agreed with another specialist clinician.	5

Of those 29, seven had tried to access NHS PrEP and 22 had not. Five of the seven eligible respondents had been prescribed NHS PrEP. The two people who had not been prescribed PrEP said that this was because, in the case of the first respondent, PrEP would interact with other medication and, in case of the second, they had missed their initial appointment.

We asked the 22 people who met the eligibility criteria why they had not tried to access PrEP. Six 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.

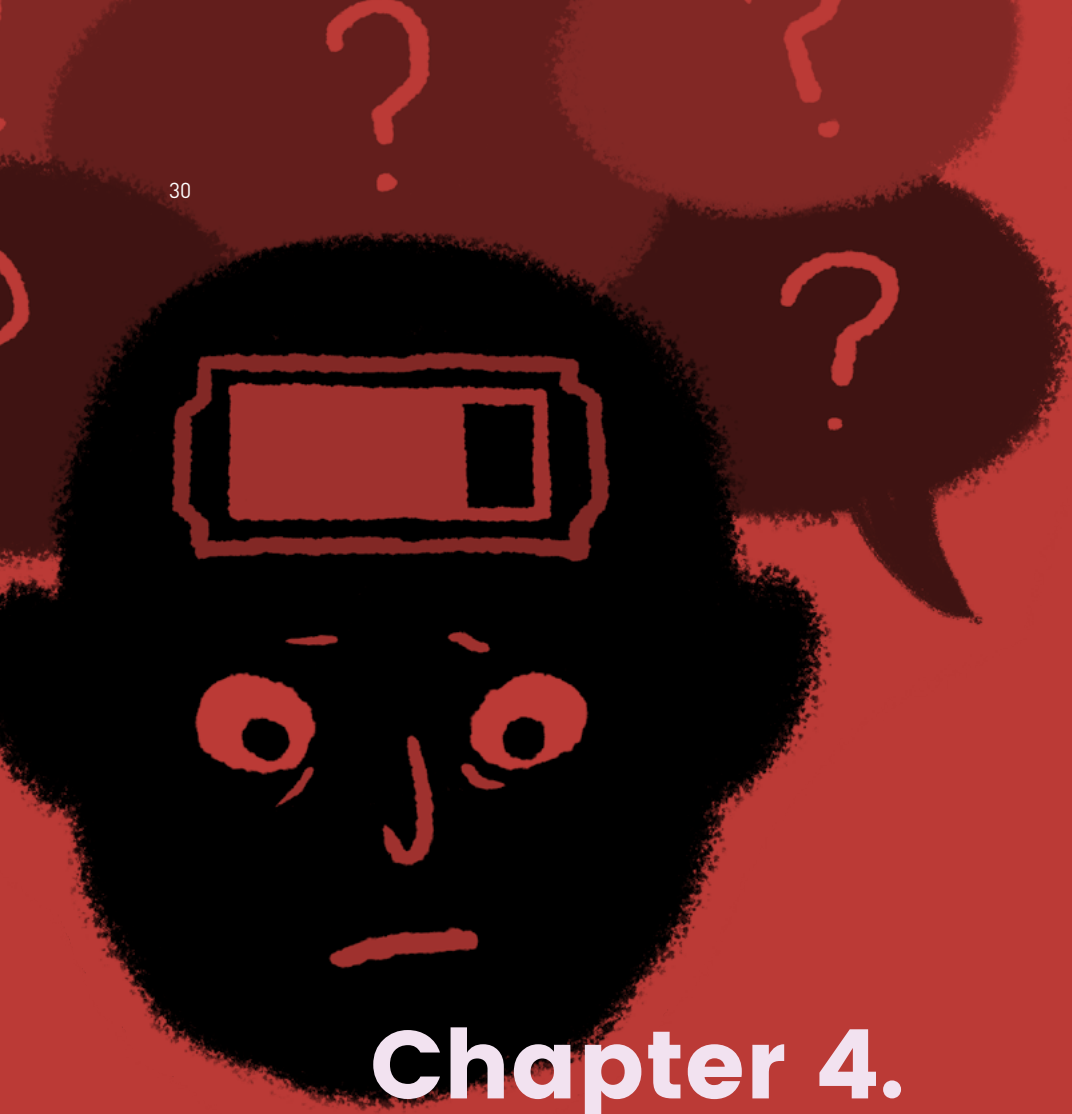
We asked all survey respondents to review the NHS PrEP criteria and then asked whether they felt the criteria were trans inclusive. 43% of respondents agreed that the criteria were inclusive, 31% disagreed, and 26% were not sure.

We gave respondents the option to provide further feedback on the criteria and the reasons for their answers. 133 people provided further comments. 46% commented on the absence of non-binary people from the criteria. 26% commented on the way in which gender was referred to within the criteria, for example suggesting that the criteria should refer to types of sex and the body parts involved, rather than

referring to gender. 16% said that they felt the criteria was inclusive, with some commenting that it was positive to see trans people explicitly mentioned. 16% said they found the criteria confusing. As our qualitative findings also suggest, there is further work to be done to ensure that trans people are able to use the PrEP criteria to understand whether they are at risk of contracting HIV and would therefore benefit from accessing PrEP.

The next four chapters use our qualitative data to explore some of the themes raised by the quantitative evidence in more depth, including: fear and anxiety about engaging with sexual health services, non-binary inclusion, access to sexual health information and services, and tackling gendered assumptions to provide trans-inclusive sexual health care.





## Chapter 4. Individual barriers and facilitators

As discussed in the introduction, we used an adapted socio-ecological model to frame and understand participants' experiences of accessing sexual health services. This involved looking at facilitators and barriers to access at the individual, social, organisational and policy levels. The next four chapters explore our findings from each of those levels in turn. Although discussed separately, we would emphasise that each of the levels described are interrelated, with organisational and policy level barriers often affecting participant's perspectives at the individual level.

We begin by discussing barriers and facilitators to engaging with sexual health services at the individual level. We found that participants' knowledge, perceptions and feelings about sexual health and sexual health services played a key role in enabling or preventing them from accessing relevant services.

## 4.1. Fear

The majority of our focus group and interview participants identified fear as a barrier to accessing sexual health services. Having the space to disclose fears to a caring and concerned sexual health clinician or practitioner could help address fears and enable access to services. Fears around STI transmission could also play a role in motivating people to access services. Fear operates as a barrier to trans people accessing a range of health services (Ellis, Bailey and McNeil 2015; Seelman et al. 2017) and so it is unsurprising that our findings reflect this evidence, particularly given the intimate nature of sexual health care.



At the beginning of each group, we asked all participants to think about words they associated with sexual health. Responses included:

*Terrifying. I think that's probably the first word for me that crops up.*

*Intimidating, terrifying, Anxiety-provoking.*

*Nerve wracking*

For some participants, feelings of fear and anxiety were motivated by previous negative experiences of accessing sexual health clinics. A survey respondent explained:

*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.*

Another commented that 'previous experiences haven't been the best; it can be a very intimidating place to go.' Similarly:

*My previous experience at the [the clinic] deterred me from going back in future. I feel I cannot trust or rely on the service to properly meet my needs and it causes me stress and anxiety thinking about...returning.*

Some recalled previous negative experiences of engaging with their GP practice about sexual health, which led to fear of future engagement with sexual health care:

***[I] went back once I'd started transitioning, for a smear, and the nurse that was running, doing my smear test, said, 'Pop yourself up on the table, take all your bits off and do your thing.' Then shortly before she went to do anything, I said, 'Look, I'm really, really nervous about this, is there anything that you can do to help?' and she sort of went, 'No, nobody likes this,' and I went, 'Ah ha, but I am trans, can you help me?' She just went, 'No, no woman likes this,' and I went, 'I'm not a...' Then she proceeded to do the procedure and I left in tears.***

In a review of health care issues affecting trans people in Northern Ireland, McBride and Hansson (2010) found that just one poor experience with a service provider is likely to make a trans person feel unable to access that service again. Indeed, as indicated in the second quotation above, some of the people we spoke to said that they were too anxious to return to sexual health services after a negative experience.

However, many of our participants' fears and anxieties were based on the perception that they would receive poor treatment at a sexual health clinic, rather than past experiences. These fears were so significant that they prevented people from accessing essential screening and other services. A focus group participant explained:

***It's not even like that particular centre or doctor or anything has done anything wrong yet. It's like the knowledge that I'm 99.9 per cent sure that they will, means that I don't go. I used to have to do annual smears and I've missed one of them, which is really bad. I was like, I can't do it. I can't go and do this horrible thing where they will treat me, like, really badly.***

A survey respondent similarly observed:

***I'd be nervous that staff at the clinic wouldn't be used to treating trans people. I've been on testosterone for so long that people would probably make assumptions about what kinds of genitals I have - and I think this would be awkward and I wouldn't want to have to deal with it. Similarly, because I'm non-binary I'd be worried that that would add an extra layer of complication, that would make the appointment even more awkward.***

Others talked about their fears specifically in relation to dysphoria, explaining that the experience of taking about body parts or having a physical examination would be too difficult. A survey respondent explained that they had not attended a sexual health clinic because they were 'too dysphoric around my body'. Another said that they were 'afraid of being misgendered or treated poorly because I am trans. Talking about my genitals or receiving care can also be very dysphoria inducing.'

Some participants talked about the positive aspects of engaging with sexual health services, because it was a means to allay fears about STI status or sexual health more generally. Some of the more positive words participants used to describe sexual health services included 'positive' and 'healthy'. One participant said 'relief, if you get a test done and you haven't got cancer.' This reflects existing research on access to testing, which has shown that fear of diagnosis can positively motivate people to access testing services (Shepherd and Smith 2017).

In relation to addressing and managing fears, participants talked about wanting to feel reassured, comfortable and cared for when attending sexual health clinics. During the visual mapping exercise we carried out during focus groups, participants shared some of the attributes that they felt practitioners should have. Responses include 'trustworthy', 'compassionate', 'ally', 'accepting' and 'non-biased'. A key facilitator for participants in overcoming fears and anxieties was to feel cared for when accessing sexual health services. A focus group participant explained:

*I think that care of, 'are you doing okay?' 'Is there a way that we could adapt for the future?' That would really help just in general. It keeps them in the know as well. I think a lot of the time, I wouldn't say if I was uncomfortable with anything in a clinic but being able to say, 'I'm really nervous. I'm really uncomfortable, because I'm doing this,' then you can*

*at least prepare and that the person you're seeing will know.*



Participants wanted to feel that practitioners understood the trauma that many trans people had experienced and why they may have legitimate fears about engaging with health services:

*[I want there to be an] understanding that there is a lot of trauma there for trans people. One day, hopefully, there won't be. An understanding from doctors that we do not trust them and we do not trust them for good reason, and that they have to earn that back, to an extent. Which hey, may suck for them. They individually may have never, ever have been transphobic, ever, maybe, but they still need to appreciate that we have valid fears and that they are there to alleviate them and give us care. Not to compound them into even worse fears.*

'There needs to be care throughout'

Another participant commented on the way in which intersecting identities and experiences could make engaging with services especially difficult, noting that ‘accessing sexual health services following sexual assault as a black trans sex worker is very traumatic.’

Talking about the ways in which practitioners could support people who found accessing services traumatic, an interviewee explained the importance of feeling that their concerns had been taken seriously and not minimised:

*I feel like they should take it more seriously. I get that they're trying to be upbeat and trying to put you at ease but it comes across as minimising rather than supportive, so just a bit of a sense of them taking it seriously would be really helpful.*

This sentiment is reflected in the experience recounted above, when a participant had tried to ask a nurse for help before a smear test and had been dismissed with the comment that ‘no woman likes [smears]’. Participants said it was important that sexual health clinicians listened to, and acknowledged, their fears, rather than trying to brush over or minimise these. Trusting a sexual health practitioner enabled participants to raise sexual health concerns:

*See, I really don't feel comfortable talking to my GP about [sexual health] at all. I just wait for my appointments with [the nurse at my local sexual health clinic] because I trust [them].*

## 4.2. Understanding of sexual health information and risk factors

The extent to which trans people could understand how sexual health information applied to their circumstances and, especially, STI and HIV risk factors, played an important role in mediating engagement with sexual health services. The degree to which people had the energy and ability to explain their circumstances and potential risk factors to clinicians, as well as self-advocate for appropriate testing and care, also played a role.

The role of sexual health information in enabling or preventing people from understanding risk and accessing prevention options was evident in relation to PrEP. As mentioned in the previous chapter, many survey respondents felt that it was challenging to understand whether non-binary people were eligible for PrEP based on the current NHS criteria. One of our peer interviewers had the following exchange with a non-binary participant when looking at the NHS PrEP criteria:

## Do you know if you would be eligible, looking at this?

*Are you a transgender woman? No. Are you a bisexual man? No. A man who has sex with men? No, because obviously, I'm not a man or a woman! So, that sends you down the wrong path there, doesn't it?*

The interviewee went on to say:

*Yes, that's not great. I think I looked at it before, and I thought, do I just fit into that, or not?*

Survey respondents reported similar difficulties identifying whether they would be eligible for PrEP or not. One respondent explained:

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

Another person said:

*As a transgender that has not undergone surgery or hormonal treatment, I feel it has to be clear that people like me are also contemplated. As a non-binary, I'm considering to use Mx in the future...If I pass well as a guy and feel no need to have surgery and hormones, will this include me?*

Participants explained that they would be better able to understand whether they were eligible for PrEP if the criteria were

explained in anatomical, rather than gendered terms. One respondent said:

*It doesn't really include non-binary people? Plus it's a bit confusing and I couldn't really follow anyway, I think it'd probably be easier if it just directly said whatever body parts or partners it meant rather than all the labels, or even just 'people', like 'people reporting condomless [anal sex]'?*

Another agreed:

*Generally it's not including non-binary people - it says men and women - and in one case 'irrespective of gender', which is good. Surely it's better to stick to the body parts, rather than try and predict the bodies of any gender? As in, rather than try and anticipate what the body of a trans man would look like by saying 'trans gay men', just say 'anyone having penetrative anal sex', or 'penis-in-anus sex'. It can be specific without misgendering.*

It is important to highlight that understanding risk factors and the available prevention options did not always enable people to engage with services. Some participants told us that, while they understood potential HIV and STI risks, they found it difficult to make their circumstances understood by sexual health practitioners. Often this required the person to have the energy to provide a full account of their circumstances and to self-advocate for appropriate testing or other interventions:

*I didn't feel able to tell them I'm non-binary as I didn't feel they'd respect or understand that. So it was easiest just to let them think I'm female. It was dysphoric but I just had to get on with it to get the tests done. I had to struggle quite hard to get them to do a throat swab as they kept insisting that as a 'woman' I am low risk, even though I engage in similar behaviours to men who have sex with men, with respect to unprotected oral sex with penises of many different people.*

Another participant explained:

*I often judge what information I'm going to give based on how much energy I have. If I'm up for a fight I'll be like, 'I'm a trans polyamorous pansexual, sex worker, treat me'. And then if I'm not, I'll just be 'Yes I'm a woman and I have a husband'.*

The second example above is of particular note because sex with multiple partners and sex work should be important factors for sexual health practitioners to be aware of, yet in this case, the person did not feel able to fully describe their situation.

While both participants above ultimately attended services, but did not always provide full information, this was not the case for others. Some participants told us that although they understood that they were at risk, the risks of harm to their mental health from a bad experience at a sexual health clinic outweighed the risks to their sexual health. One participant explained:



*We're taking calculated risks because there is an unknown amount of harm from not taking the tests and there is a known amount of harm to your mental health, and we have to make that judgement ourselves. And sometimes it is legitimately less harmful to just not get tested, even though that's a massively dangerous thing which is an important...that is how that is.*

Discussing a recurrent gynaecological issue, another participant said:

*This thing isn't killing me even though it's putting me in, like, loads of pain, but mental health-wise how long do I stick it out before it's going to take months to recover? In my head I'd have to sit in a hospital and balance it out. Can I go through a couple of weeks of pain and this re-occurring again or months of mental health recovery?*

As we discuss in the following chapters, although participants experienced multiple barriers at the individual level, such as fear and access to relevant information, several of these barriers could be addressed by facilitators at the social and organisational levels.



## Individual factors: summary

### Barriers

- ✘ Fear
- ✘ Uncertainty about risk factors

### Facilitators

- ✔ Feeling listened to and cared for by sexual health practitioners
- ✔ Energy and knowledge to self-advocate



## Chapter 5. Social barriers and facilitators

This chapter explores social factors that enabled or prevented people from accessing sexual health information and services. We found that peer support facilitated people to attend services and to overcome fear and anxiety. While there could be trust and accuracy concerns with community-generated information, peer and community support played an important role in enabling access to sexual health information and services. Many participants wanted to see the inclusion of trans people within sexual health service delivery, either in clinical or support roles.

## 5.1. Peer support and encouragement

Peer encouragement and practical support facilitated people to engage with sexual health information and services. A survey respondent explained:

*I was embarrassed to [attended sexual health services]. I am going in the next few weeks though as my partner and my family are encouraging me to do so.*

Wanting to protect a partner, especially when a new relationship started, could play an enabling role:

*Just say this is what happened, I would like myself tested and then if there is another question, just say I've had a new relationship. I have had a risk, and I want to protect my partner.*

Participants also told us that it could be helpful to bring a friend or partner with them when attending sexual health appointments, and that this could help in addressing or managing fears. One participant explained:

*Any kind of reproductive health things, I tend to bring a woman with me, a friend who's a woman with me...it helps you feel less out of place in the waiting room[.]*



Similarly, when discussing factors that would enable access to services, some participants said that having a friend or partner accompany them to consultations would help alleviate anxiety. A focus group participant commented:

*I know people who have gone in and who have brought their partner, or who have like brought cushions to make the bed more comfortable.*

Despite the positive impact that support from another person could have, some participants told us that they had experienced problems when trying to bring along a friend or partner to testing and screening appointments:

*[It] varies so much...I think there's only been one time when I have had to go do the smear, where I've had a friend come in with me, sit by my head and hold my hand. They were like, 'Oh no, they can't come inside the room with*

*you.' I was like, 'Well, I consent to that, I want them there,' and they wouldn't let me. So that's like, I want that to be [allowed].*

Two other participants reported similar experiences:

*My fiancé and I also had the same experience and I was only allowed in with him once they started having a meltdown.*

And:

*I was allowed them in the room, but not behind the curtain and it was literally my partner, and I was like, 'They've seen it all before'.*

General Medical Council guidelines on intimate examinations state that patients should be offered the option of having an impartial adviser (chaperone) present during the examination (General Medical Council 2013). The guidance explains that, as a relative or friend would not be impartial, they would usually not be a suitable chaperone. However, the guidance also notes that doctors should comply with a reasonable request to have a friend or relative present, as well as a chaperone, if this is requested.

We understand that there is a need to make sure people can be honest about intimate health issues, especially if there may be a coercive or abusive dimension to their relationships. However, we also understand from speaking to

practitioners that this can be managed by finding time to speak to the person in private, while also allowing them to have someone present during the examination. It is therefore unclear why some participants were prevented from having a partner or friend present during intimate examinations.

## 5.2. Community-generated information

Peer and community networks played an important part in enabling our participants to access sexual health information. As we discussed in the previous chapter and revisit in the next chapter, participants often struggled to access sexual health information from services that were tailored to the needs of trans people. However, while community networks in person and online were identified as important sources of information, participants expressed concerns about the validity of the information they were accessing. In this way, community-generated information could also be a barrier to accessing accurate and tailored sexual health information.

We asked people how they accessed information about sexual health. Some participants accessed trans community spaces on Facebook, YouTube, and other online platforms:

*I used to get a lot of [information] from YouTube and trans YouTubers. [However], anything that the algorithm leads to sex is now blocked which... is a nightmare if you are legitimately looking for information about sex because you're trans. It's really destroying the positive work that loads of these people have spent years building because there is such a massive hole in sexual health and reproductive health services.*

*that. But then I'm also, are you getting the information you need, especially if people are in early stages of transition or whatever. It's like, who's helping you out because...I'm not, like, I'm going to come and help you and tell you all of these things. More just, like, if you're not getting that conversation is it just, like, piecing inaccurate information together on the internet. It does really concern me.*

Similarly:

*Facebook groups...I know there's one, like a huge one for trans men that, again, I don't like it but loads of my friends have had really good experiences, asking questions and then having lots of people being like, 'This was my experience'.*

Others spoke to friends and peers:

*I still wouldn't say that I'm entirely clued up despite having all that research – most of my research is from speaking to other trans people and asking their experiences, but even then not everyone's experience – it's just so difficult.*

Some felt that face-to-face sources of information were more reliable than online sources:

*I mean, we talk about sex, that's what we do. And there are some people who are quite visibly uncomfortable, and then I'm right okay I'm not going to do*

As the comments above suggest, while the internet and peers could be a valuable source of information, there were limitations to this. Participants expressed concern about the volume of and variation in information available:



'There needs to be care throughout'

*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.*

Another person commented that they had to 'go to 20-odd different websites and then join the dots'.

While, as we discuss in the next chapter, the involvement of trans people in sexual health information – and indeed service – delivery, can be an enabler to engaging with care, our participants wanted to know that the information they were receiving was accurate and evidence-based. Face-to-face and online community networks currently enable trans people to access sexual health information (of varying reliability) because, as we explore in the following chapter, there is an absence of such information and resources from services. It was clear that while participants valued accessing information via trans community spaces, they wanted some certainty that this information was reliable.

### 5.3. Involving trans people in service delivery

Many participants wanted to see the visible involvement of trans people in the delivery of sexual health services. Some people felt that having trans staff would

help assuage some of the difficulties experienced within sexual health services:

*If it's a trans person actually giving you the health care then you'd know that they're not going to randomly ask you about the sex if it's not appropriate.*

Another person felt that having queer practitioners within sexual health services could be helpful, but would not necessarily address concerns with processes:

*That includes as well having queer practitioners, such as at CliniQ, which I think is like brilliant and admirable and should be rolled out everywhere, but none of that negates the process itself, which is what I have the issue with.*

Some participants suggested that there could be a non-clinical role for trans staff within sexual health services. This would involve providing support and advocacy for trans patients. One person suggested introducing a 'trans liaison role', while another explained:

*Yes, to have a specific department or person or whatever you can go to, if your needs within health care are not being met, then you have a point of reference where you know how to go about making sure that isn't the case, or having someone who can step in and do that for you, so you don't have that emotional labour.*

Almost all of the nine participants at the group where this was suggested agreed that this would be helpful.

Some participants felt that all sexual health staff should deliver trans-inclusive care, rather than providing a

separate service for trans people. One person suggested the introduction of a 'charter' scheme, to show that a sexual health practitioner was knowledgeable and confident delivering sexual health information to trans people.

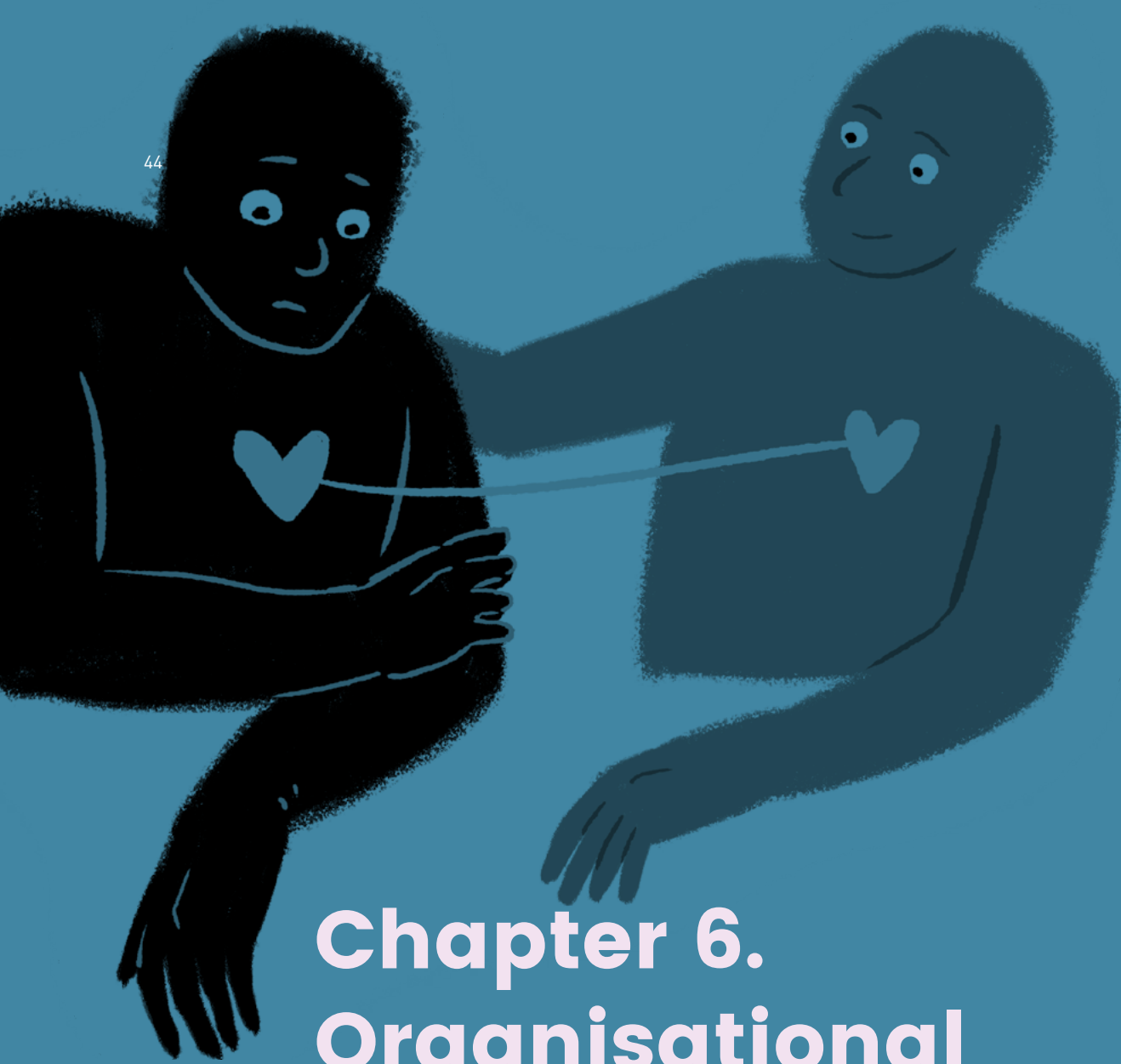
## Social factors: summary

### Barriers

- ✘ Not allowed a companion in appointments
- ✘ Inconsistent and unreliable information from community spaces

### Facilitators

- ✔ Support from friend or partner at appointments
- ✔ Involvement of trans community in NHS/third sector service delivery
- ✔ Access to sexual health information within community spaces (both online and in physical spaces)



## Chapter 6. Organisational barriers and facilitators

This chapter explores organisational barriers and facilitators to trans people accessing sexual health services. The chapter primarily focuses on NHS sexual health services, but also draws attention to the role of the third sector. We found that location and environment, processes and practice, and the position of gender identity services within sexual health services all played a significant role in either preventing or enabling participants to engage with sexual health information and services. Throughout this chapter we reference frequently to the BASHH (2019) recommendations for integrated sexual health service for trans people, highlighting where our findings align with this existing guidance.

## 6.1. Location and access options

Participants talked extensively about the location of sexual health services, exploring factors such as geographic location, remote access options, and accessibility needs. Many of the facilitators our participants talked about are relevant to the wider population and, if implemented, would enable better access to services for all.

Our participants felt that, as a basic starting point, sexual health services should be accessible. This included geographic accessibility, as well as ensuring disabled access. One person explained that services should be:

*[Local] to people, where they are in terms of, related to kind of disabilities or particular needs people may have whether it's physical or learning disabilities[.] It should be totally accessible.*

Participants felt that it was essential to have a range of ways to access sexual health information and services, both remotely and in-person. In particular, people said that there should be digital and postal access options, to benefit both people who lived in rural and remote areas, as well as those who experienced fear and anxiety attending clinics in person. Referring to the process of making appointments, one person explained:

*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 people we spoke to said that it was important to be able to access information and services online. A few participants said they would like to access a live chat service, where they could ask sexual health questions via online messaging services:

***You could talk to someone and see if you need to go in. You could probably get some answers just from talking to someone online.***

Another person noted that digital access options would improve accessibility:

***Also, it makes it accessible for deaf and hard of hearing people, so even if they have just an email, even if it isn't a live chat, even if it's an email, being able to book appointments maybe by email or non-phone things.***

As discussed earlier, the people who took part in our research often had difficulty accessing reputable information from online sources, as the available information on NHS and other reliable websites was not tailored to the needs of trans people. Participants said that it would be helpful to have online information from an 'official' source:

***Like you were saying about there are some things that you would need that you don't actually need to go for a physical space...There's a lot of things that you can worry about and you want to know what you should do. Having access to official information online, for example, like on the NHS website or something like that, that would be enough to deal with certain issues.***

Participants highlighted that many online health resources were not trans inclusive, and therefore could not be relied on to access sexual health information:

***With NHS Inform, I've had many instances where I've had a [problem] and you go to NHS Inform. Great, there's a health self-help guide! It asks you, are you male or female?... Are you male, do your testicles hurt?! Well, no! Also then I find it have to misgender myself to access the actual information that I need and then I've had a hysterectomy...It's difficult to access information that's actually suitable online within, say, NHS Inform so coming up with something like that that might be trans-suitable.***



In addition to digital services, participants identified services via post as another way to overcome some of the barriers to accessing face-to-face services. Explaining why they would prefer to access postal testing services, one person explained:

***Privacy would be a big part as well, but I think being trans [is] always just an added complication. It's always an added complication and it's one of those things where the main reason [I would use postal testing] is social anxiety; that sort of thing. But, being***

*trans and having to go, and then explain everything on top of that explaining being trans to the doctor on top of that; that's just even added. So not having to have any human interaction...If I was cis then it'd probably be a preference thing, but because I'm trans it's even more of a preferred thing.*

Where face-to-face service delivery was required, participants said that physical accessibility should be a key consideration. For example, some people talked about stairs within sexual health clinics, making clear the importance of offering lift access. Participants said that staff should not make assumptions based on appearance and should always offer lift access, as well as any other alternative options, to ensure equal access to services.

## 6.2. Environment

Many of those we spoke to talked about the environment within sexual health services, with some suggesting that a relaxed and non-clinical looking environment would both improve accessibility and operate as a wider facilitator to engaging with care. During the visual mapping exercise we carried out with focus group participants, several participants described their ideal sexual health service atmosphere as 'non-clinical', with one person commenting that they would like sexual health service waiting areas to be 'more homely'.

Describing their local sexual health service, a participant said:

*It looks very clean. It's very white it's very straight-edged. I would like to go to a place with beanbags and maybe has more of a sensory consideration, with low lights and colours.*

Discussing CliniQ, a London-based sexual health and wellbeing service for trans people, another person commented:

*One of the things that I really liked about [the setup at CliniQ] was this super kind of relaxed atmosphere that they had there. They talked about how people would come in and play instruments and so on but also I think did they mention that they had peer-to-peer support as well.*

As suggested by some of the comments above, our participants identified environmental factors as important in making services more accessible:

*I would love if these services were genuinely accessible. Things that weren't designed to put you into meltdown and sensory overload.*

Some of the people we spoke to said that fluorescent lights, loud radios, and television screens were environmental factors that could make waiting areas inaccessible to people with autism and others who may experience sensory overload. Recognising that it may not be possible to change lighting and sound

in the main waiting areas in clinics, participants suggested that it would be helpful for clinics to have an additional, quiet room where people could wait if they did not want, or were not able, to wait in the main area.



Our participants noted that waiting areas should be gender neutral, explaining that leaflets and posters about topics such as PrEP, HPV and cervical smears were often aimed at men or women. Gender-neutral toilets should also be available. These suggestions reflect BASHH (2019) guidance on the delivery of integrated sexual health services to trans people. The guidance recommends that toilets and waiting rooms should not be segregated by gender, and that waiting room leaflets, posters and health promotion messaging should be inclusive of trans identities.

As a final point, it is worth highlighting that some participants felt discomfort at the locating of gender services within sexual health services. As mentioned at the beginning of the report, the two main gender services in Scotland are located within sexual health services in Glasgow and Edinburgh, as is the gender service in Inverness. The inclusion of gender services within sexual health services was a source of discomfort to some of the people we spoke to and presented a barrier to engagement with other sexual health services. One participant explained:

*I don't like the fact that there's a sexual health clinic linked to a service for transitioning anyway, because, as trans people, we're already over fetishised. Having them both in the same building – it's not, like, the worst practical problem, it's more of an ideological [problem], but it makes me uncomfortable that basically the same rooms and the same people...because being trans has nothing to do with sex, like, at all.*

Another person agreed:

*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.*



We recognise that there could be feasibility issues in changing the location of gender services in Scotland. However, participants suggested that a shorter-term solution could be to have a separate reception and waiting area for gender identity clinic (GIC) appointments and for wider sexual health appointments.

### 6.3. Access within the community

While some participants wanted to access services within an adapted and more accessible NHS setting, others said that they would find it easier to access sexual health services that were completely separate from NHS buildings. In particular, participants said that they would like to access STI testing in non-clinical venues within their local community. People had a variety of suggestions for where such testing could take place, including in local authority venues, such as libraries,

as well as community spaces, such as foodbanks. One person had accessed testing on their university campus, via the Pride society, and felt that had been a positive and accessible experience. Another had accessed testing via a fetish club and preferred that environment to an NHS clinical space. A few participants talked about accessing third sector organisations for sexual health information and services:

*I always go to one of these charities or online so people just send [a test] to me in the mail.*

However, we found that there was generally low knowledge of the sexual health services delivered by charities in Scotland. One person, who recognised that they should access testing, explained that they did not know about alternatives to their local NHS sexual health clinic:

*I wouldn't know what third sector organisation to approach. I suppose that Chalmers is the one from NHS that everyone could go with...I was thinking about my sexual health, I was thinking more about a smear, but recent experiences had led to experience with sexually that I haven't an experience before, and realising that I was encouraging risks, that I wasn't aware of...so it would be a better idea to get tested.*

Another participant made clear that third sector sexual health services should make explicit that they were trans inclusive:

***Third sector stuff I've very rarely engaged with. A lot of the time if it's not broadcasting itself as a specifically trans thing, I tend to assume that it's not for trans people.***

A non-binary participant talked about using a third sector service for gay and bisexual men but experiencing negative feelings about this, because the service was not openly non-binary inclusive:

***I use [a local third sector service], but I feel really, really weird and bad almost for using it, because it's specifically focused on gay men and bisexual men. The same goes for things like PrEP because they're specifically targeted at gay men and bi-men...So from that point of view I feel fairly uncomfortable with the fact that I feel like am doing something wrong almost by using that service, because it's technically not for me.***

In addition to being explicitly trans inclusive, the people we spoke to advised that third sector services should make clear that they were free:

***I think I have the assumption that third party means costs a lot of money, so I tend to only think of what's accessible on the NHS. That may not be a correct assumption, but it doesn't occur to me that there may be other organisations that aren't NHS that can do that sort of thing.***

While some of our participants felt that the third sector had a role to play in sexual health information and service

delivery, it was clear that third sector services had to make visible that they were trans inclusive. Linking back to the findings discussed in the previous chapter, it would also be beneficial for both third sector and NHS services to work in partnership with trans community groups and online spaces to disseminate information, as well as to promote – and potentially deliver – sexual health services. BASHH (2019) suggests that outreach clinics and services may be beneficial in reaching trans people who have low awareness of sexual health services and how to access them.

## 6.4. Processes and practice

Our participants talked at length about the kind of service they would like to receive when attending sexual health services. They made several suggestions relating to processes and practice, which we have split across four sub-sections for clarity. The sub-sections cover registration and intake, taking a sexual history, understanding sexual health needs, and electronic recording. The experiences shared relate to NHS sexual health services, but are also relevant to third sector organisations who deliver sexual health services.

### 6.4.1. Registration and recording pronouns

Participants talked about ways to make arrival and registration inclusive in order

to facilitate access to sexual health services. Those who had previously attended a sexual health clinic had generally been asked to fill in a form upon arrival. The way in which these forms asked about gender varied depending on location. In some clinics there was only a male or female option, while in others there was an additional 'transgender' option. None of our participants had filled in a registration form with a 'non-binary' option. Our participants felt that gender should be asked about in a way that enabled them to accurately and fully express their identity.

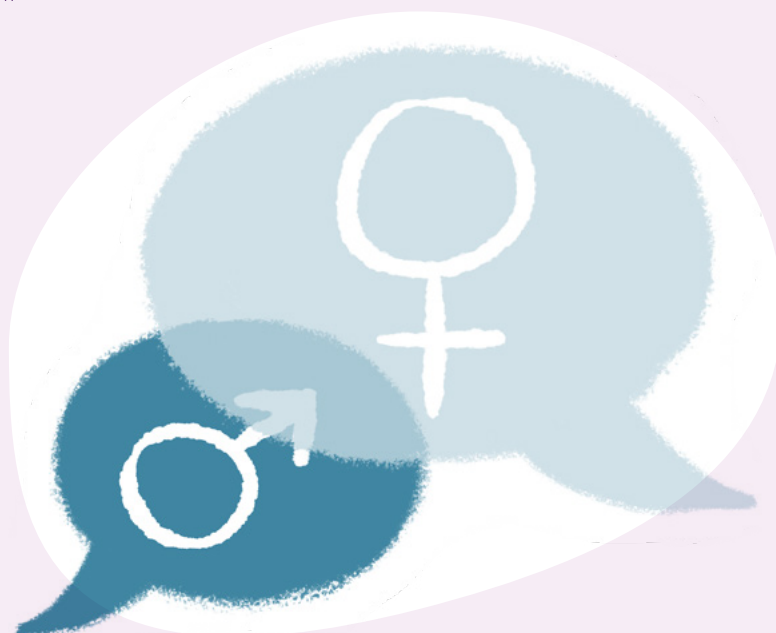
Some participants suggested that the initial intake form could include a section where people could highlight their pronouns, how they would like practitioners to refer to their genitals, as well as to mention other issues of which the practitioner should be aware:

*It is like that thing with the forms as well, like being able to say in advance, 'This is how I want you to refer to my genitals. This is how I want you to deal with touch'. Being able to flag in advance, 'You need to tell me everything you're doing or I don't want to know about it. Don't talk about it'.*

One person noted that a sexual violence support service used this approach:

*Yes, they were actually really nice because when I first saw them it was a while back but when I first signed up I don't remember what gender options there are but they do ask what terms*

*should we use, what terms shouldn't we use to talk to you about your body, and what should we avoid doing? It might not be very comfortable for people but it's for survivors of sexual assault so they're very good at consent and making that very ingrained in their process and I think that's something that I'd like to see taken to other services. I mean it feels like once you get it, oh this is great, but also it's the bare minimum.*



Participants made clear that, if staff – including reception staff – did not know a person's pronouns, then they should not assume or guess. 'They/them' should be used until the staff member found out the person's pronouns. In particular, our non-binary participants shared experiences of misgendering and incorrect pronoun use:

*I shouldn't have to explain the entire gender spectrum just to get you to use my pronouns. I shouldn't have to*

*explain that yes, there are more than men and women, and explain exactly where on the gender spectrum I exist and then to validate my non-binary identity, then finally get you to use, or make a slight attempt to use my pronouns for about three sentences before you revert back to she/her.*

It will be recalled that, in our quantitative data, only 41% of non-binary survey respondents said that sexual health clinic staff has used the correct pronouns when talking to or about them. This was compared to 70% of trans men and 90% of trans women who said the same. Within our focus groups, non-binary participants talked at far more length about experiences of being misgendered within sexual health services, reflecting these quantitative findings. As mentioned earlier, non-binary people may be more likely to use gender-neutral pronouns, such as they/them, potentially explaining this divergence. This would suggest better training and awareness of non-binary identities is required within services, as well as guidance to use they/them pronouns until explicitly informed of a person's pronouns.

Participants who reported positive experiences at clinics noted that they had been asked about their pronouns:

*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.*

Similarly:

*Staff were very approachable whilst maybe not knowledgeable, they were respectful of pronouns and only asked necessary questions regarding where would need swabbed.*

BASHH (2019) guidance recommends that practitioners ask about pronouns at the beginning of consultations, as well as checking that they are using the right name for the patient. It also advises that practitioners establish with the patient what terms they use for their genitals and any words they would like the practitioner to use (and avoid).

## 6.4.2 Taking a sexual history

Participants said that they would like to be asked open, necessary, and non-gendered questions by practitioners when beginning a sexual health consultation. BASHH (2019) recommends that practitioners ask about sexual history in a non-gendered way, without making assumptions about anatomy. This recommendation was strongly echoed by our participants, who talked at length about the way in which they had been asked about sexual history in gendered terms when accessing services. A survey respondent commented:

*One of the first questions they ask to triage people is 'do you have sex with men, women, or both' and when*

*I challenged this, they insisted it was trans inclusive. It's obviously not non-binary inclusive, and it's not really trans-inclusive either: the information they seem to be asking for is about sexual behaviour, not the genders of my partners...But, staff seem squeamish or reluctant to ask actually useful questions, like if I have receptive penetrative sex.*

A focus group participant shared a similar experience, highlighting the difficulty that gendered questioning presented in terms of understanding sexual activity and identifying risk:

*I'm polyamorous so I have multiple partners of many different genders, so they were, like, what's your sexuality and I was, like, pansexual [and] I'm polyamorous and they were, like, oh, so have you got a girlfriend or a boyfriend? I've got both. And they were, like, oh right then. Well, do you have sex with them, and I was, like, what are you trying to ask?...I was, like, my girlfriend has a penis though. You're, like, asking all of the wrong questions and they just sat there for a minute, and I was, like, you want to know if I have sex with penises or vaginas or both penises and vaginas so you should have asked me that.*

Participants recommended that practitioner should frame questions in relation to body parts:

*That would apply to any sort of first point of contact; so whether that is the app, whether that's the internet that*

*we're talking about, that's where it needs to be accessible, first point of call, so that needs to [non-gendered] language. [I would prefer] we talk about body parts, we talk about type of activity. We talk about what parts of the body we're using for that activity. None of this is gendered. None of this is based on your status in any way, other than the bits that you have and the type of activity that you're involved in.*

### 6.4.3. Understanding sexual health needs

Participants talked about the challenges they experienced in making their sexual health needs understood, which operated as a barrier to accessing care. Sometimes this was due to practitioners not asking the right questions and therefore not understanding their specific needs, while on other occasions was due to a lack of knowledge about trans bodies and sexual health needs.

A trans masculine participant shared details of their experience:

*I was asked if I was absolutely sure I [did not] fit regular sized condoms. The clinical staff seemed unaware trans masculine bodies do not fit condoms, but also didn't acknowledge I may use toys of various sizes – it was astounding the lack of such key knowledge. I was given correct advice eventually, to use internal condoms on partners. The clinic was inclusive, but lacking knowledge.*

A survey respondent shared similar difficulties in accessing appropriate testing and accurate information about PrEP, although also highlighted cases of good practice:

***She didn't understand that my body was different and didn't offer any vaginal swabs until I asked for them. [She also] recommended PrEP on demand, which is not proven effective for trans men (though she called me later that day to tell me this). The one who runs the PrEP clinic is amazing, as [is] everyone else I've seen. They also have been very respectful/knowledgeable when it comes to people who have gone to them after having slept with me.***

Discussing cervical screening, another participant said:

***It was Clinic T at Chalmers, so trans-specific sexual health clinic. I haven't had a sexual health check-up since, though I should, but am apprehensive about attending a non-trans [non-binary] specific service at this point. Even with Clinic T I had to suggest the clinician add a note to say I'm on testosterone to my smear info, as it can influence [the] result, and she was unaware of this.***

We would note that several of the issues raised above, such as those related to testing and screening, are dealt with by the BASHH (2019) recommendations for integrated sexual health services for trans people. The recommendations

provide clinical guidance in relation to examination, investigations, vaccinations, HIV, Pep and PrEP, contraception and screening.



Like all of the participants above, many of the people we spoke to felt that they had to educate practitioners about trans people's sexual health needs, rather than gaining information from their consultations. One person said 'you have to be the expert before you even see an expert'. Another explained:

***I feel like a lot of the time it feels like it's not worth even going, because you know you're going to have to spend the first three, maybe four appointments just explaining the basics to the doctor...And you've got to dedicate like an hour a week or a month to do that for them and even at the end of that they're still going to look at you and go, no, I don't get it. Then you're going to walk away without the test or the meds or whatever it is you needed anyway.***

As well as understanding trans people's sexual health needs, the people we spoke to said that, ideally, they would also like practitioners to be aware of some of the wider issues affecting trans people. This included awareness of poor mental health among the community, as well as delivering trauma-informed care. Some people told us they wanted practitioners to be conscious of the specific needs of sex workers, noting that trans people were more likely to be involved in survival sex work. Knowing that practitioners had an awareness and understanding of these issues was an enabler to accessing care and overcoming some of the individual fears and anxieties identified in chapter 3.

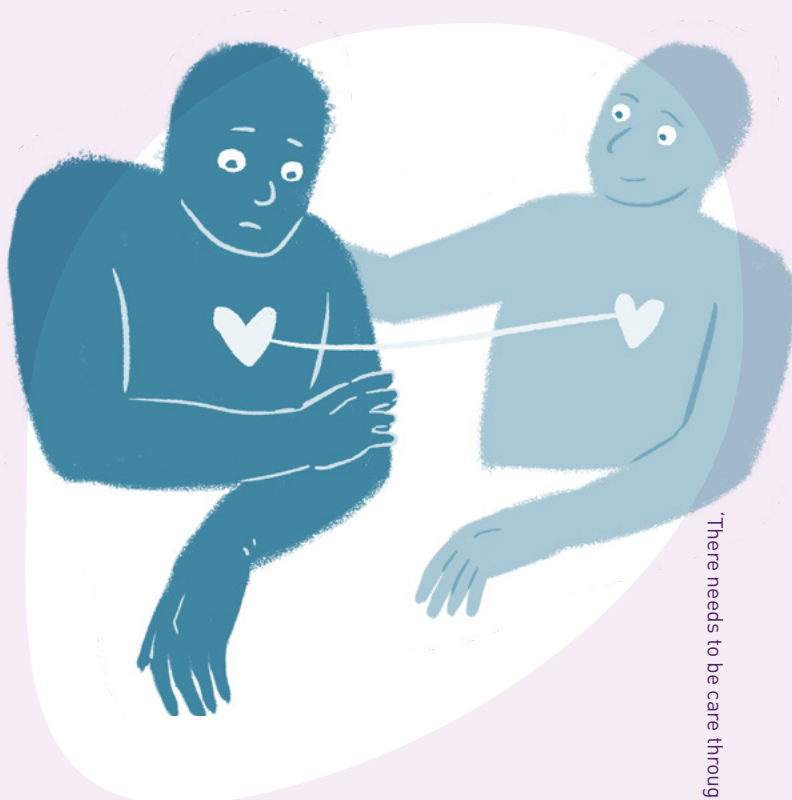
Participants did not expect practitioners to know everything, but emphasised that if they did not know something, the practitioner should go to the effort of finding out, rather than expecting the patient to do this:

***Yes, you don't need somebody to be all-knowing but they have to be open to going and finding out if they don't know, or even just telling you that they don't know is really helpful, rather than trying to muddle along.***

In terms of addressing gaps in knowledge that arose when a person was in a consultation, participants felt that practitioners could mitigate harm by showing genuine care and compassion, as well as a willingness to address gaps in knowledge. The people we spoke to acknowledged that,

inevitably, practitioners would get it wrong sometimes, but that if they were genuinely apologetic and demonstrated concern, this could mitigate some of the harm caused. One person said:

***Even the doctors have gone like, I'm really sorry I don't know this, because I should know this and you shouldn't have to teach me this, but can I ask you this question? Actually, what you're saying about them not caring, it's a huge difference. Like they care, and they're prepared to be like I'm sorry I don't know shit about this specific thing that you're here for and that's not good enough, but can we work together to find out how I am better with that. And you shouldn't have to do that but it's a really great environment.***



*'There needs to be care throughout'*

Some of the people we spoke to said that, rather than always trying to find out sexual health information in consultations, it would be helpful to have information evenings or workshops run by sexual health practitioners. This would enable people to come along, find out information and ask questions if they wanted to. One person said it would be helpful to have:

*‘Somewhere where you could just, like, you could have a cup of tea and you could ask someone the questions that you’re sure are going to be completely stupid and they could tell you, no, that’s a reasonable question.’*



Another person agreed:

*‘It would be quite good to have literal workshops or classes that was, like, ‘Oh, we run these twice a month, if you want to come in and learn about how this specific thing works, or this specific thing.’*

Echoing the views of participants, BASHH (2019) recommends that sexual health services consider providing drop-in and support services for trans people, ideally doing this in partnership with community organisations or organising trans-led sessions

#### 6.4.4 Electronic recording

As mentioned earlier, some participants were uncomfortable with gender services being located within sexual health services. Related to this issue were concerns raised around electronic recording and access to patient information. As part of sexual health services, gender services use the same clinical electronic records system as wider sexual health services. This is known as the National Sexual Health System (NaSH). This means that a person’s record of having accessed wider sexual health services is viewable to staff working in gender services, and vice versa. GPs and other health service areas cannot view information on NaSH.

One participant explained their discomfort of the shared use of NaSH and the barriers this presented:

*I [needed] to go and contacted them because I was worried that I might need [post exposure prophylaxis]. I phoned [my local clinic] and there was no way that I could get myself to go because something that they don't always tell you, but if you're at either Sandyford or Chalmers, the GIC staff can read everything on your sexual health notes and the sexual health clinic can see that you're a gender patient. Nobody outside of Chalmers can read your Chalmers notes, but everybody inside it can read each other's. I've had the experience of going to an endocrinology appointment at the gender clinic and the doctor saying, 'I see that you've been to the sexual health clinic recently and that everything was fine?' I'm, like, 'That's not why I'm here!' So it makes me feel very uncomfortable if I need a screening or whatever, I don't want that to be picked up the next time that I'm at the gender clinic. I found this nurse and apparently, it's absolutely fine to [attend the] sexual health clinic under a pseudonym, they will create a fake name and date of birth and stuff for you, but they don't tell you that unless you ask.*

On hearing this account, another person commented:

*And now I feel less comfortable going for a sexual health check!*

Another participant shared a similar experience of having information from a gender appointment brought up within a general sexual health appointment:

*I've had it both ways, when I was having a sexual health check-up, I've had the clinician, going, 'Oh I see you have a gender clinic appointment,' then also the nurse in the gender clinic being, 'You mentioned you do this play, but you haven't had this test, we need to do that'.*

Due to the confidentiality of sexual health records from GPs and other areas of the health service, it is understandable that people may not realise that their records from gender services and other sexual health services are documented in the same system. As described above, this can present a barrier to trans people openly engaging with sexual health services.

We recognise that it would not be straightforward to move gender service records to an alternative electronic monitoring system and, further, that this could create additional problems by potentially enabling NHS staff outside sexual health services to view gender service records, depending on the system used. However, it is of the utmost importance that staff within gender services and wider sexual health services are open and transparent with trans patients – and indeed all patients – about information recording. Proactive steps should be taken to ensure that people accessing gender services are made aware that the same electronic records system is used across all sexual health services.

As discussed in the next chapter, we acknowledge that clinical staff may have concerns about people accessing services under false names. However, if patients are not comfortable with their gender service and other sexual health service information being stored together, they should be given the option of accessing wider sexual health

services under a pseudonym. While not necessarily preferable from a clinical perspective, this will ensure that people are able to be open and candid about their sexual health needs. There should also be openness and consistency around offering people the option to access services using an assumed name.

## Organisational factors: summary

### Barriers

- ✘ Lack of geographic and disabled access
- ✘ Gendered environment within services, e.g. in leaflets or when a sexual history is taken
- ✘ Lack of knowledge of trans sexual health needs among practitioners
- ✘ Lack of tailored sexual health promotion resources for trans people
- ✘ Lack of transparency and consistency around use of NaSH

### Facilitators

- ✔ Non-assuming approach from practitioners, avoiding assumptions about gender, pronouns, or sexual activity
- ✔ Genuine listening, care and concern from practitioners, with a willingness to address gaps in knowledge
- ✔ Relaxed and non-clinical waiting spaces, separate from gender service waiting area
- ✔ Varied access options, including face-to-face and digital access options



## Chapter 7. Policy barriers and facilitators

This brief chapter explores the policy-related factors that participants felt played a role in their experiences of accessing sexual health information and services. Participants felt that transphobia, particularly around ongoing public debates about reform of the Gender Recognition Act 2004 (GRA) and wider trans equality and inclusion, impacted on access to services. To a lesser extent, participants also discussed the impact of austerity on access to public services, including sexual health services.

## 7.1. Transphobia

Participants talked about the way in which transphobia within society and, in particular, heightened public, political and media hostility around reform of the GRA, influenced their engagement with services. A participant explained:

*I think it's one of those things that might not directly impact our access to services but because of the environment it may do so solely because you might just feel uncomfortable being visibly trans in any sort of intimate personal environment, such as going to a sexual health clinic.*

The same person went on to explain further:

*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. Even if it's completely unjustified and even if they've done nothing at all to make you think they might not support you, you just want to naturally withhold information because you're scared.*



Others agreed, explaining that it was difficult to be open to health care providers within the current environment:

*Yeah, I mean, I'm not going to be particularly forthcoming about my gender when it feels like the world is unfriendly.*

Similarly:

*I have come across enough transphobia already that I am unlikely to choose to put myself in a position where I have to out myself and let someone else decide if my gender is valid in order to be able to access basic health care.*

Some participants felt that the lack of recognition of non-binary people within the recent Gender Recognition Reform (Scotland) Bill had demonstrated to public services that they similarly did not need to recognise non-binary people:

*When the GRA interim announcement was made and they decided not to include non-binary people obviously that was a green light for sort of non-recognition of non-binary to also be upped. So we're not included in any forms and services now they don't need to recognise we exist.*

While the clear facilitator in this situation would be to address transphobia within society and ensure the timely reform of the GRA, at the time of writing GRA reform has been halted due to the ongoing COVID-19 coronavirus pandemic. As a short-term measure, one participant had a suggestion for ways in which sexual health service providers could visibly demonstrate that they were trans allies:

*Something I just wanted to add, because it's a difficult and bleak conversation, is just that with everything negative in the media with [the GRA] is that if I am going to use a service and I go into someone's office, and I see something like a trans ally badge or poster on the wall about trans health care, or being a trans ally, or just something trans related, it means the world. It means so much more. And going into a room to use a service and seeing something like that just something about it makes*

*everything so much easier, and for that moment everything seems ok. When we have a positive experience, because of how bleak the situation is at the moment, it means so much more and it's so much more noteworthy.*



## 7.2. Austerity

A small number of participants talked about the wider impact of austerity upon the health service and the limited resources within the NHS. This created a barrier to participants accessing services because of reduced appointment availability and long waiting times. Reflecting on changes in the availability of practitioners in rural Scotland, one participant commented:

*In [my local area]... the lack of practitioners could be viewed as being an issue, but that's austerity for you. You can't phone up your GP and get necessarily an appointment that day. Similar with sexual health.*

Some participants talked about a desire to see waiting lists reduced:

*More clinics so there's not year-long waiting lists for everything. If we can do this type of clinic, if we [could] not have waiting lists for every single thing that trans people ever need to do, that would be good.*

Discussing the impact of long waiting times on their engagement with sexual health services, a participant reflected:

*If I had to wait three months then what's the point? So I probably wouldn't even bother waiting even though I should.*

While long waiting times are an access barrier faced by the wider population, for trans people and other marginalised groups, these general barriers add a further layer of difficulty to accessing services, on top of the population specific barriers outlined in the previous chapters.


## Policy factors: summary

### Barriers

- ✘ Transphobia, linked to reform of GRA
- ✘ Austerity

### Facilitators

- ✔ Service providers showing that they are trans allies



## Chapter 8. Practitioners' perspectives

In this final empirical chapter, we explore the perspectives and experiences of sexual health practitioners. As detailed in chapter 3, we interviewed eight sexual health practitioners about their experiences of delivering services to trans people. Our interviewees were doctors, nurses and support staff from NHS sexual health clinics in NHS Greater Glasgow and Clyde, Lothian and Highland. Two had experience of working in gender identity services and we have highlighted throughout where quotations are used from these practitioners. As in previous chapters, we frame the discussion with reference to barriers and facilitators to the delivery of trans inclusive care.

‘There needs to be care throughout.’

## 8.1. Access to information and training needs

None of the practitioners we interviewed had received training or information about the sexual health needs of trans people. One person said that a colleague from gender identity services had delivered a Continuing Professional Development (CPD) session on trans identities with other staff, but they had not been able to attend. While there may be many minority communities that staff have not received training on, the prevalence of HIV among trans women globally led us to expect that staff might have received some information or training on HIV prevention among trans people, if not trans people's sexual health needs more widely.

Interviewees noted that they had completed a half-day training session on LGBT+ identities, but had not received any specific training on trans people's sexual health needs:

*I suppose we do the LGBT training and everything that goes with that and that's mandatory now really for everybody to do. We try and do in-house training and everything, but to be fair I suppose when I started [here], I hadn't done any LGBT training, so I think there's much more awareness about that now, and much more training now than there used to be.*

When asked where they would access additional information about trans sexual health, most practitioners said that they would ask more well-informed colleagues:

*[My colleague in the GIC] has done sessions with us, and she's signposted me to an online website for training, which I haven't done as yet, but we will do. Generally, we have conversations and it's a real awareness of trans health, just because it's within our department.*

Another interviewee said that, in addition to speaking to colleagues, they would look online:

*I can't think of [where there is information available]. Not really. I suppose you'd go online, speak to colleagues, ask peers, colleagues what their opinions would be. If you were having problems, you know. Looking up websites and things. I suppose it would always be good to have points of good access.*

One interviewee acknowledged that, if they were struggling, they may ask the patient to share their expertise:

*I try to be led by the patient, because the other thing I don't want to do is go, 'I've done trans training. I know this craic; I know exactly what you want'. That's not okay, because it's not like... I can treat everybody exactly the same... I try to be led by the patient. With the trans people, I just tell them*

*that I don't actually know very much about the terminology and how things are going; and I really don't want this to be uncomfortable for them – can they help me? That's some of the way we get through it – I have expertise that can help them, but they've got expertise that can help me. So I try to just be as open with them as I can, and just say that I'm doing this along with them.*

While recognising the benefits of a person-centred and patient-led approach, it is worth recalling our findings from the previous chapter, which suggested that trans people did not want to be called upon to educate practitioners. While recognising the good intentions of the practitioner quoted above and the desire to provide good care, preferably practitioners would be well informed and able to provide patients with accurate information, rather than vice versa. This would encourage and facilitate trans people to engage with sexual health services.

Some interviewees told us that they, or their colleagues, wanted to deliver good care to trans patients but were frightened of saying the wrong thing. One interviewee explained:

*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.*

Later the same person explained:

*As I said, my big driver here is that people leave here feeling better; that's my job, that's why I'm called a nurse, so that's what I do, and I want people to [feel] that. So I think I want to know what would be offensive to people – because if I did offend somebody, it would be totally unintentional and I'd be gutted that I'd done that to somebody. So I would like to know what can I say and what can I not say?*

Reflecting on levels of confidence among their colleagues, another interviewee said:

*I think sometimes people, they're frightened to ask in certain ways because they're frightened to have failed and they don't want to have failed, but sometimes by not wanting to fail makes it even more obvious and creates an almost awkwardness which doesn't need to be there.*

Most of our interviewees said that they, or their colleagues, would benefit from further training and information about trans people's sexual health. One participant noted that this was something that they and colleagues had requested internally:

*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.*



Interviewees suggested that training should cover good practice when delivering services to trans people, including topics such as how to ask about pronouns, how to take a sexual history in an inclusive way, and information on what trans people were looking for from sexual health services. One interviewee explained that they and their colleagues would like to know:

*How to broach the subject of how to find out what the pronouns are, what phrase do you actually use? Is it okay to ask that? They might not understand that asking if someone's partner's a male or female might be problematic for that patient.*

The same interviewee went on to say:

*I think people would appreciate probably some kind of non-judgemental space, even if it initially is one just for colleagues to ask their questions without feeling like they're being too non-PC or making mistakes. I know it's notoriously difficult to get everybody together for things, but we have, what's the word, we have protected learning time when we have training sessions; I think it would be really interesting to give people that space.*

Another interviewee suggested that it would be useful to learn about key terminology and phrasing questions:

*I think for people that I manage; I think it would be useful questions. Useful vocabulary, useful questions and how trans or non-binary people feel they would like to be asked. Is there anything they would say? Would they prefer to be addressed this way, this is the vocabulary that we don't like?*

Someone else made the suggestion that an online resource could be helpful:

*Something like e-learning for health, we've got the online learning resources for NHS, which is free access that people can go on and do. Something like that would be useful for us to be able to signpost clinicians to for more information. The other thing that would be useful is what do trans patients want. For us to know what they would like and how they would like to be [addressed].*

It is worth highlighting here that most practitioners had low awareness of non-binary identities and of treating, to their knowledge, non-binary patients. Most of those we interviewed talked about engaging with patients who were trans men or trans women, but only a few said that they had knowingly interacted with a non-binary patient. It can be recalled that in our quantitative data, non-binary respondents more frequently reported that they had been misgendered and their pronouns had not been used when compared with trans male and trans female respondents. This would suggest that any trans awareness training delivered to practitioners needs to be fully inclusive of non-binary identities. Training should reflect that trans people's experiences are diverse and are likely to be impacted by whether or not they have medically transitioned, their sexual orientation, and life experiences.

## 8.2. Registration and forms

We talked to sexual health practitioners about how they would gather information from a patient about their background, sexual history and reason for their visit. Most told us that, if a trans person had previously attended the clinic or had accessed gender identity services, then they would be able to see this on the electronic patient record. This may include a note of a person's new name and their pronouns.

One interviewee said that background information, including pronouns, would be collected on an initial intake form:

*The pronoun stuff and what people want to be called, and whether they want to have male or female tests [will] be dealt with by our reception staff. So when you come in, there's a piece of paper and you can fill in all your demographics and things in that.*

Most clinics used some form of initial registration form, but practice appeared to vary in terms of how these asked about gender and whether sharing pronouns was an option. One clinic asked people whether they were male, female or transgender, while another asked only if the person was male or female because:

*If they're a new patient to us, we have a patient information document... I'll see if I can find it. I think [my colleague] has pointed that out and I think we only ask male or female on that because, from our point of view, if you've got trans male, they're identifying as either male or female. So then to make an issue of them being trans, I don't know whether this is right or wrong, because if you've got a trans woman, they're a woman. Should we be specifically asking each patient that comes in, 'Are you a trans woman?' I don't know whether that's the right answer or not.*

One practitioner, who also had experience of working in gender identity services, said that they were conscious that current intake forms were not as inclusive as they could be. However, when we raised the possibility of asking about gender using the template provided in BASHH (2019) guidance (first asking the person their gender and then if this is the same as the sex they were assigned at birth), they expressed reservations. The interviewee explained:

*My colleagues [and] I think I would share some anxiety about, if you ask everybody to complete that, you're probably going to have more conversations explaining to people who don't understand why the questions might apply to them, or how they're supposed to answer them, than would actually give you a benefit. If it becomes a source of confusion, it ceases to provide that information that you're looking for, because people aren't filling it in properly. If you ask everybody about the sex they're assigned at birth and people don't understand that question properly, nobody will pay attention to it properly...Whereas, I think we are probably going towards just having a blank space for gender and I guess, people will have the opportunity to write what they would like to and they can choose what they want to disclose then. It's probably a better way...It's difficult because it's not as inclusive as I'd like it to be, but I worry that if you have something that doesn't perform well, people start to mistrust it, so they don't actually pay attention to it.*

It is important to note that an open text box asking about gender would not necessarily enable practitioners to identify if a person was trans. This would still need to be followed up with a second question, asking if the person considered themselves to be trans or if their gender was the same as the sex they were assigned at birth.

It is also worth highlighting that National Records of Scotland (NRS) have introduced a two-part question about sex and gender for Scotland's 2022 census. This question asks respondents first whether they are male or female, and then whether they consider themselves to be trans or have a trans history. This question has undergone public acceptability, cognitive, and quantitative testing, which showed that it was acceptable to the general population and produced good quality data (NRS 2018). As detailed in our recommendations, we therefore advise that clinics adopt a similar format in digital or paper registration forms, first asking the patient their gender and then whether they consider themselves to be trans.

As some interviewees highlighted, information on registration forms and in a person's electronic notes was only useful if practitioners read the notes before an appointment. One person we spoke to stressed the importance of this:

*I think we've all been, not necessarily caught out but I can remember one young man coming in to see me, chatting away, absolutely fine and I'd not been here that long. We were*

*talking about the various tests that we were going to do. He asked me for a pregnancy test. Very quickly in my head I thought it's the one time. I was running late and hadn't had the chance to look at the clinical notes and had I done I would have realised [he] was a trans man. So, professionally I was just like, 'Yes, absolutely, of course' and you do it, but then in hindsight you think to yourself, had I read the notes I would have been forewarned that that man is a trans man but actually hadn't undergone any sort of transformation operations or anything at that point. So, yes. That's one thing we always educate the staff. Before you call somebody, just have a quite look at their notes. Give yourself a bit of an idea.*

*I usually start off with, 'Are you in a relationship at the moment?' If they are, 'Is that a male, female...' And that then informs what your next set of questions are going to be and then, what type of sex they're engaging in, is it vaginal, oral, anal?*

Similarly:

*I always start off with medical history and allergies. The next bit of NaSH, the computer system we use, is lifetime sexual history. That's where it has the questions about have you been sexually active? Has that sex always been with or without your consent or both? Have you ever had sex with anybody from abroad? How do you identify your sexual partners? Are they male? Female? Both? Other?*

### 8.3. Consultations

We asked interviewees about usual practice when carrying out a consultation, exploring how they would approach taking a sexual history and finding out why the person had attended the clinic. After asking about medical history, most practitioners told us they would take a sexual history. If patients were or had been sexually active, half of the practitioners we interviewed said that they would then ask whether the person's sexual partners were 'male, female or both'. One interviewee explained the process:



'There needs to be care throughout'

As the interviewee mentioned, this form of questioning is prompted by the options available on NaSH, the electronic records system used by sexual health services. We mentioned to practitioners the issues that gender-based questioning could create in terms of fully understanding a trans person's sexual history. Most practitioners said that they would follow on from a question about the gender of sexual partners with more detailed questions about the kind of sex a person was having:

***One of the first questions I'll ask is... 'Are you sexually active?'... because people might attend us when they're not sexually active, so are they sexually active, when was the last time they had sex, and are your partners male, female or both. I wouldn't generally ask them if they were trans straight out, but if that was something that they disclosed or it was part of that conversation, then you would want to know. If I was doing an STI screen, for example, for any patient you would want to know the sites of penetration. So are you talking about, is it oral, is it vaginal, is it anal?... So you would actually need to know what sexual intercourse they have, and we're fairly explicit in saying, 'Is it vaginal intercourse? Is it anal? Are you engaging in both?'***

However, another interviewee reflected that, even with more detailed questions about types of sex, they may not always ask about a person's position during anal sex if the patient was female:

***I suppose if they tell you they've got a female partner, I would still ask what type of sex they've been having, have they been having vaginal, oral, anal? If they have a female partner, they've been having anal sex, would I still ask? I was going to say at that point, I would still ask whether they were top, bottom or versatile but... well, actually, if that's female, I might not ask that question typically.***

Some practitioners told us that they did not use gendered terms when taking a sexual history, which we highlight as cases of good practice. One person explained:

***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.***

Another explained that they would avoid using gendered language until directed by the patient:

***We would say things like partner or not kind of use a pronoun if like assuming that's the one that's going to fit. We'll maybe wait for them to use one or something and then figure it out from there.***

One interviewee, who had experience of working in gender identity services, explained how they would avoid using the wording prescribed by NaSH when asking about sexual history:

*When I'm asking people about sexual history, because I know that's there, I'll just ask about, tell me about the gender or the anatomy of the person you had sex with, what sort of sex did you have, what did you do them, what did they do to you. It's the type of question I'll ask if somebody's prepared to answer that, and usually, that gets you to where you need to be. If somebody looks a little bit uncertain, it's like, I'm actually just trying to keep you safe here, so you don't have to answer my questions, but if you tell me exactly what happened, I can be sure to tell you everything you might want to be tested for or what you might want to know. I try and reassure somebody that I'm not being nosy, I'm just trying to keep everybody all right, really.*

## 8.4. Information recording

We asked practitioners about the issues raised in the previous chapter relating to the use of NaSH to record engagement with gender identity services, as well as other sexual health services. Many thought it was positive for wider sexual health services to access a person's gender identity records, and vice versa. A practitioner with experience of working in gender services explained:

*Information sharing provides much better medical care and the same with if you go to your GPs, and see different GPs with different problems, it would help, as the GP, to be able to see what that patient been in and had before. Say we have a hospital appointment, the notes in different clinics are seen by everybody... I can't see that it's a bad thing, because everything is confidential, and so if it's on the same note.*

While recognising the advantage that information sharing can bring from a clinic perspective, sexual health information is particularly sensitive. These sensitivities are why NaSH cannot be accessed by GP and other NHS services, as it enables people to be open about their sexual health history and needs. It is not unreasonable for people, who may not be familiar with the structure of NHS services and associated electronic monitoring systems, to assume that their general sexual health records would not be accessible to gender identity services.

Practitioners had mixed perspectives on whether and in what way a person's gender identity records would be used within sexual health services, and vice versa. Another interviewee with experience of working in gender identity services said:

*There's a huge advantage to having gender records in there, and gender services are part of sexual health, so it's not that they're in the wrong place, it is actually where they belong. If somebody really wanted everything to be separated, I think I'd want to probably have a quick conversation as to what*

*the rationale was for that. There would be a way to do it if that was really important to them, but we're not looking, we're not interested in somebody's sexual health records... If it went on to main hospital records, I think that would be exposed to a lot more people... I think it is part of your health record and it is kept very securely, and we really don't have time and we wouldn't look at things that weren't relevant to us, because that's not what we're here to do.*

Contrary to what this practitioner said about staff not having time to look at other appointment records, another interviewee suggested that they would look through a person's notes from the

gender identity service, as this would be good practice:

*It's important that the patients know why we know what we know. The reason that I know that is because their notes are there because these guys are in the same building as us, and it's almost good practice to flip through.*

This suggests some inconsistency among practitioners around when they might access a person's gender identity service records and why this would be done. It would be helpful to have clarity and consistency about this, as is reflected in our recommendations.


## Practitioner perspectives: summary

### Barriers

- ✘ Fear of saying the wrong thing
- ✘ Low awareness of non-binary identities
- ✘ Lack of training on trans identities and sexual health needs
- ✘ Reliance on gendered terminology when taking sexual history

### Facilitators

- ✔ Being patient-led, open, caring, non-judgemental and acknowledging service user's expertise about their own life and identity
- ✔ Access to training and expert sources of advice, including guidance on how to ask questions about gender and sexual activity in an inclusive way
- ✔ Time to review a patient's notes prior to a consultation



## Chapter 9: Conclusion and Recommendations

In this final chapter, we summarise key findings and outline a series of recommendations to NHS sexual health services, third sector sexual health and blood borne virus (BBV) organisations, trans advocacy organisations, and the Scottish Government.

Our quantitative findings demonstrated that while many trans people have had positive experiences of accessing sexual health services, there is more to be done to ensure services are accessible to all people in need of sexual health care. In particular, our quantitative findings highlighted that further work is required

to make sure trans people at risk of contracting HIV can access NHS PrEP. Using a socio-ecological model, our qualitative findings provided detailed insight into factors that can prevent and enable trans people to engage with sexual health services, as summarised in the table below:

	✘ Barriers	✔ Facilitators
<b>Individual</b>	Fear	Feeling listened to and cared for by sexual health practitioners
	Understanding risk factors	Energy and knowledge to self-advocate
<b>Social/ community</b>	Being prevented from having a companion at appointments	Support from friend or partner at appointments
	Inconsistent/unreliable information from community sources	Involvement of trans community in NHS/third sector service delivery Access to sexual health information within community spaces (both online and in physical spaces)
<b>Organisational</b>	Lack of geographic and disabled access	Varied access options, including face-to-face and digital access options
	Gendered environment within services, e.g., in leaflets or when a sexual history is taken	Relaxed, non-clinical, and gender-neutral waiting spaces, separate from gender service waiting area
	Lack of knowledge of trans sexual health needs among practitioners	Genuine listening, care and concern from practitioners, with a willingness to address gaps in knowledge
	Lack of tailored sexual health promotion resources for trans people	Non-assuming approach from practitioners, avoiding assumptions about gender, pronouns, or sexual activity
	Lack of transparency and consistency around use of NaSH	
<b>Policy</b>	Transphobia, linked to reform of GRA	Service providers showing that they are trans allies
	Austerity	

Our interviews with practitioners provided further insight to factors that can enable or limit sexual health service providers from delivering trans-inclusive care, as summarised below:

✘ Barriers	✔ Facilitators
Fear of saying the wrong thing	Being patient-led, open, caring, non-judgemental and acknowledging service user's expertise about their own life and identity
Low awareness of non-binary identities	Access to training and expert sources of advice, including guidance on how to ask questions about gender and sexual activity in an inclusive way
Lack of training on trans identities and sexual health needs	
Reliance on gendered terminology when taking sexual history	Time to review a patient's notes prior to a consultation
Not checking a patient's notes prior to a consultation	

We have used these findings to produce the following set of recommendations, many of which reflect existing BASHH (2019) recommendations for integrated sexual health services for trans, including non-binary, people.

## 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 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.

## 9.1 Final comments

**As noted in our introduction, we carried out this research with no appreciation of the significant impact COVID-19 would have on the delivery of health services.**

Almost overnight, the NHS and third sector had to change and adapt how essential sexual health services were delivered. This has prompted the rapid expansion of innovative approaches to service delivery, such as video consulting and HIV self-testing. Such approaches have overcome some of the barriers presented by the physical environment of a sexual health clinic or service, however, at the same time, new barriers have emerged, such as varying levels of access to technology and digital literacy. We now have an opportunity to radically rethink how sexual health care is delivered and, in doing so, must ensure accessibility and inclusivity are embedded within services. We look forward to working with the Scottish Government, the NHS, third sector partners, and the trans community to take our recommendations forward, ensuring inclusive and equitable access to sexual health services across Scotland.

## 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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